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December 1, 2025

The Honorable Bill Ferguson
President of the Senate
State House, Room H-107
100 State Circle
Annapolis, Maryland 21401

The Honorable Adrienne A. Jones
Speaker of the House of Delegates
State House, H-101
100 State Circle
Annapolis, Maryland 21401

RE: Report required by SB 684/Ch. 233, 2024 and HB 1074/Ch. 234, 2024 (MSAR 15467) – Final Report on Nonquantitative Treatment Limitations and Data

Dear President Ferguson and Speaker Jones:

Pursuant to Senate Bill 684 (Ch. 233) and House Bill 1074 (Ch. 234) 2024 (MSAR 15467), and in accordance with § 2-1257 of the State Government Article, the Maryland Insurance Commissioner issues the Final Report ("Report") on Nonquantitative Treatment Limitations and Data to the General Assembly. The attached Report describes the mental health parity reports submitted by health insurance carriers on July 1, 2024 under § 15-144 of the Insurance Article. The Report also analyzes the efficiency and effectiveness of the reports.

Five printed copies of this report have been mailed to the Department of Legislative Services Library for its records.

Should you have any questions regarding this report, please do not hesitate to contact me or my Associate Commissioner of External Affairs and Policy Initiatives, Jamie Sexton, at Jamie.Sexton@Maryland.gov. .

Sincerely,

Marie Grant
Insurance Commissioner

cc: Sarah T. Albert, Department of Legislative Services (5 copies)

Nonquantitative Treatment Limitations and Data

2025 Final Report

SB 684/Ch. 233, 2024 and HB 1074/Ch. 234, 2024

Marie Grant
Commissioner

December 1, 2025

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This document is available in alternative format upon request
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The Administration's website address: insurance.maryland.gov

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Executive Summary

The Maryland Insurance Administration ("MIA" or "the Administration") is submitting this report regarding the review of analyses of nonquantitative treatment limitations ("NQTLs") submitted pursuant to § 15-144 of the Insurance Article.

Nonquantitative treatment limitations, or "NQTLs", are elements of a health plan's design or operations that may limit access to care, such as utilization review requirements or network composition. These may be important to control costs or ensure care meets quality standards, but may pose barriers to patients. It is important to ensure that the barriers are no worse for patients seeking mental health or substance use disorder care than for patients seeking medical or surgical care.

The MIA previously issued an interim report in December of 2023 that outlined issues with the filings that were received in 2022. There were no complete filings received for that filing year. The report made recommendations that were adopted in laws passed in 2024.

There are positive developments since the 2023 Interim Report was issued. Although carriers submit incomplete reports despite clear instructions from the MIA on submission, several carriers submitted complete reports for at least one NQTL after additional feedback was provided by the MIA. These reports could be reviewed for compliance with the Parity Act, and at least one was found compliant at the time of this report.

Changes to the law in 2024 meant that the MIA received more robust data, and could require more data supplements from carriers as part of their filings. Data related to outcomes and disparities in access is essential to identify areas of potential noncompliance. The data show the effects on consumers. As carriers become more accustomed to measuring outcomes, it is hoped that future reports will provide stronger explanations of discrepancies in the data.

For the incomplete submissions, the MIA is issuing orders with penalties for failure to submit complete reports. For complete, but non-compliant, submissions, the MIA has begun issuing notices of noncompliance to the carriers as required by the statute.

Legislative History

Maryland has a long history of requiring health plans to provide mental health and substance use disorder benefits. Over time, the approach has been strengthened to provide greater consumer protections. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA" or "Parity Act") is a federal law that imposed additional requirements for coverage of mental health and substance use disorders ("MH/SUD") to be comparable to coverage for medical and surgical ("M/S") services. Maryland law changed to meet these requirements.

On April 23, 2018, the United States Department of Labor ("DOL") published a detailed Self-Compliance Tool for the Parity Act, and committed to periodically update this tool. The

2020 Self- Compliance Tool includes a section describing best practices for NQTL analyses, which closely mirrors the analysis process described in § 15-144 of the Insurance Article. The 2020 Self-Compliance Tool also highlights the importance of measuring quantitative outcomes data as part of the comparative analysis for NQTLs and provides guidance on reimbursement comparisons, measurement of denial rates, as well as others.

At the end of 2020, the United States Congress enacted the Consolidated Appropriations Act of 2021 ("CAA"), which codified a requirement for health plans and carriers to conduct and document a comparative analysis of the design and application of all NQTLs imposed by the plan. The comparative analysis described in the CAA followed the same process outlined in the DOL 2020 Self-Compliance Tool and § 15-144 of the Insurance Article. The CAA also required health plans and carriers to make their comparative analyses available to applicable federal and state agencies upon request beginning on February 10, 2021. Thus, with the passage of the CAA, the required process for performing and documenting an NQTL comparative analysis under federal law aligned with Maryland law. The Departments of Labor, Health and Human Services, and Treasury (the "tri-agencies") jointly published FAQ, Part 45, on April 2, 2021 to provide guidance related to the Parity Act requirements under the CAA. Much of the FAQ, Part 45 guidance was incorporated into the MIA MHPAEA Compliance Reporting Instructions for NQTLs.[1]

Chapters 211 and 212, Laws of 2020, created § 15-144 of the Insurance Article to require biennial reporting of NQTL analyses as part of Maryland law. The MIA held workgroups and received comments from stakeholders in 2020 and 2021. The MIA received the first filings of MHPAEA compliance reports on March 1, 2022. The MIA submitted an interim report on the law to the General Assembly on December 1, 2023 ("2023 Interim Report")[2]. The report noted numerous problems with the filings submitted by carriers, and provided recommendations to improve the law.

In the 2024 legislative session, House Bill 1074 and Senate Bill 684 were passed as emergency measures to enact many of the recommendations in the 2023 Interim Report.[3]

Key changes in the 2024 law for filings:

- Each carrier subject to § 15-144[4] must submit an NQTL report for each product offered by the carrier in the individual, small, and large group markets. In 2022, carriers had to identify the five health benefit plans with the highest enrollment for each product and submit a separate report for each of those health benefit plans. For 2024 and subsequent years, NQTL reports should be completed at the product level.
- The filings must include a statement that for each product, the NQTLs listed and the processes, strategies, evidentiary standards, or other factors used in designing and applying those NQTLs to mental health benefits, substance use disorder benefits, and

[1] *See* Workgroups.
[2] *See* 2023-Interim-Report-on-Nonquantitative-Treatment-Limitations-and-Data.pdf.
[3] Id.
[4] All statutory citations herein are to the Insurance Article, Maryland Annotated Code, unless otherwise noted.

medical/surgical benefits, are the same for all plans within the product, as written and in operation. If the carrier is unable to provide this attestation for any product, the carrier must note the exception(s) and must submit a separate comparative analysis and related data supplement for the applicable plans within that product that impose different NQTLs or use different factors.

- Section 15-144 requires that the Commissioner may select no fewer than five NQTLs. Of these, not more than two may be for utilization review (such as prior authorization, concurrent review, or retrospective review) and at least one must be for network composition, which can include reimbursement rate setting.

  The changes also gave the MIA additional enforcement tools.

Implementation of Parity Act Reporting in Maryland after 2023

The 2023 Interim Report[5] provided a detailed discussion of the implementation of the Parity Act including the process used by the MIA to develop template reporting forms, data supplements, and regulations for the 2022 filing year. Following the submission of the 2023 Interim Report[6] and subsequent legislative changes adopted by the Maryland General Assembly, the MIA revised the NQTL reporting requirements and timing. These changes are summarized below.

Context for the MIA's Regulatory Approach

Prior to and following passage of Chapter 212 of the Laws of 2020, the MIA experienced significant challenges in obtaining sufficient documentation of complete NQTL analyses from carriers. Although federal law required carriers to perform and provide the analyses upon request, the documentation submitted by carriers overwhelmingly did not reflect a full analysis of NQTLs. When the filings were required in 2022, carriers did not always follow the instructions and none of the filings were sufficient to determine substantive compliance with the Parity Act. For the 2022 filing year, the MIA also experienced challenges reviewing the volume of material contained in the NQTL reports, which included 213 plans submitted by 17 different health insurance carriers.[7] These reports were at the plan level, and many duplicated information for similar plans. Each plan might cover a relatively small number of people, so data were difficult to analyze meaningfully. As described in the 2023 Interim Report[8], "MIA determined that the reports submitted by carriers were uniformly and significantly inadequate, impeding the ability to reach parity determinations."

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[5] *See* 2023-Interim-Report-on-Nonquantitative-Treatment-Limitations-and-Data.pdf.
[6] Id.
[7] For clarity, the report may use the term "health insurance" to refer to health plans issued by entities such as health maintenance organizations and nonprofit health service plans, and may use the term "carriers" to include all of the entities that may issue health plans subject to reporting requirements.
[8] *See* 2023-Interim-Report-on-Nonquantitative-Treatment-Limitations-and-Data.pdf.

For the 2022 filings, the MIA worked with experts on MHPAEA enforcement, and contractual employees with expertise in the reviews. The MIA reviewed other states' requirements for NQTL filings for guidance, and participated in the National Association of Insurance Commissioners' working group for MHPAEA. The MIA continued this approach for the 2024 filings. These factors contributed to making the MIA's approach consistent with the best practices from other jurisdictions.

The MIA has, in part, addressed staffing issues through the use of services from a vendor selected through the State's procurement process. This has added additional reviewers with prior experience in reviewing NQTL analysis reports. MIA supervisors or managers carefully review the work to ensure it complies with specific Maryland laws and the MIA's interpretation of § 15-144. For most of 2025, there was a full time Director of the unit. The Director has since departed and MIA is actively recruiting for the role, but has been able to allocate other staff and resources to completing the work.

NQTL Selection

On February 13, 2024, the MIA issued Bulletin 24-5[9] in response to emergency legislation enacted by House Bill 1074 and Senate Bill 684, indicating potentially changing reporting requirements to be implemented close in time to due dates for MHPAEA reports already in existence. The MIA delayed the filing deadline for the 2024 NQTL reports from March 1 to July 1, 2024, so that the reports could incorporate the changes made to the laws by the pending legislation, which was approved by the Governor on April 25, 2024.

Consistent with the requirements of § 15-144(c)(5) of the Insurance Article, the Commissioner prioritized NQTLs considered to have the greatest impact on access to care. Section 15-144 requires that the Commissioner may select no fewer than five NQTLs. Of these, not more than two may be for utilization review (such as prior authorization, concurrent review, or retrospective review) and at least one must be for network composition, which can include reimbursement rate setting.

The MIA announced the required NQTLs via a Bulletin 24-10[10] on April 15, 2024. The NQTLs were:

1. Prior Authorization Review Process
2. Prescription Drug Formulary Design
3. Provider (Including Facility) Reimbursement
4. Strategies for Addressing Provider Shortages
5. Provider Network Directories

[9] *See* 24-5-2024-Mental-Health-and-Substance-Use-Disorder-Analysis-Reports-and-Data-Reports.pdf.
[10] *See* 24-10-2024-Mental-Health-and-Substance-Abuse-Disorder-Analysis-Reports-and-Data-Reports.pdf.

Of these five NQTLs, and in accordance with the new provisions of § 15-144(c)(5)(ii), one was for utilization review – NQTL 1 Prior Authorization; two addressed network composition – NQTL 3 Provider (Including Facility) Reimbursement and NQTL 4 Strategies to address Provider Shortages; and two addressed frequent consumer concerns with access to medicines and in-network providers – NQTL 2 Prescription Drug Formulary Design and NQTL 5 Provider Network Directories.

Template Reporting Forms

As it did in 2022, the MIA used its internally developed reporting form and instructions to guide the carrier through the required seven-step analysis and disclosure requirement reporting.[11] The MIA also developed data supplements to assist in identifying potential violations for each NQTL. The MIA provided detailed instructions on filings on its website.[12]

The 2024 form and format of the template reporting form were generally consistent with the 2022 template developed by the MIA, with some modifications to streamline the form and eliminate unnecessary submission of information. The form requires the carrier to list product and plan information, and each covered service with an indication of whether the covered service is considered M/S, MH, or SUD. The form then requires the carrier to identify the Parity Act benefit classifications and sub-classifications for the covered service. For each NQTL, the template requires carriers to proceed through seven steps that are sequential and directly related to one another. In Step 1, the carrier is asked to discuss the benefits, provider type, drugs, etc. that should reflect the covered services listed under the benefit classifications section. In Step 2, carriers are asked to identify the factors and the source for each factor used to determine it is appropriate to apply each NQTL to each classification, sub-classification, or certain services within such classification/sub-classification for both MH/SUD and M/S benefits. Step 3 asks carriers to define each factor, including the specific evidentiary standard(s) for each of the factors, and any other evidence relied upon to design and apply each NQTL. Step 4 asks carriers to provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written, to MH/SUD benefits than to M/S benefits. Step 5 requires carriers to provide analysis to confirm the written policies from step 4 are functioning as intended in operation. Step 6 summarizes the plan's efforts to coordinate with its delegated entities, if any, on MHPAEA analysis activities. In Step 7, carriers summarize their MHPAEA compliance findings from the analysis, including the data supplement report. The analysis report form includes separate sections for the carrier to provide information on each of the elements specified in § 15-144(c)-(e) for the five different NQTLs.

Each element of the analysis builds on the prior steps. The factor definitions and evidentiary standards of Step 3 build on the factor and source list of Step 2. The comparative analysis of the NQTL as written draws from the definitions and evidentiary standards of Step 3. The comparative analysis of the NQTL in operation proceeds from the analysis of the NQTL as

[11] *See* Appendix A.
[12] *See* Workgroups.

written. The final analysis of compliance is based in large part on the analyses in Steps 4 and 5, with further discussion and explanations of any disparities shown in data reporting. A carrier that fails to provide sufficiently detailed and specific information for Steps 2 and 3 will have difficulty performing the analysis required by Steps 4 and 5. To complete Step 7, a carrier needs to have adequately conducted the analyses in Steps 4 and 5 and be able to discuss the data supplements.

As required by § 15-144(e)(7), carriers must identify the process used to comply with the Parity Act disclosure requirements for MH benefits, SUD benefits, and M/S benefits. Specifically asking the carriers to report the process for disclosing the criteria used for a medical necessity determination for MH and SUD benefits; the process for disclosing the reasons for a denial of benefits for MH and SUD; and the process for disclosing plan documents that contain information about the processes, strategies, evidentiary standards and any other factors used to apply an NQTL for MH/SUD and M/S benefits in connection with a member's request for group plan information and for purposes of filing an internal coverage or grievance matter and appeals.

Instructions Specific to Particular NQTLs

The MIA's instructions provided both general guidance on completion of the template and data supplements, and also instructions specific to each NQTL.

For NQTL 1, Prior Authorization, carriers were told that there were three components of the process that every analysis was required to address:

- First, a comparative analysis must be provided for the processes, strategies, evidentiary standards, and all factors the carrier uses to determine the list of services/benefits that are subject to a prior authorization requirement.
- Second, a comparative analysis must be provided for the administrative processes, including timelines, that the provider/member must use when submitting a prior authorization request, and that the carrier adheres to when processing the request.
- Third, a comparative analysis must be provided for the criteria the carrier uses to determine whether to approve or deny prior authorization requests when reviewing the underlying services for medical necessity, level of care, appropriateness, or other applicable considerations.

Carriers were also instructed to include a description of the consequences or penalties that apply when the NQTL requirement is not met, e.g. whether failure to obtain prior authorization would result in denial or reduction of benefits.

For NQTL 2, Prescription Drug Formulary Design, the MIA directed carriers to address how formulary decisions, including tier placement, specialty designation, and exclusions are made for the diagnoses and medically necessary treatment of M/S and MH/SUD conditions. Carriers were also required to include pertinent pharmacy management processes, such as

generic substitution and step therapy, and the exception process for any step therapy or formulary limitations.

For NQTL 3, Provider Reimbursement, the MIA instructed carriers to address the process for determining reimbursement rates for in-network and out-of-network providers, and to provide separate analyses for practitioners and facilities under each applicable benefits classification or subclassification. Carriers' responses are required to include consideration of Maryland law establishing rate methodologies for particular services or providers.

For NQTL 4, Strategies for Addressing Provider Shortages, the MIA told carriers to address all considerations taken into account by the carrier when evaluating whether the provider network is sufficient to meet the needs of members, beyond compliance with minimum standards for network adequacy. The MIA laid out specific questions to be addressed:

- Does the carrier set its own standards for network sufficiency for any provider types that are in excess of the minimum standards required under Maryland regulations, COMAR 31.10.44? If so, which provider types, and what is the rationale for establishing additional standards for these particular provider types?
- How does the carrier determine if the need for a specific provider type justifies negotiating fee schedules, or offering incentives to join the network?
- Does the carrier audit its reimbursement rates at the upper percentiles (e.g. 75th and 95th) to assess the rate that will incentivize providers to join networks?
- How does the carrier determine which providers are eligible for performance/quality bonuses?
- How does the carrier determine the amount of performance/quality bonuses that a provider may be eligible for?
- Does the carrier negotiate fees or differentiate fee schedules based on provider group size?
- How often does the carrier assess for provider shortages, and what is the process for making the assessment?

For NQTL 5, Provider Network Directories, carriers were directed to address all considerations taken into account in the design and maintenance of the directory, with a particular focus on the comparability between M/S and MH/SUD in the accuracy of the directory and the level of specificity with which provider information is displayed and searchable. Carriers were directed to address specific questions:

- What is the process for updating the directory and correcting inaccurate information? This includes the process for adding new participating providers to the directory, removing providers from the directory who are no longer participating, and updating provider-specific information displayed in the directory for existing participating providers.

- What methods are used for obtaining and verifying each type of provider-specific information displayed in the directory?
- What methods are used for verifying that a provider listed in the directory continues to participate as an in-network provider?
- How does the carrier determine which specialty, subspecialty, and facility types will be displayed in the directory and which specialty, subspecialty, and facility types will be separately searchable?
- How does the carrier determine which types of specific services offered by providers will be displayed in the directory and which services will be separately searchable? This question is focused on how the carrier selects the universe of possible services that may be listed in the directory, not how the carrier determines which services are offered by a particular provider.
- Is there a limit on the number of specialty areas or types of services that can be attributed to a single provider listed in the directory?
- What, if any, additional assistance does the carrier provide to members who have difficulty using the directory to locate an available provider with the necessary training and expertise to treat the member without unreasonable delay or travel?

Data Supplements

Consistent with § 15-144(f), the MIA developed additional standardized data templates. The purpose of the data templates was to identify a measure of whether the NQTL was comparable in operation. Building on its experience from the 2022 reporting year,[13] the 2024 reports required five data templates, one for each NQTL, to facilitate comparisons of outcomes data between M/S and MH/SUD. While outcomes data cannot prove compliance or noncompliance with the Parity Act by itself, it is an essential component of a complete "in operation" comparative analysis. Carriers were directed to address disparities in data between MH/SUD and M/S in Step 7 of their reports. Each data supplement is briefly described below:

- Data Supplement (DS) 1 is required to support the in-operation analysis for the prior authorization process NQTL report. Originally developed for the 2022 NQTL reports which included concurrent and retrospective reviews, DS1 requires carriers to report information related to the number of prior authorization reviews conducted and approved by benefit classification, in-network/out-of-network, and whether the service was mental health/substance use disorder. DS1 also collects data related to fail-first requirements and member requests to receive services from an out-of-network provider pursuant to § 15-830 of the Insurance Article.

[13] The Mental Health Treatment and Research Institute issued a brief dated December 23, 2021 on Maryland's, and other states', use of data supplements to assess NQTL compliance: https://filesmhtari.org/NQTL_Issue_Brief.pdf.

- DS 2 is required to support the in-operation analysis for the prescription drug formulary design NQTL report. Originally developed for the 2022 NQTL reports, DS2 requests specific data on prescription drug formulary exception requests, and is required to support the in operation analysis for the NQTL of prescription drug formulary design. Based on the 2022 submissions, the original 2022 DS was modified to request more specific information on categories within the formulary, rather than asking about the entire formulary.

- DS3 is required to support the-in operation analysis for the reimbursement NQTL report. Originally developed for the 2022 NQTL reports, DS3 requires carriers to report data on the weighted average allowed amounts for specific CPT codes for four groups of providers: primary care physicians; non-psychiatrist M/S specialist physicians; psychiatrists; and psychologists and clinical social workers. DS3 calculates plan weighted average allowed amounts as a percentage of the national Medicare fee schedule.

- DS4 is required to support the in-operation analysis for the NQTL of addressing provider shortages. Developed for the 2024 NQTL reports by the MIA, DS4 requires carriers to report information related to their networked providers including the number of professional providers in the network, percentage of providers with a negotiated fee schedule, and percentage of providers whose contracts included a bonus potential. DS4 also requires carriers to report information on out-of-network claims utilization for M/S and MH/SUD providers for four types of services: acute inpatient facility states, sub-acute inpatient facility stays, outpatient facility stays, and office visits. DS4 calculates the difference in the percentage of submitted claims for out of network services for MH/SUD compared to M/S as well as how often MH/SUD services were provided relative to M/S services.

- DS5 is required to support the in-operation analysis for the NQTL of provider network directories. Developed for the 2024 NQTL reports by the MIA, DS5 requires carriers to report the number of M/S, MH, and SUD providers and facilities listed and searchable in the directory and the number of these providers listed, searchable and accepting new patients. DS5 also requires carriers to report the number of providers in the directory who had not filed a claim for the six-month period prior to the end of the plan year by PCPs, non-PCP, non-psychiatrist medical/surgical specialist physicians, psychiatrists, psychologists, and clinical social workers.

In developing the data supplements, the MIA reviewed and incorporated elements of similar quantitative data templates being used by other states and the Mental Health Treatment and Research Institute. The MIA considered how to incorporate elements of Maryland law, such as § 15-830, to make the data supplements state-specific. The relationship of the data supplements to the NQTL was also reviewed carefully.

Receipt and Preliminary Review of 2024 Reports

Section 15-144 requires each carrier to submit a separate NQTL analysis report for each product offered by the carrier in the individual, small group, and large group markets. Student health plans are considered part of the individual market under § 15-144, in accordance with the federal definition of individual health benefit plans. Short-term limited duration health plans are also considered part of the individual market, and carriers offering those plans were required to file analysis reports.

"Product" was defined in the MIA's 2024 MHPAEA instructions consistent with the definition stated in § 15-1309(a)(3): "a discrete package of health benefits that are offered using a particular product network type within a geographic service area. 'Product' comprises all plans offered within the product." This definition allows plans that had reports filed separately to be combined in one report when the NQTL was consistent across the plans.[14]

The Maryland General Assembly adopted product level reporting in 2024 in order to reduce the burden on the MIA and carriers. In 2022, carriers submitted separate reports for each of the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small group, and large group markets. This led to a large number of filings, but data reports for each filing were sometimes small numbers that did not provide useful information. Reporting at the product level provides a larger group for data sets.

The MIA's instructions to carriers stated, consistent with § 15-144:

> However, if, for any plan within a product, the processes, strategies, evidentiary standards, or other factors used in designing and applying the reported NQTLs to mental health benefits, substance use disorder benefits, or medical/surgical benefits are different, as written or in operation, from the other plans within the product, a separate analysis report shall be submitted for that plan. In this case, the information described above should be provided at the plan level instead of the product level.

The Administration intentionally sought to educate carriers about this reporting change through Bulletin 24-10[15], and explicitly discussed the change in the 2024 MHPAEA Compliance Reporting instructions posted on the Administration's website.

An NQTL Comparative Analysis Report includes narrative and tabular information described above and plan documents. Plan documents can include documents in which the carrier describes a requirement related to an NQTL, or the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, including a policy, certificate of coverage, medical policy, medical necessity criteria or guidelines, or provider manual. Plan documents can also include any document reflecting analyses conducted or results from such analyses related to the comparability and stringency of an NQTL for mental health/substance use disorder benefits as compared to medical/surgical benefits.

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[14] *See* Appendix A.

[15] *See* 24-10-2024-Mental-Health-and-Substance-Abuse-Disorder-Analysis-Reports-and-Data-Reports.pdf.

Following receipt of the NQTL report, the submission is reviewed by staff of a vendor selected through the State procurement process or MIA contractual employees to assess compliance with the reporting requirements. A manager or supervisor at the MIA then reviews and edits the memo to the carrier. It has been the practice of the Administration to issue detailed memoranda, letters of determination, and Orders, outlining specific deficiencies in the NQTL reports and providing additional deadlines by which corrected reports can be submitted and reviewed. These detailed memos can be more than 20 pages and generally included more than 50 deficiencies upon initial review. For the 2022 filings, the MIA combined NQTLs into a single letter to the carriers; for 2024 filings, the MIA sent a letter to each carrier for each NQTL. This process allowed the MIA to move more efficiently through reviews.

Preliminary Filing Issues

For 2024 carriers, including those that offered only student or short-term limited duration policies, were required to submit a complete NQTL report to the Commissioner for each product offered by the carrier in the individual, small, and large group markets by July 1. As of July 1, 2024, the MIA received reports from 17 different carriers, representing seven different corporate groups. Despite extensive discussion during the 2024 legislative session and formal and informal communication from the Administration, all 17 carriers failed to provide the NQTL analysis reports and data supplements that met all of the requirements of § 15-144 of the Insurance Article and the filing instructions provided by the MIA. Based on the initial filing review, the Administration identified numerous filing errors. For example, one carrier did not file analysis reports for large group products.

Carriers struggled to provide the templates at the distinct product level. Several large carriers aggregated products across markets instead of providing reports for each product and market. Other carriers filed information at the plan level despite the legislative change to require product-level submissions.

Carriers also inappropriately combined data supplement submissions for multiple products, even if the data supplement required product level information. For example, one carrier filed one Data Supplement 5 for all products across all affiliated companies. Another carrier submitted identical Data Supplements 3, 4, and 5 for multiple products and affiliated companies.

The MIA needed to address these overall filing issues before beginning to review the reports in detail. This took time and delayed the process to reach more specific and substantive reviews. Only when the carriers had submitted reports that appeared to be for the correct company and program could the MIA begin to review by NQTL.

In order to facilitate review, the Administration reviewed one submission from each carrier or corporate entity for each NQTL. The Administration instructed the carrier to carry out any revisions to its other submissions as appropriate based on the reviews.

In-Depth Reviews

Once review of specific NQTL reports began, the Administration found deficiencies with the reports that needed to be addressed. A typical error would be that Step 3 did not include definitions for all of the factors listed in Step 2. The Administration has worked to educate carriers on how to complete the report accurately. The MIA has also been available for meetings with carriers to answer questions and to discuss reviews.

Although initial reports were generally insufficient, there were at least three large carriers that submitted complete reports during the course of the reviews for one or more of their NQTLs. This is an improvement over the 2022 reporting review. The MIA was able to review these reports to determine whether the information provided in the reports reflects a Parity Act violation.

The MIA allowed for up to three rounds of insufficiency reviews for each NQTL for each large carrier that offers health benefit plans. This means that the MIA reviewed the NQTL, sent a letter detailing the insufficiencies, and reviewed the responses up to three times for each. The MIA also met as needed with the carriers.

Some submissions reflected a lack of understanding of the instructions for completing the report. One carrier asserted that tiering of prescriptions was not part of an NQTL analysis or part of the formulary design process. However, the definition of "Prescription Drug Formulary Design" states that it may include "processes to place drugs on specific tiers," and the instructions state that "[t]he comparative analysis for the Prescription Drug Formulary Design NQTL should address how formulary decisions, including tier placement… are made."

For Step 2 of each NQTL, carriers were directed to identify the factors, and the source for each factor used to determine whether to apply an NQTL. Examples were given, such as "excessive utilization." For Step 3, the carrier was directed to define the factor, and identify and define the evidentiary standards for each factor in Step 2. The instructions include examples, such as "[e]xcessive utilization may be considered as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care."

One carrier wrote "not quantifiable" in response to the MIA's questions about the evidentiary standards for factors. If an evidentiary standard is not quantifiable, then the carrier is required to supply a detailed and reasoned explanation of how the carrier ensures the factors are being applied comparably and no more stringently to MH/SUD services. A specific example was that "inadequate volume of existing peer-reviewed, evidence-based, scientific literature is not quantifiable" in response to the MIA's inquiry as to the number of publications needed to be considered adequate to demonstrate viability and low safety risk.

Carriers sometimes changed factors upon resubmission in response to the Administration's questions. For the Prior Authorization NQTL, one carrier stated that the National Committee for Quality Assurance ("NCQA") standards were a factor used to establish the administrative process for prior authorization for prescription drugs. When asked to describe the specific NCQA standards, the carrier responded that NCQA was identified in error. The same

carrier also failed to explain the evidentiary standards for other sources such as "published peer-reviewed clinical literature" and asserted that the MIA misunderstood the law requiring the carrier to explain how the factor was being applied comparably and no more stringently when there were no evidentiary thresholds.

These examples are provided to illustrate the challenges in reviewing the reports to determine whether there was sufficient information to determine whether NQTLs were being applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. When carriers failed to provide clear information in the early Steps of the template, it was not possible for them to provide an analysis of comparability in writing and in operation, or of compliance, as required by the later Steps.

Complete Reports

At the completion of up to three reviews of each NQTL, Aetna, Cigna, CareFirst, and Kaiser Permanente all submitted at least one complete analysis report for a total of eight complete reports received. The MIA appreciates the cooperation displayed by the carriers in this process. Of the complete reports, three were found to demonstrate compliance with the Parity Act. The complete reports that demonstrated compliance were for Provider Directories and Disclosure Requirements.

Complete reports that did not demonstrate compliance with MHPAEA were for Provider Directories, Provider Reimbursement, and Addressing Provider Shortages.

For the determination of a violation for Provider Reimbursement, a carrier submitted a provider fee schedule and fee exceptions policy only for MH/SUD providers. The carrier did not have corresponding documents for medical/surgical providers. The carrier will be directed to submit a compliance plan to have comparable written processes for both MH/SUD and medical/surgical services.

Another carrier was also found to have a violation for its provider reimbursement policies. For medical/surgical non-physician practitioners, the carrier reported that the average contracted rate was 115% of Medicare rates, but for MH/SUD, the average rate as a percentage of Medicare was 100%. The carrier did not provide a sufficient explanation of the disparities in discussion of how the reimbursement was comparable and not more stringently applied to MH/SUD to resolve concerns about the disparities in the data.

For the determination of a violation for Provider Directories, the carrier had differences in quality assurance monitoring for MH/SUD provider directories compared to medical/surgical provider directories. Both listed GeoAccess Analysis, customer and provider satisfaction survey results, and ongoing access and availability results, but medical/surgical procedures included wait-time monitoring. The data management for the two categories of providers is not the same. The data supplement for this NQTL showed that this carrier's PPO plan had 32% of primary care providers who were listed but had not filed claims in six months, 63.3% of medical/surgical specialists who had not filed claims in six months, but 58.3% of listed psychiatrists had not filed

claims in six months, 70.5% of listed psychologists had not filed claims in six months, and 77.5% of listed licensed clinical social workers had not filed claims in six months. These disparities suggest that a higher number of MH/SUD providers were not in fact actively participating in the network despite being included in the directory.

The MIA is issuing notices of noncompliance to the carriers pursuant to § 15-144(i)(1), which states:

> (i) (1) The Commissioner shall:
>
> (i) review each report submitted in accordance with subsections (c), (d), and (f) of this section to assess each carrier's compliance with the Parity Act for each Parity Act classification;
>
> (ii) notify a carrier in writing of any noncompliance with the Parity Act before issuing an administrative order; and
>
> (iii) within 90 days after the notice of noncompliance is issued, allow the carrier to:
>
> 1. submit a compliance plan to the Administration to comply with the Parity Act; and
>
> 2. reprocess any claims that were improperly denied, in whole or in part, because of the noncompliance.

After a carrier receives a notice of noncompliance, the carrier has the opportunity to submit a compliance plan, which the MIA can review and ensure that improperly denied claims are reprocessed.

The MIA received initial comments on the NQTL selection asserting that Provider Directories, Provider Reimbursement, and Addressing Provider Shortages were subsets of broader NQTLs related to provider credentialing and networks. However, it appears that focusing on a single issue within a broader category allowed carriers to submit compliant reports more easily.

Updated Perspective on NQTL Analysis

One area of improvement is that the MIA received sufficient reports from several carriers, albeit after initial reports that were insufficient. The reports on the Provider Directories were most likely to be sufficient, but the MIA also received sufficient reports for the NQTLs of Provider Reimbursement and Strategies to Address Provider Shortages.

The MIA continued to find that data supplements are useful to identify areas where further inquiry was necessary. Part of Step 7 of the NQTL reports was a requirement to address

disparities in the data that indicated that the NQTL was applied more stringently to MH/SUD than to medical/surgical services. The carriers had an opportunity in Step 7 to explain how they were in compliance with MHPAEA despite the data suggesting otherwise.

Enforcing the requirements that NQTLs are applied comparably, and no more stringently, to MH/SUD as compared to M/S benefits, requires detailed analysis. Early guidance from federal agencies indicated that outcomes data could be used to identify potential violations, but was not dispositive. Since then, it has become clear that outcomes data are a key piece of an analysis to determine compliance. Maryland, other states, and federal agencies have seen the importance of data.

The 2024 Report to Congress from the Departments of Treasury, Labor, and Health and Human Services described ways that reviews conducted at the federal level used data to determine compliance.[16] Some of the issues discovered are similar to the issues found by the MIA:

> Some plans and issuers minimize the importance of out-of-network utilization as a red flag by arguing that participants and beneficiaries seek out-of-network providers by choice. EBSA[17] acknowledges that some people may, at times, prefer out-of-network providers. Still, plans and issuers have failed to explain how these preferences alone could account for the vast disparities in out-of-network utilization for MH/SUD providers as compared to M/S providers that EBSA has seen in some of its investigations, and generally have failed to explain how they have ensured their NQTLs comply with parity requirements.
>
> For example, in one investigation, data showed that plan participants used out-of-network providers significantly more often for MH/SUD benefits than for M/S benefits. … In light of the specific disparities in processes, strategies, evidentiary standards, and other factors, as well as the out-of-network utilization rates that suggest potential disparity and noncompliance in operation, EBSA issued an initial determination letter citing the plan for violating MHPAEA's NQTL requirements. EBSA is working with the plan to develop a corrective action plan (CAP).[18]
>
> ***
>
> Because EBSA views high out-of-network utilization for MH/SUD services compared to M/S services as an indicator of concern, EBSA reviews out-of-network utilization data in all its cases investigating NQTLs related to network composition. Specifically, EBSA reviews plan data on how often participants and beneficiaries go to out-of-network providers for care.[19]
>
> ***

[16] *See* Appendix E.
[17] EBSA is the Employee Benefits Security Administration, within the Department of Labor.
[18] 2024 MHPAEA Report to Congress, p. 27.
[19] Ibid. p. 27.

> EBSA was particularly troubled by its secret shopper survey results that indicated many providers listed in network directories were not available for an appointment. As highlighted in Section II.A.1.a, only 8 to 28 percent of MH/SUD providers in each survey effectively offered the caller a way to obtain the services sought as compared to 24 to 37 percent of M/S providers.
>
> Moreover, if plans and issuers use their own inaccurate directory data that does not reflect the actual availability of their providers to patients to assess whether they meet network adequacy metrics, then those assessments may have little bearing on actual access to care under the plan.[20]

The experience of federal regulators is similar to that of state regulators, including the MIA. While data collection and analysis are not a formal part of the requirements, it is difficult for carriers to give a sufficient explanation of their processes and compliance with MHPAEA without using data in some ways.

Maryland works with insurance regulators in other states through the National Association of Insurance Commissioners ("NAIC"). The NAIC is divided into zones; Maryland is in the Northeast Zone. In 2024 and 2025 the Northeast Zone developed an NQTL narrative template and quantitative data supplement for prior authorization processes. Maryland played an active role in the process because of the State's previous experience reviewing prior authorization NQTL reports. Like Maryland's template, the Northeast Zone template includes asks for carriers to describe processes by benefit classification and in-network and out-of-network coverage, as well as demonstrate the comparability and stringency of the carrier's processes as written and in-operation. Similar to Maryland, the Northeast Zone's data template includes outcomes data including the total number of prior authorizations submitted and number approved. The Northeast Zone data supplement also collects more detailed information than Maryland's form including the number of prior authorizations approved after appeal and the median and average number of days to approval. Several states have used the template and its data tool for reports in 2025, either as a mandatory filing or a pilot program.

In August 2025, Connecticut announced that it would be requiring carriers to demonstrate compliance with NQTLs on an annual basis. Connecticut's 5-step analysis includes a requirement that carriers provide the comparative and stringency analysis on any NQTL data analytic final benefit outcome measure that produces a substantially non-comparative disparate result for MH/SUD benefits than for the similarly mapped Medical/Surgical benefit classification.[21] Connecticut reports that its NQTL reporting requirements start on March 1, 2026, and annually thereafter.[22]

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[20] Ibid. p. 32.
[21] Connecticut Insurance Department, The 5-Steps to Demonstrate NQTL Benefit Parity Compliance. Available at: https://portal.ct.gov/-/media/cid/1_bulletins/bulletin-mc-24b-5-step-instructions.pdf.
[22] Connecticut Insurance Department, MH/SUD Parity Submission Guidelines, August 15, 2025. Available at: https://portal.ct.gov/cid/-/media/cid/1_bulletins/bulletin-mc-24b.pdf?rev=db992bd678d8442e81ede88ad4172a89&hash=FA6891BFFE93BC8D9EE80AEBBBABCE09.

2024 Final Rule Non-Enforcement

On September 9, 2024, U.S. Departments of Health and Human Services, Labor, and the Treasury issued new final rules implementing MHPAEA. The rules became effective on November 22, 2024. The Department of Labor issued a fact sheet that highlighted that the rules:

- Make clear that MHPAEA protects plan participants, beneficiaries, and enrollees from facing greater restrictions on access to MH/SUD benefits as compared to M/S benefits.
- Reinforce that health plans and issuers cannot use NQTLs that are more restrictive than the predominant NQTLs applied to substantially all M/S benefits in the same classification. Examples of NQTLs include prior authorization requirements and other medical management techniques, standards related to network composition, and methodologies to determine out-of-network reimbursement rates.
- Require plans and issuers to collect and evaluate data and take reasonable action, as necessary, to address material differences in access to MH/SUD benefits as compared to M/S benefits that result from application of NQTLs, where the relevant data suggest that the NQTL contributes to material differences in access.
- Codify the requirement in MHPAEA, as amended by the Consolidated Appropriations Act, 2021, that health plans and issuers conduct comparative analyses to measure the impact of NQTLs. This includes evaluating standards related to network composition, out-of-network reimbursement rates, and medical management and prior authorization NQTLs.
- Prohibit plans and issuers from using discriminatory information, evidence, sources, or standards that systematically disfavor, or are specifically designed to disfavor, access to MH/SUD benefits as compared to medical/surgical benefits when designing NQTLs.
- Implement the sunset provision for self-funded non-federal governmental plan elections to opt out of compliance with MHPAEA.

These rules were an important step to implement the 2021 CAA provisions requiring NQTL analysis reports. In particular, the use of data to identify areas of differences in access to care related to the application of an NQTL, and that a material difference was a strong indicator of a MHPAEA violation, was a change from prior guidance. The fact sheet also made clear that states may request additional data for any particular NQTL in a comparative analysis.

On May 15, 2025, the tri-agencies announced that the Departments will not enforce the September 2024 Requirements Related to the Mental Health Parity and Addiction Equity Act Final Rule (2024 Final Rule) or pursue enforcement actions based on a failure to comply with the 2024 Final Rule.[23] The federal government has indicated that it is considering either revising or

[23] *See* *Statement of U.S. Departments of Labor, Health and Human Services, and the Treasury regarding enforcement of the final rule on requirements related to the Mental Health Parity and Addiction Equity Act | U.S. Department of Labor*.

rescinding the 2024 Final Rule[24] in response to the suit filed in the U.S. District Court by the ERISA Industry Committee.[25] The prior MHPAEA rules may still be enforced.

MIA has authority under § 15-144 of the Insurance Article to continue to enforce the requirements of the 2024 Final Rule under Maryland law until and unless the Rule is formally rescinded. In evaluating the potential impacts of the federal rule change, the Administration found that many of the provisions of the 2024 Final Rule are consistent with the MIA's interpretation and enforcement of the Parity Act under § 15-144 prior to the publication of the 2024 Final Rule. Even if the 2024 Final Rule is rescinded, the MIA would continue to enforce those requirements.

However, there are certain requirements under the 2024 Final Rule that are completely new and had not previously been required by the MIA. Specifically, the 2024 Final Rule clarifies that that for purposes of determining comparability and stringency under the design and application requirements of 26 CFR 54.9812-1(c)(4)(ii)(A), 29 CFR 2590.712(c)(4)(ii)(A), and 45 CFR 146.136(c)(4)(ii)(A), plans and issuers are prohibited from relying upon any factor or evidentiary standard if the information, evidence, sources, or standards on which the factor or evidentiary standard is based discriminate against mental health or substance use disorder benefits as compared to medical/surgical benefits.

Conclusions and Recommendations

There are encouraging signs that carriers are improving in some respects, as shown by the complete analysis reports that were eventually received for some NQTLs. Clearly, carriers also continue to struggle with providing analysis reports and data supplements that are complete and follow the instructions. When carriers succeeded in providing complete information, some were able to show compliance with the Parity Act. Where incomplete reports continued to be received or where compliance was not demonstrated, the MIA is actively pursuing next steps in enforcement actions to ensure carriers are complying with the Parity Act. The Administration continues to face challenges with hiring and retaining a Director to oversee the staff performing the reviews of the reports. State employee compensation is not competitive with private industry. The Administration continues to rely on staff through a vendor; the staff have extensive experience and expertise but are not State employees.

The Administration recommends continuing the current schedule and number of reports. It was possible to complete meaningful reviews in the two-year time frame for reviews. These are highly technical, detailed reports, and it requires significant attention to detail and knowledge of the Parity Act to review them. The reviews are time consuming, and the two year period allowed for complete reviews of representative reports.

[24] 26 CFR § 54; 29 CFR §2590; 45 CFR §146-147 (2025).
[25] *See* *Statement of U.S. Departments of Labor, Health and Human Services, and the Treasury regarding enforcement of the final rule on requirements related to the Mental Health Parity and Addiction Equity Act | U.S. Department of Labor*

The Administration also recommends specifically adding some provisions of the 2024 Rules to Maryland law. This would enhance consumer protections in the event that the 2024 Rule is repealed. The provisions that should be added include:

- Definitions of mental health and substance use disorder benefits that are consistent with generally recognized independent standards of current medical practice.
- A requirement that carriers collect and evaluate relevant data in a manner reasonably designed to assess the impact of each NQTL on relevant outcomes related to access to MH/SUD and medical/surgical benefits.
- A standard that if the data indicate that the NQTL contributes to material differences in access to MH/SUD benefits as compared to medical/surgical benefits, the differences will be considered a strong indicator of noncompliance.
- Requirements that the analysis reports include an explanation of the material differences shown by the data, and a discussion of actions taken to address the differences.

Maryland has a strong program to determine MHPAEA compliance in a way that is transparent and flexible. The current approach should be continued to benefit Maryland consumers.

APPENDIX

Appendix A

Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Reporting Instructions

Non-Quantitative Treatment Limitations (NQTL)

Seven Step Analysis

Data Reporting

Contact: mhpaea.mia@maryland.gov

Table of Contents

Introduction:

The analysis report template and supplements are prepared to satisfy the requirements of §15-144, Insurance Article, Annotated Code of Maryland, to create a standard form for entities to submit the NQTL report in accordance with subsection §15-144(c)-(f). The templates have been updated to reflect only the five NQTLs selected by the Commissioner for the 2024 reporting period. Carriers are encouraged to review the prior versions of the template forms posted on the MIA website for direction on how to document comparative analyses for additional NQTL categories not included on the 2024 template forms. These instructions include general guidance for performing and documenting comparative analyses for all NQTLs, as well as specific guidance related to the five NQTLs selected by the Commissioner for 2024.

Complete analysis reports must include all data and information identified in COMAR 31.10.51 and in these instructions in the manner and format specified. Section 15-144(j) describes the actions the Commissioner may take if a carrier fails to submit a complete report, including imposing administrative penalties, charging the carrier for any additional expenses incurred by the Commissioner to review additional reports, and ordering the carrier to cease or modify the disputed conduct or practice. The failure to submit a complete analysis report is a violation of the Mental Health Parity and Addiction Equity Act ("Parity Act").

Narratives and data shall be entered into the fields of the template or supplemental form.

In completing the analysis report, the analysis for MH may be combined with the analysis for SUD when the design and application of factors, processes, strategies, evidentiary standards, and sources are the same for both. If the design and/or application of factors, processes, strategies, evidentiary standards, or sources is different for mental health benefits vs. substance use disorder benefits as written or in operation, then mental health benefits and substance use disorder benefits shall be reported separately.

The steps outlined in these instructions are sequential and directly related to one another. The benefits, provider type, drugs etc. that are discussed in Step 1 should reflect the covered services listed under the benefit classifications section. Steps 2 and 3 are directly related and both must be addressed in the written policies analyzed in Step 4. Step 5 must consist of results of the reviews conducted to confirm the written policies from step 4 are functioning as intended, including any data and numerical results. Step 6 will summarize the plan's efforts to coordinate with its delegated entities, if any, on MHPAEA analysis activities. In step 7 carriers will summarize the MHPAEA findings from each step of the analysis including the data supplement reports. **Because of this, an incomplete response to any step in the process may render the response for an entire NQTL incomplete.**

The following responses are likely to occur when differences between M/S and MH/SUD covered benefits are not accounted for and may result in a finding that a carrier failed to submit a complete analysis report:

1. Production of documents without a clear explanation of how and why each document pertains to the comparative analysis. This includes how each document has been analyzed in a comparative manner and how the comparability and stringency NQTL tests have been met, both in writing and in operation;

2. Generalized statements concerning factors, processes, standards, procedures, etc., as well as mere recitations of the legal standard and conclusions regarding compliance, without specific supporting evidence and detailed explanations of comparative analyses;

3. Identification of factors, evidentiary standards, and strategies without a clear description of how the factors, evidentiary standards, and strategies are defined and applied for M/S or MH/SUD benefits;

4. Identification of processes, strategies, sources, and factors without the required clear and detailed comparative analyses;

5. Statements that all factors, evidentiary standards and/or criteria, processes and/or strategies are the same for M/S and MH/SUD without detailed definitions and specific comparative analyses for each factor, evidentiary standard, criteria, process, strategy, etc. that substantiate such statements;

6. Reference to factors, evidentiary standards, and/or criteria that inherently rely on quantitative measures and/or are defined or applied in a quantitative manner, without the precise quantitative definitions; note that the MIA may now require a carrier to establish specific quantitative thresholds for evidentiary standards and perform a new comparative analysis if the report is insufficient in this regard;

7. Responses that do not to include comparative analyses, including results, and information necessary to examine the development and/or application of each NQTL, and do not clarify the methodologies utilized for such comparative analyses**;**

8. Analysis that is not for the applicable time period;

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

10. Failure to include specific data used in an analysis or audit to determine whether the NQTL is comparable to and no more stringently applied to MH/SUD benefits than to M/S benefits in operation.

11. Failure to provide an explanation for any disparities in comparative data analyses, as outlined in the instructions for Step 7.

Definitions:

The terms in the instructions and the analysis report are defined in COMAR 31.10.51 or have the meaning indicated below. Use of these definitions in completing the report is mandatory.

"Facility" means a person, other than an individual, that provides health care services. "Facility" includes entities that bill for a bundled set of services that include services provided by staff employed by the facility. Examples of facilities include hospitals, outpatient radiology centers, opioid treatment services providers, community mental health centers, and residential treatment centers.

"Measures" means the steps, plan, methods, or course of action taken by a carrier to assess compliance in the development and implementation of an NQTL when the carrier has delegated management of covered benefits to another entity. Measures include written policies, procedures, and guidelines, as well as operational controls, checks, audits, and safeguards.

"Plan documents" means all documents under which the plan is established or operated in which a carrier describes a requirement related to an NQTL, or the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, including a policy, certificate of coverage, medical policy, medical necessity criteria or guidelines, or provider manual. Plan documents also include any document reflecting analyses conducted or results from such analyses related to the comparability and stringency of an NQTL for MH/SUD benefits as compared to M/S benefits.

"Prescription Drug Formulary Design" means a continually updated list of prescription drugs approved for reimbursement, including generic, brand, and specialty drugs, and plan features that base reimbursement, cost-sharing, or authorization requirements on the formulary category into which a drug is placed. Prescription Drug Formulary Design may include processes to place drugs on specific tiers, or to exclude a drug from the formulary, as well as processes to impose step therapy requirements or quantity limits.

"Prior authorization" means the process that a carrier or any entity delegated by the carrier to manage mental health, substance use disorder, or medical/surgical benefits on behalf of the carrier requires a member or provider to follow prior to the rendering of services to determine if coverage will be provided based on considerations such as medical necessity, level of care, appropriateness of health care services, provider type, geographic location, or diagnosis exclusions. Prior authorization includes, but is not limited to, preauthorization, precertification, prospective review, preadmission review, pretreatment review, utilization review, and any requirement that a member or provider notify the carrier or organization prior to receiving or delivering a health care service. Prior authorization includes reauthorization of services or benefits that had received preauthorization, but for which the approval period has lapsed at the time the request is submitted. A request for prior authorization is one received during the reporting period, regardless of whether or when services are delivered or whether or when a claim is submitted.

"Product" has the meaning stated in § 15-1309(a)(3) of the Insurance Article, and means a discrete package of health benefits that are offered using a particular product network type within a geographic service area. "Product" comprises all plans offered within the product.

"Provider Network Directory" means a list of the providers who participate with a carrier as an in-network provider under a particular product. For the purposes of this definition, "provider" includes physicians, non-physician practitioners, facilities, pharmacies, laboratories, and any other person or entity under contract with the carrier to provide covered services, items, or supplies to a member of the carrier. A Provider Network Directory may be online or in printed form, and it includes any provider-specific information disclosed by the carrier in the directory, such as provider name, telephone number, digital contact information, practicing specialty, services offered, quality ratings, physical address of practicing locations, whether the provider offers telehealth services, hours of operation, whether the provider is accepting new patients, languages spoken, race, ethnicity, gender; and other demographic and practice information.

"Provider Shortages" means deficiencies in the number or availability of in-network providers with appropriate training and expertise to sufficiently meet the needs of a carrier's members to obtain covered services without unreasonable delay or travel. "Provider Shortages" includes determinations by a carrier that additional providers are required for the product's network based on factors and evidentiary standards used by the carrier to measure network composition or to address network deficiencies in addition to meeting network adequacy standards set by a state or federal regulator.

"Reimbursement" means compensation or the amount allowed to a health care provider, member, or other person entitled to reimbursement by a carrier, or the combined amount of the carrier's payment and member's cost-sharing responsibility, for providing health care services, medications, or supplies to members of the health benefit plan. Reimbursement includes, but is not limited to, fee for service payments, capitation payments, bundled or global payments, and bonuses or other incentive payments.

NQTL Analysis Report Template Completion Instructions

NQTL Analysis Report Template Forn

Specific Guidance for the 5 NQTLs Selected for 2024:

When providing the required comparative analysis information for the 5 NQTLs listed below, carriers must include information on any practice or process that meets the definition of the applicable NQTL, as defined in the preceding section of these instructions. In addition to addressing all of the items provided below for each step of the analysis in the "Important Guidance" section of these instructions, carriers must address the following NQTL-specific issues when completing the 2024 NQTL reports.

1) Prior Authorization Review Process

When completing Step 1(b), all services for which prior authorization is required must be listed under the applicable benefit classification or sub-classification. The services listed, and the categorization of a service as either M/S or MH/SUD, must be consistent with the Covered Service information provided in Step (a) of the Benefit Classifications section of the template form.

As required by COMAR 31.10.51.04G(4)(j), an NQTL analysis report must include a description of the consequences or penalties that apply when an NQTL requirement is not met. In the case of prior authorization, the carrier must explain whether failure to obtain prior authorization when required will result in a denial of benefits or an alternative penalty, such as a reduction in the amount of benefits otherwise payable. If the penalty varies based on the requested service or other circumstances, a comparative analysis must be provided to demonstrate comparability and relative stringency in the design and application of the penalty between M/S benefits and MH/SUD benefits.

There are three main components of the Prior Authorization Review Process that every analysis must address:

- First, a comparative analysis must be provided for the processes, strategies, evidentiary standards, and all factors the carrier uses to determine the list of services/benefits that are subject to a prior authorization requirement.
- Second, a comparative analysis must be provided for the administrative processes, including timelines, that the provider/member must use when submitting a prior authorization request, and that the carrier adheres to when processing the request.
- Third, a comparative analysis must be provided for the criteria the carrier uses to determine whether to approve or deny prior authorization requests when reviewing the underlying services for medical necessity, level of care, appropriateness, or other applicable considerations.

Data Supplement 1 must be submitted to support the in operation comparative analysis under Step 5 for the Prior Authorization Review Process NQTL.

2) Prescription Drug Formulary Design

The comparative analysis for the Prescription Drug Formulary Design NQTL should address how formulary decisions, including tier placement, specialty designation, and exclusions are made for the diagnosis and medically necessary treatment of M/S and MH/SUD conditions. Pertinent pharmacy management processes, including, but not limited to, cost-control measures, generic and/or therapeutic substitution, and step therapy must be described. If not addressed in PA NQTL, that information should be included in this NQTL Carriers must identify the disciplines, such as primary care physicians, internists, pediatricians, specialty physicians (e.g., psychiatrists), and pharmacologists, that are involved in the development of the formulary for medications to treat M/S and MH/SUD conditions. An analysis of the exception process for any applicable step therapy requirements or other formulary limitations must also be included.

When completing Step 1(a), a copy of the applicable formulary list must be provided. The version of the formulary provided shall be the most recent version on which the comparative analysis was based, including any in-operation data provided in response to Step 5. The formulary list shall identify the date it was effective.

Data Supplement 2 must be submitted to support the in operation comparative analysis under Step 5 for the Prescription Drug Formulary Design NQTL.

3) Provider (Including Facility) Reimbursement

The comparative analysis for the Provider (Included Facility) Reimbursement NQTL must address the process for determining reimbursement rates for in-network and out-of-network providers. A separate analysis must be provided for practitioner reimbursement vs facility reimbursement under each applicable benefits classification/sub-classification. To the extent there are differences in the process for determining reimbursement rates for physician practitioners vs non-physician practitioners (e.g. physician assistants, nurse practitioners, licensed social workers, and psychologists), separate analyses should be provided at this level as well. Any variance in rates applied by the carrier to account for factors such as the nature of the service, provider type, market dynamics, or market need, or availability (demand) must be comparable and applied no more stringently to MH/SUD benefits than M/S benefits.

Carrier responses must include consideration of any Maryland laws that establish specific rate methodologies for particular services or providers (i.e., §§ 14-205.2 and 15-604 of the Insurance Article and §§ 19-710(e) and 19-710.1 of the Health-General Article). The existence of a statutorily required reimbursement methodology for certain provider types within a benefit classification does not obviate the need for a comparative analysis for that benefit classification, since the Maryland laws do not apply to all providers and services. However, the focus of the comparative analyses in these cases should be on the providers and services not subject to the applicable law.

Data Supplement 3 must be submitted to support the in operation comparative analysis under Step 5 for the Provider (Including Facility) Reimbursement NQTL.

4) Strategies for Addressing Provider Shortages

The comparative analysis for the Strategies for Addressing Provider Shortages NQTL must address all considerations taken into account by the carrier when evaluating whether the provider network is sufficient to meet the needs of members, **beyond compliance with state or federal minimum standards for network adequacy**. The analysis must also address any and all adjustments made to provider admission standards when a network deficiency is identified, including increasing reimbursement rates, accelerating/streamlining the credentialing and contracting process, or offering other incentives to join the network. In describing the strategies employed in this area, the carrier must specifically address the following issues for both M/S and MH/SUD providers:

- Does the carrier set its own standards for network sufficiency for any provider types that are in excess of the minimum standards required under Maryland regulations, COMAR 31.10.44? If so, which provider types, and what is the rationale for establishing additional standards for these particular provider types?

- How does the carrier determine if the need for a specific provider type justifies negotiating fee schedules, or offering incentives to join the network?
- Does the carrier audit its reimbursement rates at the upper percentiles (e.g. 75th and 95th) to assess the rate that will incentivize providers to join networks?
- How does the carrier determine which providers are eligible for performance/quality bonuses?
- How does the carrier determine the amount of performance/quality bonuses that a provider may be eligible for?
- Does the carrier negotiate fees or differentiate fee schedules based on provider group size?
- How often does the carrier assess for provider shortages, and what is the process for making the assessment?

Data Supplement 4 must be submitted to support the in operation comparative analysis under Step 5 for the Strategies for Addressing Provider Shortages NQTL.

5) Provider Network Directories

Provider Network Directories function as an NQTL because the ability to locate and receive treatment from an in-network provider, which is contingent on the accuracy of the directory and the inclusion of only those providers who currently participate in the network and actively deliver services, is essential for ensuring members have meaningful access to benefits. The comparative analysis for the Provider Network Directories NQTL must address all considerations taken into account by the carrier in the design and maintenance of the directory, with a particular focus on the comparability between M/S and MH/SUD in the accuracy of the directory and the level of specificity with which provider information is displayed and searchable. The carrier must specifically address the following issues for both M/S and MH/SUD providers:

- What is the process for updating the directory and correcting inaccurate information? This includes the process for adding new participating providers to the directory, removing providers from the directory who are no longer participating, and updating provider-specific information displayed in the directory for existing participating providers.
- What methods are used for obtaining and verifying each type of provider-specific information displayed in the directory?
- What methods are used for verifying that a provider listed in the directory continues to participate as an in-network provider?
- How does the carrier determine which specialty, subspecialty, and facility types will be displayed in the directory and which specialty, subspecialty, and facility types will be separately searchable?
- How does the carrier determine which types of specific services offered by providers will be displayed in the directory and which services will be separately searchable? This question is focused on how the carrier selects the universe of possible services that may be listed in the directory, not how the carrier determines which services are offered by a particular provider. Identifying and verifying the services offered by a particular provider should be addressed in response to the first two bullet points above.
- Is there a limit on the number of specialty areas or types of services that can be attributed to a single provider listed in the directory?

- What, if any, additional assistance does the carrier provide to members who have difficulty using the directory to locate an available provider with the necessary training and expertise to treat the member without unreasonable delay or travel?

When completing Step 1(a), the carrier must include a complete list of the unique specialty practitioner types and facility types for M/S and MH/SUD that are separately listed and searchable in the provider network directory.

Data Supplement 5 must be submitted to support the in operation comparative analysis under Step 5 for the Provider Network Directories NQTL.

Important Guidance for Completing Template Form:

Product/Plan Information

Provide a brief description of the product, including an explanation of any features or characteristics that differentiate this product from other products offered by the carrier in the same market. Provide the form numbers, approval dates, and SERFF tracking numbers for all forms comprising the entire contract of insurance for the product. If there are separate schedule of benefits forms for each plan within the product, it is only necessary to provide the identifying information for one sample schedule of benefits form.

A separate analysis report shall be submitted for each product. However, if, for any plan within a product, the processes, strategies, evidentiary standards, or other factors used in designing and applying the reported NQTLs to mental health benefits, substance use disorder benefits, or medical/surgical benefits are different, as written or in operation, from the other plans within the product, a separate analysis report shall be submitted for that plan. In this case, the information described above should be provided at the plan level instead of the product level.

Benefit Classifications

(a) List each covered service under the product/plan in the table provided on the template form. Indicate whether the covered service is treated as M/S or MH/SUD, and identify which of the following classifications or sub-classifications the covered service has been assigned to: In Network Inpatient; Out of Network Inpatient; In Network Outpatient (OR: In Network Outpatient-Office; In Network Outpatient-All Other); Out of Network Outpatient (OR: Out of Network Outpatient-Office; Out of Network Outpatient-All Other); Emergency; or Prescription.

Do not list non-medical dental or vision benefits in the list of covered services, and do not include these benefits in the NQTL analyses. Dental care that is customarily covered under medical policies, e.g. injury to sound natural teeth or treatment for cleft lip/cleft palate, should be included as a medical benefit.

For the purposes of the NQTL analyses for each product/plan, a carrier may elect to use the outpatient benefit classifications, or divide benefits furnished on an outpatient basis into the two sub-classifications described in 45 CFR § 146.136(c)(3)(iii)(C) for "office visits" and "all other outpatient items and services." The election to use either the outpatient classifications or the outpatient sub-classifications shall be made at the product/plan level, and may not vary for different NQTLs under the same product/plan.

(b) Explain the methodology used to assign M/S and MH/SUD benefits to each classification and/or sub-classification. Note: Classification of covered services must remain consistent across NQTL analyses within the same product/plan. In determining the classification in which a particular benefit belongs, the same standards must be applied to M/S benefits and to MH/SUD benefits. Intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) must be assigned to the existing six classifications in the same way that intermediate medical/surgical benefits are assigned to these classifications. For example, if a product/plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a product/plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well

Step 1 NQTL Description, Application and Methodology:

(a) Provide a description of the plan's applicable NQTLs as applied to M/S or MH/SUD benefits in the table provided on the template form.

Describe the specific NQTL plan language and procedures, as applied to M/S benefits and as applied to MH/SUD benefits, including identification of associated triggers, timelines, forms, and requirements.

Provide cross references to plan documents that contain language related to application of the NQTLs (i.e., all member documents, posted medical policies, internal documents and applicable provider manual references which are pertinent to providing notice of and information regarding the NQTL requirements). Note that for the purposes of Step 1(a), the term "plan documents" refers only to the documents describing the NQTL itself, and does not include documents reflecting analyses conducted or results from such analyses related to the comparability and stringency of an NQTL for MH/SUD benefits as compared to M/S benefits.

Copies of the applicable policy or certificate of coverage should be available, but are not required to be included with the submission. Copy the specific language from the policy or certificate into the report. Provide the page number, section number, and form number where the provision can be found in the policy or certificate. For plan documents other than the policy, certificate of coverage, or other form that has been previously filed with the MIA for approval, provide actual copies of the documents or internet links where the documents may be accessed online.

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the area provided on the template form. Indicate whether the NQTL applies to all services within the classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

For the purposes of the NQTL analyses for each product/plan, if a carrier has elected not to divide benefits furnished on an outpatient basis into the two sub-classifications described in 45 CFR § 146.136(c)(3)(iii)(C) for "office visits" and "all other outpatient items and services," then the "Outpatient-Office sub-classification" columns shall be used to identify the NQTLs applicable to the outpatient classification in general. In this case, the carrier shall include the following explanation in the "Outpatient-Office sub-classification" columns before identifying whether the listed NQTLs

are applicable: "Outpatient sub-classifications were not utilized for the NQTL analysis for this [product/plan]. Responses apply to outpatient classification in general."

Steps 2 – 7 shall be performed for *each* benefit classification and/or sub-classification. Where applicable, responses should be conspicuously separated by benefit classification/sub-classification to clearly delineate differences in factors, sources, evidentiary standards, comparative analyses, etc. from one benefit classification/sub-classification to another. If all elements of the design and application of a particular step in the analysis of an NQTL are the same across one or more benefit classifications/sub-classifications, this must be expressly stated, and must be supported by the evidence and documentation provided.

Step 2 Factors and Sources by Benefit and Classification:

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification, or certain services within such classification or sub-classification for both MH/SUD and M/S benefits respectively. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Include responses in the applicable cells in the chart provided on the template form. Number each factor and corresponding source to clearly identify the sources and factors that go together. If the factors or sources are the same across any benefit classifications/sub-classifications, include a note to this effect instead of repeating all factors and sources. For example, the factor cell for a certain classification may state: "Same as factors for In Network Outpatient-Office" or "Factors 2 and 4 for In Network Outpatient-Office also apply to this classification."

- Identify the factors that the plan uses to determine whether each benefit, service, or procedure/revenue code, as a matter of plan policy, is deemed subject to the NQTLs.

Illustrative examples of factors include, but are not limited to:

- Excessive utilization;
- High cost of treatment;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis, or type or length of treatment;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- High variability in quality of care;
- Lack of adherence to quality standards;
- Claim types with high percentage of fraud;
- Clinical efficacy of the proposed treatment or service;

- Severity or chronicity of the MH/SUD or medical/surgical condition;
- Current and projected demand for services;
- Licensing and accreditation of providers;
- Geographic market (i.e., market rate and payment type for provider type and/or specialty);
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty;
- Supply of provider type and/or specialty;
- Network need and/or demand for provider type and/or specialty;
- Medicare reimbursement rates;
- Training, experience, and licensure of provider.

- Identify the source of the information the carrier used to assign the factors that the plan refers to when determining whether each service or code is deemed subject to the NQTLs, as a matter of plan policy.

Illustrative examples of sources of factors include, but are not limited to:

- Internal claims analysis;
- Medical expert reviews;
- State and federal requirements;
- National accreditation standards;
- Internal market and competitive analysis;
- Medicare physician fee schedules;
- Internal quality standard studies;
- External healthcare claims database;
- Current Medicare Physician Fee Schedule;
- Medicare RVUs for CPT codes.

- Identify factors that were considered, but rejected. If there were no factors that were considered and later rejected, the response should provide confirmation of this.

- If a factor was given more weight than another, what is the reason for the difference in weighting? Differences in weighting of factors include circumstances where multiple factors must generally be present to trigger the application of the NQTL, but the existence of a particular factor, by itself, will trigger the application of the NQTL, even if other factors are not present. An example of weighting would be if the factors and evidentiary standards are applied in a sequence or hierarchy. If all factors are weighted the same, the response should provide confirmation of this.

- If artificial intelligence (AI) is used or consulted in any capacity for the design or application of an NQTL, identify all types of AI decisions and outputs that are factors in the development, design, or implementation of the NQTL. Also identify the algorithms and training data (i.e. the data that is fed to the system to "train" the AI during the design/development phase) that are sources for the AI decisions.

- The fact that all services in a particular classification or sub-classification are subject to the NQTL does not eliminate the requirement to identify the factors and sources for each factor.

Step 3 Evidence for Each Factor:

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

For each factor identified in Step 2, identify, define, and provide the source for the evidentiary standard and/or data source, and any other evidence relied upon, to determine that the NQTLs apply to MH/SUD and M/S services. Include responses in the applicable cells in the chart provided on the template form. Number each factor and corresponding evidentiary standard and source to clearly identify the factors, evidentiary standards, and sources that go together.

In some circumstances, the sources listed for an evidentiary standard in Step 3 may be identical to the sources identified for the underlying factor for the evidentiary standard in Step 2. However, it is generally expected that the sources listed for the evidentiary standards in Step 3 will be more specific than the sources listed for the factors in Step 2. The sources identified in Step 3 should be the sources used to establish the specific threshold or definition for the evidentiary standard. For example, if "excessive utilization" is a factor, the source identified in Step 2 may be "internal claims analysis." If the corresponding evidentiary standard in Step 3 is "utilization that is two standard deviations above average utilization per episode of care," the source listed in Step 3 would be the particular guideline/article/best practice that established that threshold.

If the factors or evidentiary standards/sources are the same across any benefit classifications/sub-classifications, include a note to this effect instead of repeating all factors and evidentiary standards/sources. For example, the evidentiary standards cell for a certain classification may state: "Same as evidentiary standards for In Network Outpatient-Office" or "evidentiary standard 3 for In Network Outpatient-Office also applies to this classification."

- Using vague and subjective terms (such as "cost-effective" or "excessive") within the definitions for factors is not sufficient, unless those terms are further defined with precise parameters identifying the applicable sources and evidentiary standards.
- Identify any threshold or quantitative evidentiary standard at which each factor will implicate the NQTL.
- For example, if high cost is identified as a factor used in designing a prior authorization requirement, the carrier would identify and explain:
    - The threshold dollar amount at which prior authorization will be required for any benefit;
    - The data analyses, and methodology and results used to determine the benefit is "high cost"; and how, if at all, the amount that is to be considered "high cost" is different for MH/SUD benefit as compared with M/S benefits, and how the carrier justifies this difference.
- Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to:

- Excessive utilization may be considered as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care;

- Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased 10% or more per year for two years;

- Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30% of the time based on clinical chart reviews;

- High level of variation in length of stay may be considered as a factor when claims data shows that 25% of patients stayed longer than the median length of stay for acute hospital episodes of care;
- High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period;

- Lack of clinical efficacy may be considered as a factor when more than 50 percent of outpatient episodes of care for specific diseases are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12-month sample of claims data.

➢ Clear thresholds are critical to demonstrating comparability and relative stringency for comparative analyses required in Step 4 and Step 5. If specific thresholds are not used to determine when the factor will implicate the NQTL, a specific, detailed, and reasoned explanation of how the carrier ensures the factors are being applied comparably and no more stringently to MH/SUD services must be provided. In accordance with § 15-144(j)(3), the Commissioner may require the carrier to establish specific quantitative thresholds, if appropriate, if the carrier fails to provide a sufficiently reasoned explanation of comparability and relative stringency.

➢ Evidentiary standards and processes that a carrier relies on may include any evidence that a carrier considers in developing its medical management techniques, including internal carrier standards, recognized medical literature and professional standards and protocols (such as comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

➢ If a source such as NCQA is used in determining comparability, the standards for that source and any analyses developed internally or provided to NCQA or other external agencies must be provided. NCQA standards for health plan accreditation are a roadmap for improvement, for use by organizations to perform a gap analysis and align improvement activities with areas that are most important to states and employers, such as network adequacy and consumer protection. However, using the standards for accreditation does not imply compliance with MHPAEA in terms of comparability

➢ Failure to include all of the information described in the instructions for Step 3 will result in a finding that a carrier failed to submit a complete analysis report and may result in the actions specified in § 15-144(j) of the Insurance Article.

Step 4 Comparable Written Policies:

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

- ➢ Conclusory statements that the carrier determined that its processes were comparable and no more stringently applied, without additional explanation of the analysis leading to that conclusion, are not sufficient. Documentation must be provided that a comparative analysis was actually performed, and a clear explanation of the methodology must be included.

- ➢ Indicate how the factors, as defined and explained by the evidentiary standards identified in Step 2 and Step 3, are applied comparably to establish the written policy as to which services, MH/SUD and M/S, are subject to the NQTL.

- ➢ Explain comparability of how the factors are defined and applied between MH/SUD and M/S services (i.e., clearly delineate and explain any differences in factors, definitions of factors, or evidentiary standards used to determine application of the NQTL, and provide an explanation as to why and/or how the factors, definitions of factors, and evidentiary standards are deemed comparable).

- ➢ Include a brief description of each step, and comparative analysis, for the processes used in applying the NQTLs to MH/SUD and M/S services, and demonstrate comparable and no more stringent application to MH/SUD services at each step.

- ➢ Include information on the composition and deliberations of the decision-making staff responsible for the written policies, including the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

- ➢ Demonstrate that there are not arbitrary or unfairly discriminatory differences in the written standards for applying underlying processes and strategies to NQTLs with respect to medical/surgical benefits versus MH/SUD benefits.
- ➢ Examples of methods/analyses demonstrating that factors, evidentiary standards, and processes are comparable include, but are not limited to:

    - Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency and magnitude with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL;

    - A consistent methodology (e.g., internal claims analysis) for analyzing which MH/SUD and medical/surgical benefits had "high cost variability" (defined by identical factors and evidentiary standards for all services) and were therefore subject to the NQTL;

    - Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and medical/surgical benefits were the same, both as developed and applied; Internal Quality Control Reports showing that the factors, evidentiary standards and processes with respect to MH/SUD and medical surgical benefits are comparable and no

more stringently applied to MH/SUD benefits;

- Summaries of research (e.g., clinical articles) considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was similarly utilized for both MH/SUD and medical/surgical benefits;

- Internal review of published treatment guidelines by appropriate clinical teams (with comparable compositions and qualifications for both MH/SUD and medical/surgical benefits) to identify (using comparable standards and thresholds for both MH/SUD and medical/surgical benefits) covered treatments or services which lack clinical efficacy;

- Internal review to determine that the carrier's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.

➢ Failure to include all of the information described in the instructions for Step 4 will result in a finding that a carrier failed to submit a complete analysis report and may result in the actions specified in § 15-144(j) of the Insurance Article.

Step 5 Comparable In-Operation Audits/Reviews:

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

- Provide the Carrier's analyses that demonstrate the comparability of the implementation of the written policies and procedures governing application of the NQTL.

- The analyses should include discussion of quality assurance and oversight policies, processes and metrics that the plan applies to monitor in operation compliance. Examples of information to include are results of comparative assessment of denial rates (both administrative and medical necessity) by service, reviews for correlation between basis for service denials and stated criteria, and internal and/or external appeals and overturn rates.

- **Note:** Disparate results or outcomes between MH/SUD and M/S services are not regarded as dispositive of parity noncompliance; however, disparities constitute a warning sign or red flag of potential noncompliance and warrant further investigation. Conversely, equal or more favorable outcomes for MH/SUD services as compared to M/S is a positive indicator; however, is not necessarily dispositive of parity compliance either.

- To ensure uniformity in reporting, the MIA may ask for data using the Medicare provider fee schedules as a metric to measure whether reimbursement rates are comparable. Carriers may also provide other comparative data in addition to Medicare benchmark data to support the comparability analysis.

- Examples of comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied in operation include, but are not limited to:

- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable;
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits;
- Audit results that demonstrate the process of consulting with expert reviewers for MH/ SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved;
- Audit results that demonstrate utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews;
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits;
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits;
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category;
- Audit/review of utilization review documentation requirements;
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines;
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/ surgical reviewers ONLY WHEN it has been demonstrated in the comparative analyses for Step 4 that the development of M/S criteria vs. MH/SUD criteria is comparable and no more stringent. It is the comparability and no more stringency of the criteria themselves, not merely consistency in the interpretation or application of the criteria that is key. For example, an IRR validation would not identify if reviewers were consistently applying a more restrictive fail first standard to MH/SUD vs M/S, or consistently applying acute criteria to sub-acute care for MH/SUD.
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification;
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

- When providing audit results, include specific details about the type and outcome of each audit that was performed. A summary statement alleging that an audit was performed revealing no statistically

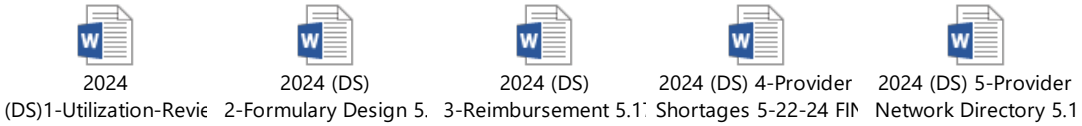
significant disparities is not sufficient, absent documentation of the review and a description of the methodology, including considerations such as sample size and operational proportionality.

- Failure to include all of the information described in the instructions for Step 5 will result in a finding that a carrier failed to submit a complete analysis report and may result in the actions specified in § 15-144(j) of the Insurance Article.

See Instructions for Data Supplements 1 – 5 which contain requests for additional required data to supplement the responses provided in Step 5 of the NQTL Analysis Report.

Although each of the Data Supplements 1-5 was primarily designed to support the in-operation analysis for a specific NQTL, some of the data points are relevant to multiple NQTLs, and the MIA may request an explanation for disparate results for the same Data Supplement under more than one NQTL.

A separate data supplement must be submitted for each product, except that an additional separate data supplement shall be submitted for any plan within the product for which a separate NQTL report is required to be submitted under § 15-144(c)(4). A separate NQTL report is required for any plan within the product where the processes, strategies, evidentiary standards, or other factors used in designing and applying the reported NQTLs to mental health benefits, substance use disorder benefits, or medical/surgical benefits are different, as written or in operation, from the other plans within the product. The data reported on each data supplement must be specific to the product or plan for the corresponding NQTL report.



Step 6 Delegated Entities:

Identify the measures used to ensure comparable design, development, and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

This step is only required if administration of a benefit subject to the applicable NQTL has been delegated to another entity, e.g. formulary design of prescription benefits has been delegated to a pharmacy benefits manager.

- ➢ If the carrier delegates administration or management of certain benefits to a third party vendor or service provider (for example, a private review agent specializing in mental health and substance use disorder benefits or a pharmacy benefits manager), the carrier is responsible for coordinating with the subcontracted entity on the development and application of NQTLs for MH/SUD and medical/surgical benefits to ensure comparability.

- ➢ Include a description of the measures, processes, and standards implemented to ensure collaboration with all vendors and subcontracted entities that exert any influence on the design, development, or application of an NQTL.

- ➢ Include any written procedures or guidelines to ensure that that the NQTL is consistently applied to similarly situated individuals.

Step 7 Specific Findings and Conclusions:

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with § 15-144 of the Insurance Article and the Parity Act. (§15-144(e)(6)).

- ➢ Explain the basis for the Carrier's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on medical/surgical benefits in each classification of benefits in which the NQTL is imposed.

- ➢ A general or conclusory statement of compliance is not sufficient.

- ➢ The analysis required for this section is not a restatement of prior sections of the report. Instead, carriers shall prepare a detailed summary of specific findings and conclusions demonstrating that the product is in compliance with the Parity Act both as written and in operation.

- ➢ To the extent there are differences noted between MH/SUD and M/S in the foregoing steps, delineate these in the summary and note how they were reconciled in the reporting. For example, if different factors were utilized to determine services to which the NQTLs would apply, explain how the processes, strategies, evidentiary standards, and other factors were determined to be comparable and applied no more stringently as written and in operation.

- ➢ To the extent there are disparities in any comparative data analyses, including quantitative disparities shown in the required data supplement forms or other in operation analyses, explain in detail how these disparities are not evidence of parity non-compliance, and whether steps will be taken to reduce these disparities. Include whether steps have been taken to ensure/improve access to in-network M/S providers and whether the same or comparable steps have been taken for MH/SUD.

Disclosure Requirements

Identify the process used to comply with the Parity Act Disclosure Requirements for MH/SUD and M/S Benefits.

Describe the process for disclosing the criteria used for a medical necessity determination for MH/SUD benefits to current or potential members, or to a contracting provider, upon request

- ☐ Carriers shall report any instructions, guidance or information available to the public concerning the carrier's obligation to respond to disclosure requests, including where requests must be sent and what information is available in response to disclosure requests.

- ☐ Carriers shall report whether the designated division and/or individual(s) responsible for responding to disclosure requests.

- ☐ Carriers shall indicate whether they responded to any disclosure requests by denying access to the requested information and the basis for such denial.

- Carriers shall report any internal review process used to respond to disclosure requests for medical necessity criteria.

- Carriers shall report any template form response used to explain medical necessity criteria in response to a participant, beneficiary, provider, or authorized representative of the beneficiary or participant.

Describe the process for disclosing the reasons for a denial of benefits for MH/SUD.

- Carriers shall report any internal review process used to respond to disclosure requests for denials of benefits.

- Carriers shall report the criteria for responding to a disclosure request based on a denial of benefits for any applicable plan.

- Carriers shall report the number of disclosure requests received for denials of benefits and the number of instances when it failed to provide a response to a participant beneficiary, provider, or authorized representative of the beneficiary or participant within 30 days of the request.

Describe the process for disclosing plan documents that contain information about the processes, strategies, evidentiary standards and any other factors used to apply a NQTL for MH/SUD and M/S benefits in connection with a member's request for individual or group plan information and for purposes of filing an internal coverage or grievance matter and appeals.

- A carrier shall report how its procedures ensure that the following information is disclosed:

    - any information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the applicable plan.
    - any records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits under any applicable plan.
    - any available details as to how the standards were applied, and any internal testing, review, or analysis done by the applicable plan to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits.

- A carrier shall report how its procedures ensure that any plan materials related to the plan's compliance with MHPAEA are disclosed in compliance with 45 C.F.R § 146.136, including the following:

    - any references to provisions as stated on specified pages of the policy or certificate, or other underlying guidelines or criteria not included in the policy or certificate that the plan has consulted or relied upon;
    - any information regarding specific related factors or guidelines, such as applicable utilization review criteria;
    - any factors, such as cost or recommended standards of care, that are relied upon by an applicable plan for determining which M/S or MH/SUD benefits are subject to a specific requirement or limitation;

- a description of the applicable requirement or limitation that the applicable plan believes has been used in any given MH/SUD service adverse decision within the relevant classification; and
- the medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.

- A carrier shall provide a list of the responses provided in the prior calendar year to requests from a member or a member's authorized representative for a copy of the NQTL comparative analysis. The actual responses are not required to be included with the initial submission, but shall be available to the Commissioner upon request.

Appendix B

MHPAEA Summary Form

MHPAEA Summary Form Instructions

The below summary form is prepared to satisfy the requirements of §15-144 (n)(2), Insurance Article, Annotated Code of Maryland. The summary form must be made available to plan members and to the public on the carrier's website.

Confidential and proprietary information must be removed from the summary form. Confidential and proprietary information that is removed from the summary form must satisfy § 15-144(h)(1), Insurance Article, Annotated Code of Maryland.

Carriers must use the terms defined in COMAR 31.10.51 and the *Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Reporting Instructions Non-Quantitative Treatment Limitations (NQTL)* to complete the summary form.

MHPAEA Summary Form

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), [carrier name] must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements—such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Treatment limitations—such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

[Carrier name] has performed an analysis of mental health parity as required by Maryland law and has submitted the required report to the State of Maryland. Below is a summary of that report.

If you have any questions on this summary, please contact [name] at [email and/or phone number].

If you have questions on your specific health plan, please call [phone number].

Overview:

We have each product we offer in the individual, small, and large group markets, as applicable. These products contain items called Non-Quantitative Treatment Limitations (NQTLs) that put limits on benefits paid. What these NQTL's are and how the health plans achieve parity are discussed below.

1. Prior Authorization Review Process

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

2. <u>Prescription Drug Formulary Design</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

3. <u>Provider (Including Facility) Reimbursement</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

4. <u>Strategies for Addressing Provider Shortages</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

5. Provider Network Directories

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

D. Identify the methods and analysis used in the development of the limitation(s); and

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Appendix C

Chapter 234

(House Bill 1074)

AN ACT concerning

Health Insurance – Mental Health and Substance Use Disorder Benefits – Sunset Repeal and Modification of Reporting Requirements

FOR the purpose of altering certain reporting requirements on health insurance carriers relating to compliance with the federal Mental Health Parity and Addiction Equity Act; altering requirements for certain analyses of nonquantitative treatment limitations required of health insurance carriers; ~~authorizing the Maryland Insurance Commissioner to exercise discretion to review subsets of nonquantitative treatment limitations under certain circumstances;~~ establishing certain remedies the Commissioner may use to enforce compliance with the Mental Health Parity and Addiction Equity Act and related reporting requirements; establishing that a health insurance carrier has the burden of persuasion in demonstrating that its health plan complies with the federal Mental Health Parity and Addiction Equity Act; repealing the requirement that the Commissioner use a certain form for the reporting requirements; repealing the termination date for the reporting requirements; and generally relating to health insurance carriers and mental health and substance use disorder benefits.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–144
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–1309(a)(1) and (3)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing
Chapter 211 of the Acts of the General Assembly of 2020
Section 2

BY repealing and reenacting, with amendments,
Chapter 211 of the Acts of the General Assembly of 2020
Section 4

BY repealing
Chapter 212 of the Acts of the General Assembly of 2020
Section 2

BY repealing and reenacting, with amendments,
Chapter 212 of the Acts of the General Assembly of 2020
Section 4

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

15–144.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer that holds a certificate of authority in the State and provides health insurance in the State;

(ii) a health maintenance organization that is licensed to operate in the State;

(iii) a nonprofit health service plan that is licensed to operate in the State; or

(iv) any other person or organization that provides health benefit plans subject to State insurance regulation.

(3) "Health benefit plan" means:

(i) for a large group or blanket plan, a health benefit plan as defined in § 15–1401 of this title;

(ii) for a small group plan, a health benefit plan as defined in § 15–1201 of this title;

(iii) for an individual plan:

1. a health benefit plan as defined in § 15–1301(l) of this title; or

2. an individual health benefit plan as defined in § 15–1301(o) of this title;

(iv) short–term limited duration insurance as defined in § 15–1301(s) of this title; or

(v) a student health plan as defined in § 15–1318(a) of this title.

(4) "Medical/surgical benefits" has the meaning stated in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(5) "Mental health benefits" has the meaning stated in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(6) "Nonquantitative treatment limitation" means treatment limitations as defined in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(7) **(I)** "Parity Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 **[**and 45 C.F.R. § 146.136 and 29 C.F.R. § 2590.712**], AS AMENDED**.

(II) "PARITY ACT" INCLUDES 45 C.F.R. § 146.136, 29 C.F.R. § 2590.712, AND ANY OTHER RELATED FEDERAL REGULATIONS FOUND IN THE CODE OF FEDERAL REGULATIONS TO IMPLEMENT OR ENFORCE THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008.

(8) "Parity Act classification" means:

(i) inpatient in–network benefits;

(ii) inpatient out–of–network benefits;

(iii) outpatient in–network benefits;

(iv) outpatient out–of–network benefits;

(v) prescription drug benefits; and

(vi) emergency care benefits.

(9) "PRODUCT" HAS THE MEANING STATED IN § 15–1309(A)(3) OF THIS TITLE.

~~(9)~~ **(10)** "Substance use disorder benefits" has the meaning stated in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(b) This section applies to a carrier that delivers or issues for delivery a health benefit plan in the State.

(C) (1) EACH CARRIER SUBJECT TO THIS SECTION SHALL:

(I) FOR EACH PARITY ACT CLASSIFICATION, IDENTIFY ALL NONQUANTITATIVE TREATMENT LIMITATIONS THAT ARE APPLIED TO MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS;

(II) IN ACCORDANCE WITH THE PARITY ACT, PERFORM AND DOCUMENT COMPARATIVE ANALYSES OF THE DESIGN AND APPLICATION OF ALL NONQUANTITATIVE TREATMENT LIMITATIONS IMPOSED ON MENTAL HEALTH BENEFITS AND SUBSTANCE USE DISORDER BENEFITS;

(III) PROVIDE THE COMPARATIVE ANALYSIS FOR EACH NONQUANTITATIVE TREATMENT LIMITATION REQUESTED BY THE COMMISSIONER WITHIN:

1. 15 WORKING DAYS AFTER A WRITTEN REQUEST; OR

2. IF ADOPTED BY THE FEDERAL GOVERNMENT, LESS THAN 15 WORKING DAYS TO ALIGN WITH THE FEDERAL RULE OR REGULATION;

(IV) WITHIN 30 DAYS AFTER A WRITTEN REQUEST, PROVIDE THE COMPARATIVE ANALYSIS FOR EACH NONQUANTITATIVE TREATMENT LIMITATION AND RELATED IN OPERATION DATA ANALYSIS, IF AVAILABLE AND REQUESTED BY A MEMBER IN ACCORDANCE WITH THE PARITY ACT DISCLOSURE REQUIREMENTS OR, FOR MEMBERS WITH INDIVIDUAL PLANS, IN ACCORDANCE WITH SUBSECTION (E)(7) OF THIS SECTION; AND

(V) SUBMIT THE REPORTS REQUIRED UNDER PARAGRAPH (2) OF THIS SUBSECTION.

~~(c)~~ ~~(1)~~ **(2)** On or before **[**March 1, 2022, and March 1, 2024**]** ~~**MARCH 1 EACH YEAR, BEGINNING IN 2025**~~ **JULY 1, 2024, AND EVERY 2 YEARS THEREAFTER**, each carrier subject to this section shall~~:~~

~~(i) identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets; and~~

~~(ii)~~ submit a report to the Commissioner **ON EACH PRODUCT OFFERED BY THE CARRIER IN THE INDIVIDUAL, SMALL, AND LARGE GROUP MARKETS** to demonstrate the carrier's compliance with the Parity Act.

~~(2)~~ **(3)** The report submitted under paragraph ~~(1)~~ **(2)** of this subsection shall include ~~[~~the following information~~]~~**:**

(I) ALL NONQUANTITATIVE TREATMENT LIMITATION ~~COMPARATIVE ANALYSIS~~ **INFORMATION REQUIRED UNDER THE PARITY ACT, SUBSECTION (D) OF THIS SECTION, AND ANY STATE REGULATIONS** for the ~~health benefit plans identified~~ **PRODUCTS IDENTIFIED** under **[**item**]** **PARAGRAPH** ~~(1)(i)~~ **(2)** of this subsection~~;~~**,** ~~INCLUDING:~~

~~(i) a description of the process used to develop or select the medical necessity criteria for mental health benefits and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;~~

~~(ii) for each Parity Act classification, identification of nonquantitative treatment limitations that are applied to mental health benefits and substance use disorder benefits and medical and surgical benefits;~~

~~(iii) identification of the description of the nonquantitative treatment limitations identified under item (ii) of this paragraph in documents and instruments under which the plan is established or operated; and~~

~~(iv)~~ **(II)** the results of ~~the~~ A comparative analysis ~~as described under subsections (d) and (e) of this section.~~ **CONDUCTED BY THE CARRIER ON NOT FEWER THAN FIVE NONQUANTITATIVE TREATMENT LIMITATIONS SELECTED BY THE COMMISSIONER IN ACCORDANCE WITH PARAGRAPH (5) OF THIS SUBSECTION; AND**

(III) SUBJECT TO PARAGRAPH (4) OF THIS SUBSECTION, A STATEMENT, SIGNED BY A CORPORATE OFFICER, ATTESTING THAT, FOR EACH PRODUCT IDENTIFIED UNDER PARAGRAPH (2) OF THIS SUBSECTION, THE SELECTED NONQUANTITATIVE TREATMENT LIMITATIONS AND THE PROCESSES, STRATEGIES, EVIDENTIARY STANDARDS, OR OTHER FACTORS USED IN DESIGNING AND APPLYING THE SELECTED NONQUANTITATIVE TREATMENT LIMITATIONS TO MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS ARE THE SAME FOR ALL PLANS WITHIN THE PRODUCT, AS WRITTEN AND IN OPERATION.

(4) IF, FOR ANY PLAN WITHIN A PRODUCT IDENTIFIED UNDER PARAGRAPH (2) OF THIS SUBSECTION, THE PROCESSES, STRATEGIES, EVIDENTIARY STANDARDS, OR OTHER FACTORS USED IN DESIGNING AND APPLYING THE SELECTED NONQUANTITATIVE TREATMENT LIMITATIONS TO MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, OR MEDICAL/SURGICAL BENEFITS ARE DIFFERENT, AS WRITTEN OR IN OPERATION, FROM THE OTHER PLANS WITHIN THE PRODUCT:

(I) THE STATEMENT REQUIRED UNDER PARAGRAPH (3)(III) OF THIS SUBSECTION SHALL NOTE THE EXCEPTION AND IDENTIFY THE PLAN; AND

(II) THE CARRIER SHALL SUBMIT A SEPARATE COMPARATIVE ANALYSIS FOR THE SELECTED NONQUANTITATIVE TREATMENT LIMITATIONS FOR THE PLAN.

(5) (I) IN SELECTING THE NONQUANTITATIVE TREATMENT LIMITATIONS REQUIRED TO BE INCLUDED FOR EACH REPORTING PERIOD, THE COMMISSIONER:

1. SHALL PRIORITIZE THE NONQUANTITATIVE TREATMENT LIMITATIONS IDENTIFIED BY THE COMMISSIONER AS HAVING THE GREATEST IMPACT ON MEMBER ACCESS TO CARE;

2. SHALL REVIEW THE SAME SUBSET OF NONQUANTITATIVE TREATMENT LIMITATIONS FOR EACH CARRIER REPORT; AND

3. MAY TAKE INTO CONSIDERATION OTHER FACTORS DETERMINED RELEVANT BY THE COMMISSIONER, INCLUDING COMPLAINT TRENDS, FEDERAL PARITY ACT GUIDANCE, AND WHETHER THE NONQUANTITATIVE TREATMENT LIMITATION WAS SELECTED FOR A PREVIOUS REPORTING YEAR.

(II) OF THE FIVE SELECTED NONQUANTITATIVE TREATMENT LIMITATIONS:

1. NOT MORE THAN TWO MAY BE FOR UTILIZATION REVIEW; AND

2. AT LEAST ONE MUST BE FOR NETWORK COMPOSITION, INCLUDING REIMBURSEMENT RATE SETTING.

(6) A FINDING OF NONCOMPLIANCE FOR A PRODUCT SHALL APPLY TO ALL PLANS WITHIN THE PRODUCT.

(d) (1) A carrier subject to this section shall conduct a comparative analysis for the nonquantitative treatment limitations ~~identified~~ **SELECTED** under subsection ~~(e)(2)(ii)~~ **(C)(5)** of this section as nonquantitative treatment limitations are:

(i) written; and

(ii) in operation.

(2) The comparative analysis of the nonquantitative treatment limitations ~~identified~~ **SELECTED** under subsection ~~(c)(2)(ii)~~ **(C)(5)** of this section shall**:**

(I) demonstrate that the processes, strategies, evidentiary standards, or other factors used in **DESIGNING AND** applying ~~the medical necessity criteria and~~ each **SELECTED** nonquantitative treatment limitation to mental health benefits and substance use disorder benefits in each Parity Act classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in **DESIGNING AND** applying ~~the medical necessity criteria and~~ each **SELECTED** nonquantitative treatment limitation to ~~medical and surgical~~ **MEDICAL/SURGICAL** benefits within the same Parity Act classification**; AND**

(II) INCLUDE ALL INFORMATION REQUIRED UNDER THE PARITY ACT.

(3) REGARDLESS OF WHETHER IT WAS USED BEFORE THE PARITY ACT WAS ENACTED AND AS REQUESTED BY THE COMMISSION, A CARRIER SHALL PERFORM AND PROVIDE A COMPARATIVE ANALYSIS FOR EACH PROCESS, STRATEGY, EVIDENTIARY STANDARD, OR OTHER FACTOR USED IN DESIGNING AND APPLYING A SELECTED NONQUANTITATIVE TREATMENT LIMITATION USED DURING A REPORTING PERIOD.

(e) In providing the analysis required under subsection (d) of this section, a carrier shall:

(1) identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including:

(i) the sources for the factors~~, INCLUDING SOURCES IN EFFECT BEFORE THE ENACTMENT OF THE PARITY ACT~~;

(ii) the factors that were considered but rejected; ~~[~~and~~]~~

~~(III) THE FACTORS THAT WERE IN EFFECT BEFORE THE ENACTMENT OF THE PARITY ACT AND ARE USED IN THE DESIGN OR APPLICATION OF THE NONQUANTITATIVE TREATMENT LIMITATION; AND~~

~~[~~(iii)~~]~~ ~~(IV)~~ if a factor was given more weight than another, the reason for the difference in weighting;

(2) identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation~~, INCLUDING EVIDENTIARY STANDARDS IN EFFECT BEFORE THE ENACTMENT OF THE PARITY ACT~~;

~~(3) IDENTIFY AND DEFINE THE PROCESSES AND STRATEGIES THAT ARE USED TO DESIGN OR APPLY THE NONQUANTITATIVE TREATMENT LIMITATION, INCLUDING THE PROCESSES AND STRATEGIES IN EFFECT BEFORE THE ENACTMENT OF THE PARITY ACT;~~

~~[~~(3)~~]~~ ~~(4)~~ include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection ~~(e)(2)(ii)~~ **(C)(5)** of this section to conduct the analysis required under subsection (d)(2) of this section for the plans **AND PRODUCTS** as written;

~~[~~(4)~~]~~ ~~(5)~~ include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection ~~(e)(2)(ii)~~ **(C)(5)** of this section to conduct the analysis required under subsection (d)(2) of this section for the plans **AND PRODUCTS** as in operation;

~~[~~(5)~~]~~ ~~(6)~~ identify the measures used to ensure comparable design and application of nonquantitative treatment limitations that are implemented by the carrier and any entity delegated by the carrier to manage mental health benefits, substance use disorder benefits, or medical/surgical benefits on behalf of the carrier;

~~[~~(6)~~]~~ ~~(7)~~ disclose the specific findings and conclusions reached by the carrier that indicate that the health benefit plan is in compliance with this section and the Parity Act **[**and its implementing regulations, including 45 C.F.R. 146.136 and 29 C.F.R. 2590.712 and any other related federal regulations found in the Code of Federal Regulations**]**; and

~~[~~(7)~~]~~ ~~(8)~~ identify the process used to comply with the Parity Act disclosure requirements for mental health benefits, substance use disorder benefits, and medical/surgical benefits, including:

(i) the criteria for a medical necessity determination;

(ii) reasons for a denial of benefits; and

(iii) in connection with a member's request for **INDIVIDUAL OR** group plan information and for purposes of filing an internal coverage or grievance matter and appeals, plan documents that contain information about processes, strategies, evidentiary standards, and any other factors used to apply a nonquantitative treatment limitation.

~~(f) On or before [March 1, 2022, and March 1, 2024] MARCH 1 EACH YEAR, BEGINNING IN 2025, each carrier subject to this section shall submit a report for the health benefit plans identified under subsection (e)(1)(i) of this section to the Commissioner on the following data for the immediately preceding calendar year for mental health~~

~~benefits, substance use disorder benefits, and medical/surgical benefits by Parity Act classification:~~

~~(1) the frequency, reported by number and rate, with which the health benefit plan received, approved, and denied prior authorization requests for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year; [and]~~

~~(2) the number of claims submitted for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year and the number and rates of, and reasons for, denial of claims; AND~~

~~(3) DATA IDENTIFIED BY THE COMMISSIONER OR FEDERAL REGULATIONS TO EVALUATE NONQUANTITATIVE TREATMENT LIMITATION COMPLIANCE WITH THE IN–OPERATION STANDARD OF THE PARITY ACT.~~

(F) THE COMMISSIONER SHALL:

(1) DEVELOP ADDITIONAL STANDARDIZED DATA TEMPLATES:

(I) TO EVALUATE THE COMPARATIVE ANALYSIS OF NONQUANTITATIVE TREATMENT LIMITATIONS IN OPERATION; AND

(II) THAT MEET OR EXCEED ANY MINIMUM REQUIREMENTS FOR DATA REPORTING SPECIFIED IN FEDERAL REGULATIONS;

(2) REQUIRE EACH CARRIER SUBJECT TO THIS SECTION TO SUBMIT:

(I) FOR EACH PRODUCT IDENTIFIED UNDER SUBSECTION (C)(2) OF THIS SECTION, THE DATA TEMPLATES DESCRIBED IN ITEM (1) OF THIS SUBSECTION FOR THE NONQUANTITATIVE TREATMENT LIMITATIONS SELECTED BY THE COMMISSIONER FOR THE REPORTING YEAR IN ACCORDANCE WITH SUBSECTION (C)(5) OF THIS SECTION; AND

(II) A SEPARATE DATA TEMPLATE FOR ANY PLANS DESCRIBED IN SUBSECTION (C)(4) OF THIS SECTION; AND

(3) POST THE DATA TEMPLATES ON THE ADMINISTRATION'S WEBSITE FOR A COMMENT PERIOD OF NOT LESS THAN 30 DAYS BEFORE ADOPTION.

(g) The reports required under ~~subsections (e) and (f) of~~ this section shall:

(1) be submitted on a standard form developed by the Commissioner **THAT** ~~**CONFORMS TO**~~ **MEETS OR EXCEEDS ANY MINIMUM REQUIREMENTS SPECIFIED IN**

THE FEDERAL REGULATIONS AND SUB–REGULATORY GUIDANCE ON NONQUANTITATIVE TREATMENT LIMITATIONS ~~COMPARATIVE ANALYSIS~~ REPORTING;

(2) be submitted by the carrier that issues or delivers the ~~health benefit plan~~ **PRODUCT**;

(3) be prepared in coordination with any entity the carrier contracts with to provide mental health benefits and substance use disorder benefits;

(4) contain a statement, signed by a corporate officer, attesting to the accuracy of the information contained in the report;

(5) be available to plan members and the public on the carrier's website in a summary form that removes confidential or proprietary information and is developed by the Commissioner in accordance with subsection **[**(m)(2)**] (N)(2)** of this section; and

(6) exclude any identifying information of any plan member.

(h) (1) A carrier submitting a report under ~~subsections (e) and (f) of~~ this section may submit a written request to the Commissioner that disclosure of specific information included in the report be denied under the Public Information Act and, if submitting a request, shall:

(i) identify the particular information the disclosure of which the carrier requests be denied; and

(ii) cite the statutory authority under the Public Information Act that authorizes denial of access to the information.

(2) The Commissioner may review a request submitted under paragraph (1) of this subsection on receipt of a request for access to the information under the Public Information Act.

(3) The Commissioner may notify the carrier that submitted the request under paragraph (1) of this subsection before granting access to information that was the subject of the request.

(4) A carrier shall disclose to a member on request any plan information contained in a report that is required to be disclosed to that member under federal or State law.

(i) **(1)** The Commissioner shall:

[(1)**]** **(I)** review each report submitted in accordance with subsections (c)**, (D),** and (f) of this section to assess each carrier's compliance with the Parity Act **FOR EACH PARITY ACT CLASSIFICATION**;

[(2)**]** **(II)** notify a carrier in writing of any noncompliance with the Parity Act before issuing an administrative order; and

[(3)**]** **(III)** within 90 days after the notice of noncompliance is issued, allow the carrier to:

[(i)**]** **1.** submit a compliance plan to the Administration to comply with the Parity Act; and

[(ii)**]** **2.** reprocess any claims that were improperly denied, in whole or in part, because of the noncompliance.

~~**(2) THE COMMISSIONER MAY EXERCISE DISCRETION TO REVIEW A SUBSET OF NONQUANTITATIVE TREATMENT LIMITATIONS FOR THE PURPOSES OF THIS SECTION IF THE COMMISSIONER:**~~

~~**(I) AFTER THE REPORTING DEADLINES ESTABLISHED UNDER SUBSECTIONS (C) AND (F) OF THIS SECTION, IDENTIFIES THE NONQUANTITATIVE TREATMENT LIMITATIONS THAT WILL BE REVIEWED BY THE COMMISSIONER;**~~

~~**(II) DESCRIBES AND POSTS ON THE ADMINISTRATION'S WEBSITE THE CRITERIA USED TO IDENTIFY THE NONQUANTITATIVE TREATMENT LIMITATIONS THAT WILL BE REVIEWED EACH YEAR;**~~

~~**(III) REVIEWS NONQUANTITATIVE TREATMENT LIMITATIONS THAT HAVE THE GREATEST EFFECT ON ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE;**~~

~~**(IV) REVIEWS THE SAME SUBSET OF NONQUANTITATIVE TREATMENT LIMITATIONS FOR EACH CARRIER REPORT;**~~

~~**(V) REVIEWS NOT LESS THAN 10 NONQUANTITATIVE TREATMENT LIMITATIONS FOR EACH CARRIER REPORT; AND**~~

~~**(VI) ISSUES A DETERMINATION IN ANY MATTER THAT IMPLICATES PARITY ACT COMPLIANCE REGARDLESS OF WHETHER A NONQUANTITATIVE TREATMENT LIMITATION AT ISSUE IN THE MATTER HAS BEEN REVIEWED UNDER THIS SECTION.**~~

(2) THE COMMISSIONER MAY REQUIRE CARRIERS TO COMPLETE DATA TEMPLATES FOR A NONQUANTITATIVE TREATMENT LIMITATION MORE FREQUENTLY THAN EVERY 2 YEARS.

(j) **(1)** If the Commissioner finds that the carrier failed to submit a complete report required under ~~subsection (c) or (f) of~~ this section, the Commissioner may**:**

(I) TAKE ACTION AUTHORIZED UNDER PARAGRAPH (2) OF THIS SUBSECTION;

(II) IN ACCORDANCE WITH § 2–208 OF THIS ARTICLE, CHARGE THE CARRIER FOR ANY ADDITIONAL EXPENSES INCURRED BY THE COMMISSIONER TO REVIEW ADDITIONAL REPORTS;

(III) IMPOSE A PENALTY FOR EACH DAY THAT THE CARRIER FAILS TO SUBMIT INFORMATION REQUIRED BY THE COMMISSIONER TO EVALUATE COMPLIANCE; OR

(IV) impose any penalty or take any action as authorized:

~~(1)~~ **1.** for an insurer, nonprofit health service plan, or any other person subject to this section, under this article; or

~~(2)~~ **2.** for a health maintenance organization, under this article or the Health – General Article.

(2) IF THE COMMISSIONER CANNOT MAKE A DETERMINATION THAT A SPECIFIC CONDUCT OR PRACTICE IS COMPLIANT WITH THE PARITY ACT BECAUSE THE CARRIER FAILED TO PROVIDE A SUFFICIENT COMPARATIVE ANALYSIS FOR A NONQUANTITATIVE TREATMENT LIMITATION, THE COMMISSIONER MAY:

(I) ISSUE AN ADMINISTRATIVE ORDER REQUIRING THE CARRIER OR AN ENTITY DELEGATED BY THE CARRIER TO TAKE THE FOLLOWING ACTION UNTIL THE COMMISSIONER CAN MAKE A DETERMINATION OF COMPLIANCE WITH THE PARITY ACT:

1. MODIFY THE CONDUCT OR PRACTICE AS SPECIFIED BY THE COMMISSIONER;

2. CEASE THE CONDUCT OR PRACTICE; OR

3. SUBMIT PERIODIC DATA RELATED TO THE CONDUCT OR PRACTICE; OR

(II) SUBJECT TO PARAGRAPH (3) OF THIS SUBSECTION, REQUIRE THE CARRIER TO PERFORM A NEW COMPARATIVE ANALYSIS.

(3) THE COMMISSIONER MAY REQUIRE THE CARRIER TO ESTABLISH SPECIFIC QUANTITATIVE THRESHOLDS FOR EVIDENTIARY STANDARDS AND CONDUCT A NEW COMPARATIVE ANALYSIS FOR A NONQUANTITATIVE TREATMENT LIMITATION IF THE COMMISSIONER DETERMINES A CARRIER FAILED TO PROVIDE A SUFFICIENT COMPARATIVE ANALYSIS BECAUSE THE CARRIER DID NOT:

(I) USE APPLICABLE QUANTITATIVE THRESHOLDS FOR THE EVIDENTIARY STANDARD; OR

(II) PROVIDE A SPECIFIC, DETAILED, AND REASONED EXPLANATION OF HOW THE CARRIER ENSURES THAT THE FACTORS FOR THE NONQUANTITATIVE TREATMENT LIMITATION ARE BEING APPLIED COMPARABLY AND NO MORE STRINGENTLY TO MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.

(4) SUBSECTION (I)(1)(III) OF THIS SECTION DOES NOT APPLY TO THE FAILURE OF A CARRIER TO SUBMIT A COMPLETE REPORT.

(k) If, as a result of the review required under subsection **[**(i)(1)**] (I)(1)(I)** of this section, the Commissioner finds that the carrier failed to comply with **[**the provisions of**]** the Parity Act, ~~[~~and~~]~~ did not submit a compliance plan to adequately correct the noncompliance~~, OR FAILED TO SUBMIT INFORMATION THAT IS REQUIRED TO EVALUATE COMPLIANCE WITH THE PARITY ACT~~, the Commissioner may:

(1) issue an administrative order that requires:

(i) the carrier or an entity delegated by the carrier to cease the noncompliant conduct or practice; ~~[~~or~~]~~

~~(II) THE CARRIER OR AN ENTITY DELEGATED BY THE CARRIER TO CEASE THE IMPLEMENTATION OF THE NONQUANTITATIVE TREATMENT LIMITATION; OR~~

~~[~~(ii)~~]~~ ~~(III)~~ the carrier to provide a payment that has been denied improperly because of the noncompliance~~, INCLUDING A FAILURE TO PROVIDE INFORMATION THAT DEMONSTRATES COMPLIANCE~~; **[**or**]**

~~(2) IMPOSE A PENALTY OF NOT LESS THAN $1,000 FOR EACH DAY IN WHICH THE CARRIER FAILS TO SUBMIT INFORMATION REQUIRED BY THE COMMISSIONER TO EVALUATE COMPLIANCE; OR~~

[(2)**]** ~~(3)~~ impose any **OTHER** penalty or take any action as authorized:

(i) for an insurer, nonprofit health service plan, or any other person subject to this section, under this article; or

(ii) for a health maintenance organization, under this article or the Health – General Article.

(L) (1) A CARRIER SHALL HAVE THE BURDEN OF PERSUASION IN DEMONSTRATING THAT ITS ~~HEALTH PLAN~~ DESIGN AND APPLICATION OF A NONQUANTITATIVE TREATMENT LIMITATION COMPLIES WITH THE PARITY ACT:

(I) IN ANY REVIEW CONDUCTED BY THE COMMISSIONER UNDER THIS SECTION; OR

(II) IN ANY ~~MATTER FILED WITH~~ COMPLAINT INVESTIGATION OR MARKET CONDUCT ACTION UNDERTAKEN BY THE COMMISSIONER THAT INVOLVES THE APPLICATION OF THE PARITY ACT.

(2) (I) A FAILURE OF A CARRIER TO SUBMIT COMPLETE PARITY ACT COMPLIANCE INFORMATION REQUIRED UNDER THIS SECTION OR IN CONNECTION WITH ~~A MATTER FILED WITH~~ AN INVESTIGATION OR EXAMINATION BY THE COMMISSIONER SHALL CONSTITUTE NONCOMPLIANCE WITH THE PARITY ACT.

(II) SUBSECTION (I)(1)(III) OF THIS SECTION DOES NOT APPLY TO A CARRIER THAT FAILS TO SUBMIT COMPLETE PARITY ACT COMPLIANCE INFORMATION.

[(l)**] (M)** In determining an appropriate penalty under subsection (j) or (k) of this section, the Commissioner shall consider the late filing of a report required under subsection (c) or (f) of this section and any parity violation to be a serious violation with a significantly deleterious effect on the public.

[(m)**] (N)** ~~On or before December 31, 2021, the~~ **THE** Commissioner shall create:

(1) a standard form for entities to submit the reports in accordance with subsection (g)(1) of this section; and

(2) a summary form for entities to post to their websites in accordance with subsection (g)(5) of this section.

[(n)**] (O)** ~~On or before December 31, **[**2021**] 2024, the~~ **THE** Commissioner shall, in consultation with interested stakeholders, adopt regulations to implement this section,

including to ensure uniform definitions and methodology for the reporting requirements established under this section.

15–1309.

(a) (1) In this section the following words have the meanings indicated.

(3) (i) "Product" means a discrete package of health benefits that are offered using a particular product network type within a geographic service area.

(ii) "Product" comprises all plans offered within the product.

Chapter 211 of the Acts of 2020

[SECTION 2. AND BE IT FURTHER ENACTED, That the standard form the Maryland Insurance Commissioner is required to develop under § 15–144(m)(1) of the Insurance Article, as enacted by Section 1 of this Act, for the report required under § 15–144(c) of the Insurance Article, as enacted by Section 1 of this Act, shall be the National Association of Insurance Commissioners' Data Collection Tool for Mental Health Parity Analysis, Nonquantitative Treatment Limitations and any amendments by the Commissioner to the tool necessary to incorporate the requirements of § 15–144(c), (d), and (e) of the Insurance Article, as enacted by Section 1 of this Act.**]**

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2020. **[**It shall remain in effect for a period of 6 years and, at the end of September 30, 2026, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.**]**

Chapter 212 of the Acts of 2020

[SECTION 2. AND BE IT FURTHER ENACTED, That the standard form the Maryland Insurance Commissioner is required to develop under § 15–144(m)(1) of the Insurance Article, as enacted by Section 1 of this Act, for the report required under § 15–144(c) of the Insurance Article, as enacted by Section 1 of this Act, shall be the National Association of Insurance Commissioners' Data Collection Tool for Mental Health Parity Analysis, Nonquantitative Treatment Limitations and any amendments by the Commissioner to the tool necessary to incorporate the requirements of § 15–144(c), (d), and (e) of the Insurance Article, as enacted by Section 1 of this Act.**]**

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2020. **[**It shall remain in effect for a period of 6 years and, at the end of September 30, 2026, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.**]**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act ~~shall take effect July 1, 2024~~ is an emergency measure, is necessary for the immediate preservation of the public

health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.

Approved by the Governor, April 25, 2024.

Appendix D

Chapter 233

(Senate Bill 684)

AN ACT concerning

Health Insurance – Mental Health and Substance Use Disorder Benefits – Sunset Repeal and Modification of Reporting Requirements

FOR the purpose of altering certain reporting requirements on health insurance carriers relating to compliance with the federal Mental Health Parity and Addiction Equity Act; altering requirements for certain analyses of nonquantitative treatment limitations required of health insurance carriers; ~~authorizing the Maryland Insurance Commissioner to exercise discretion to review subsets of nonquantitative treatment limitations under certain circumstances;~~ establishing certain remedies the Commissioner may use to enforce compliance with the Mental Health Parity and Addiction Equity Act and related reporting requirements; establishing that a health insurance carrier has the burden of persuasion in demonstrating that its health plan complies with the federal Mental Health Parity and Addiction Equity Act; repealing the requirement that the Commissioner use a certain form for the reporting requirements; repealing the termination date for the reporting requirements; and generally relating to health insurance carriers and mental health and substance use disorder benefits.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–144
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–1309(a)(1) and (3)
Annotated Code of Maryland
(2017 Replacement Volume and 2023 Supplement)

BY repealing
Chapter 211 of the Acts of the General Assembly of 2020
Section 2

BY repealing and reenacting, with amendments,
Chapter 211 of the Acts of the General Assembly of 2020
Section 4

BY repealing
Chapter 212 of the Acts of the General Assembly of 2020
Section 2

BY repealing and reenacting, with amendments,
Chapter 212 of the Acts of the General Assembly of 2020
Section 4

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

15–144.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer that holds a certificate of authority in the State and provides health insurance in the State;

(ii) a health maintenance organization that is licensed to operate in the State;

(iii) a nonprofit health service plan that is licensed to operate in the State; or

(iv) any other person or organization that provides health benefit plans subject to State insurance regulation.

(3) "Health benefit plan" means:

(i) for a large group or blanket plan, a health benefit plan as defined in § 15–1401 of this title;

(ii) for a small group plan, a health benefit plan as defined in § 15–1201 of this title;

(iii) for an individual plan:

1. a health benefit plan as defined in § 15–1301(l) of this title; or

2. an individual health benefit plan as defined in § 15–1301(o) of this title;

(iv) short–term limited duration insurance as defined in § 15–1301(s) of this title; or

(v) a student health plan as defined in § 15–1318(a) of this title.

(4) "Medical/surgical benefits" has the meaning stated in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(5) "Mental health benefits" has the meaning stated in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(6) "Nonquantitative treatment limitation" means treatment limitations as defined in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(7) **(I)** "Parity Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 **[**and 45 C.F.R. § 146.136 and 29 C.F.R. § 2590.712**], AS AMENDED**.

(II) "PARITY ACT" INCLUDES 45 C.F.R. § 146.136, 29 C.F.R. § 2590.712, AND ANY OTHER RELATED FEDERAL REGULATIONS FOUND IN THE CODE OF FEDERAL REGULATIONS TO IMPLEMENT OR ENFORCE THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008.

(8) "Parity Act classification" means:

(i) inpatient in–network benefits;

(ii) inpatient out–of–network benefits;

(iii) outpatient in–network benefits;

(iv) outpatient out–of–network benefits;

(v) prescription drug benefits; and

(vi) emergency care benefits.

(9) "PRODUCT" HAS THE MEANING STATED IN § 15–1309(A)(3) OF THIS TITLE.

~~(9)~~ **(10)** "Substance use disorder benefits" has the meaning stated in 45 C.F.R. § 146.136(a) and 29 C.F.R. § 2590.712(a).

(b) This section applies to a carrier that delivers or issues for delivery a health benefit plan in the State.

(C) (1) EACH CARRIER SUBJECT TO THIS SECTION SHALL:

(I) FOR EACH PARITY ACT CLASSIFICATION, IDENTIFY ALL NONQUANTITATIVE TREATMENT LIMITATIONS THAT ARE APPLIED TO MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS;

(II) IN ACCORDANCE WITH THE PARITY ACT, PERFORM AND DOCUMENT COMPARATIVE ANALYSES OF THE DESIGN AND APPLICATION OF ALL NONQUANTITATIVE TREATMENT LIMITATIONS IMPOSED ON MENTAL HEALTH BENEFITS AND SUBSTANCE USE DISORDER BENEFITS;

(III) PROVIDE THE COMPARATIVE ANALYSIS FOR EACH NONQUANTITATIVE TREATMENT LIMITATION REQUESTED BY THE COMMISSIONER WITHIN:

1. 15 WORKING DAYS AFTER A WRITTEN REQUEST; OR

2. IF ADOPTED BY THE FEDERAL GOVERNMENT, LESS THAN 15 WORKING DAYS TO ALIGN WITH THE FEDERAL RULE OR REGULATION;

(IV) WITHIN 30 DAYS AFTER A WRITTEN REQUEST, PROVIDE THE COMPARATIVE ANALYSIS FOR EACH NONQUANTITATIVE TREATMENT LIMITATION AND RELATED IN OPERATION DATA ANALYSIS, IF AVAILABLE AND REQUESTED BY A MEMBER IN ACCORDANCE WITH THE PARITY ACT DISCLOSURE REQUIREMENTS OR, FOR MEMBERS WITH INDIVIDUAL PLANS, IN ACCORDANCE WITH SUBSECTION (E)(7) OF THIS SECTION; AND

(V) SUBMIT THE REPORTS REQUIRED UNDER PARAGRAPH (2) OF THIS SUBSECTION.

~~(c)~~ ~~(1)~~ **(2)** On or before **[**March 1, 2022, and March 1, 2024**]** ~~**MARCH 1 EACH YEAR, BEGINNING IN 2025**~~ **JULY 1, 2024, AND EVERY 2 YEARS THEREAFTER**, each carrier subject to this section shall~~:~~

~~(i) identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets; and~~

~~(ii)~~ submit a report to the Commissioner **ON EACH PRODUCT OFFERED BY THE CARRIER IN THE INDIVIDUAL, SMALL, AND LARGE GROUP MARKETS** to demonstrate the carrier's compliance with the Parity Act.

~~(2)~~ **(3)** The report submitted under paragraph ~~(1)~~ **(2)** of this subsection shall include ~~[~~the following information~~]~~**:**

(I) ALL NONQUANTITATIVE TREATMENT LIMITATION ~~COMPARATIVE ANALYSIS~~ **INFORMATION REQUIRED UNDER THE PARITY ACT, SUBSECTION (D) OF THIS SECTION, AND ANY STATE REGULATIONS** for the ~~health benefit plans identified~~ **PRODUCTS IDENTIFIED** under **[**item**]** **PARAGRAPH** ~~(1)(i)~~ **(2)** of this subsection~~;~~**,** ~~INCLUDING:~~

~~(i) a description of the process used to develop or select the medical necessity criteria for mental health benefits and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;~~

~~(ii) for each Parity Act classification, identification of nonquantitative treatment limitations that are applied to mental health benefits and substance use disorder benefits and medical and surgical benefits;~~

~~(iii) identification of the description of the nonquantitative treatment limitations identified under item (ii) of this paragraph in documents and instruments under which the plan is established or operated; and~~

~~(iv)~~ **(II)** the results of ~~the~~ **A** comparative analysis ~~as described under subsections (d) and (e) of this section.~~ **CONDUCTED BY THE CARRIER ON NOT FEWER THAN FIVE NONQUANTITATIVE TREATMENT LIMITATIONS SELECTED BY THE COMMISSIONER IN ACCORDANCE WITH PARAGRAPH (5) OF THIS SUBSECTION; AND**

(III) SUBJECT TO PARAGRAPH (4) OF THIS SUBSECTION, A STATEMENT, SIGNED BY A CORPORATE OFFICER, ATTESTING THAT, FOR EACH PRODUCT IDENTIFIED UNDER PARAGRAPH (2) OF THIS SUBSECTION, THE SELECTED NONQUANTITATIVE TREATMENT LIMITATIONS AND THE PROCESSES, STRATEGIES, EVIDENTIARY STANDARDS, OR OTHER FACTORS USED IN DESIGNING AND APPLYING THE SELECTED NONQUANTITATIVE TREATMENT LIMITATIONS TO MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, AND MEDICAL/SURGICAL BENEFITS ARE THE SAME FOR ALL PLANS WITHIN THE PRODUCT, AS WRITTEN AND IN OPERATION.

(4) IF, FOR ANY PLAN WITHIN A PRODUCT IDENTIFIED UNDER PARAGRAPH (2) OF THIS SUBSECTION, THE PROCESSES, STRATEGIES, EVIDENTIARY STANDARDS, OR OTHER FACTORS USED IN DESIGNING AND APPLYING THE SELECTED NONQUANTITATIVE TREATMENT LIMITATIONS TO MENTAL HEALTH BENEFITS, SUBSTANCE USE DISORDER BENEFITS, OR MEDICAL/SURGICAL BENEFITS ARE DIFFERENT, AS WRITTEN OR IN OPERATION, FROM THE OTHER PLANS WITHIN THE PRODUCT:

(I) THE STATEMENT REQUIRED UNDER PARAGRAPH (3)(III) OF THIS SUBSECTION SHALL NOTE THE EXCEPTION AND IDENTIFY THE PLAN; AND

(II) THE CARRIER SHALL SUBMIT A SEPARATE COMPARATIVE ANALYSIS FOR THE SELECTED NONQUANTITATIVE TREATMENT LIMITATIONS FOR THE PLAN.

(5) (I) IN SELECTING THE NONQUANTITATIVE TREATMENT LIMITATIONS REQUIRED TO BE INCLUDED FOR EACH REPORTING PERIOD, THE COMMISSIONER:

1. SHALL PRIORITIZE THE NONQUANTITATIVE TREATMENT LIMITATIONS IDENTIFIED BY THE COMMISSIONER AS HAVING THE GREATEST IMPACT ON MEMBER ACCESS TO CARE;

2. SHALL REVIEW THE SAME SUBSET OF NONQUANTITATIVE TREATMENT LIMITATIONS FOR EACH CARRIER REPORT; AND

3. MAY TAKE INTO CONSIDERATION OTHER FACTORS DETERMINED RELEVANT BY THE COMMISSIONER, INCLUDING COMPLAINT TRENDS, FEDERAL PARITY ACT GUIDANCE, AND WHETHER THE NONQUANTITATIVE TREATMENT LIMITATION WAS SELECTED FOR A PREVIOUS REPORTING YEAR.

(II) OF THE FIVE SELECTED NONQUANTITATIVE TREATMENT LIMITATIONS:

1. NOT MORE THAN TWO MAY BE FOR UTILIZATION REVIEW; AND

2. AT LEAST ONE MUST BE FOR NETWORK COMPOSITION, INCLUDING REIMBURSEMENT RATE SETTING.

(6) A FINDING OF NONCOMPLIANCE FOR A PRODUCT SHALL APPLY TO ALL PLANS WITHIN THE PRODUCT.

(d) (1) A carrier subject to this section shall conduct a comparative analysis for the nonquantitative treatment limitations ~~identified~~ **SELECTED** under subsection ~~(e)(2)(ii)~~ **(C)(5)** of this section as nonquantitative treatment limitations are:

(i) written; and

(ii) in operation.

(2) The comparative analysis of the nonquantitative treatment limitations ~~identified~~ **SELECTED** under subsection ~~(c)(2)(ii)~~ **(C)(5)** of this section shall**:**

(I) demonstrate that the processes, strategies, evidentiary standards, or other factors used in **DESIGNING AND** applying ~~the medical necessity criteria and~~ each **SELECTED** nonquantitative treatment limitation to mental health benefits and substance use disorder benefits in each Parity Act classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in **DESIGNING AND** applying ~~the medical necessity criteria and~~ each **SELECTED** nonquantitative treatment limitation to ~~medical and surgical~~ **MEDICAL/SURGICAL** benefits within the same Parity Act classification**; AND**

(II) INCLUDE ALL INFORMATION REQUIRED UNDER THE PARITY ACT.

(3) REGARDLESS OF WHETHER IT WAS USED BEFORE THE PARITY ACT WAS ENACTED AND AS REQUESTED BY THE COMMISSION, A CARRIER SHALL PERFORM AND PROVIDE A COMPARATIVE ANALYSIS FOR EACH PROCESS, STRATEGY, EVIDENTIARY STANDARD, OR OTHER FACTOR USED IN DESIGNING AND APPLYING A SELECTED NONQUANTITATIVE TREATMENT LIMITATION USED DURING A REPORTING PERIOD.

(e) In providing the analysis required under subsection (d) of this section, a carrier shall:

(1) identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including:

(i) the sources for the factors~~, INCLUDING SOURCES IN EFFECT BEFORE THE ENACTMENT OF THE PARITY ACT~~;

(ii) the factors that were considered but rejected; ~~[~~and~~]~~

~~(III) THE FACTORS THAT WERE IN EFFECT BEFORE THE ENACTMENT OF THE PARITY ACT AND ARE USED IN THE DESIGN OR APPLICATION OF THE NONQUANTITATIVE TREATMENT LIMITATION; AND~~

~~[~~(iii)~~]~~ ~~(IV)~~ if a factor was given more weight than another, the reason for the difference in weighting;

(2) identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation~~, INCLUDING EVIDENTIARY STANDARDS IN EFFECT BEFORE THE ENACTMENT OF THE PARITY ACT~~;

~~(3) IDENTIFY AND DEFINE THE PROCESSES AND STRATEGIES THAT ARE USED TO DESIGN OR APPLY THE NONQUANTITATIVE TREATMENT LIMITATION, INCLUDING THE PROCESSES AND STRATEGIES IN EFFECT BEFORE THE ENACTMENT OF THE PARITY ACT;~~

~~[~~(3)~~]~~ ~~(4)~~ include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection ~~(e)(2)(ii)~~ **(C)(5)** of this section to conduct the analysis required under subsection (d)(2) of this section for the plans **AND PRODUCTS** as written;

~~[~~(4)~~]~~ ~~(5)~~ include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection ~~(e)(2)(ii)~~ **(C)(5)** of this section to conduct the analysis required under subsection (d)(2) of this section for the plans **AND PRODUCTS** as in operation;

~~[~~(5)~~]~~ ~~(6)~~ identify the measures used to ensure comparable design and application of nonquantitative treatment limitations that are implemented by the carrier and any entity delegated by the carrier to manage mental health benefits, substance use disorder benefits, or medical/surgical benefits on behalf of the carrier;

~~[~~(6)~~]~~ ~~(7)~~ disclose the specific findings and conclusions reached by the carrier that indicate that the health benefit plan is in compliance with this section and the Parity Act **[**and its implementing regulations, including 45 C.F.R. 146.136 and 29 C.F.R. 2590.712 and any other related federal regulations found in the Code of Federal Regulations**]**; and

~~[~~(7)~~]~~ ~~(8)~~ identify the process used to comply with the Parity Act disclosure requirements for mental health benefits, substance use disorder benefits, and medical/surgical benefits, including:

(i) the criteria for a medical necessity determination;

(ii) reasons for a denial of benefits; and

(iii) in connection with a member's request for **INDIVIDUAL OR** group plan information and for purposes of filing an internal coverage or grievance matter and appeals, plan documents that contain information about processes, strategies, evidentiary standards, and any other factors used to apply a nonquantitative treatment limitation.

~~(f) On or before [March 1, 2022, and March 1, 2024] MARCH 1 EACH YEAR, BEGINNING IN 2025, each carrier subject to this section shall submit a report for the health benefit plans identified under subsection (e)(1)(i) of this section to the Commissioner on the following data for the immediately preceding calendar year for mental health~~

~~benefits, substance use disorder benefits, and medical/surgical benefits by Parity Act classification:~~

~~(1) the frequency, reported by number and rate, with which the health benefit plan received, approved, and denied prior authorization requests for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year; [and]~~

~~(2) the number of claims submitted for mental health benefits, substance use disorder benefits, and medical and surgical benefits in each Parity Act classification during the immediately preceding calendar year and the number and rates of, and reasons for, denial of claims; AND~~

~~(3) DATA IDENTIFIED BY THE COMMISSIONER OR FEDERAL REGULATIONS TO EVALUATE NONQUANTITATIVE TREATMENT LIMITATION COMPLIANCE WITH THE IN–OPERATION STANDARD OF THE PARITY ACT.~~

(F) THE COMMISSIONER SHALL:

(1) DEVELOP ADDITIONAL STANDARDIZED DATA TEMPLATES:

(I) TO EVALUATE THE COMPARATIVE ANALYSIS OF NONQUANTITATIVE TREATMENT LIMITATIONS IN OPERATION; AND

(II) THAT MEET OR EXCEED ANY MINIMUM REQUIREMENTS FOR DATA REPORTING SPECIFIED IN FEDERAL REGULATIONS;

(2) REQUIRE EACH CARRIER SUBJECT TO THIS SECTION TO SUBMIT:

(I) FOR EACH PRODUCT IDENTIFIED UNDER SUBSECTION (C)(2) OF THIS SECTION, THE DATA TEMPLATES DESCRIBED IN ITEM (1) OF THIS SUBSECTION FOR THE NONQUANTITATIVE TREATMENT LIMITATIONS SELECTED BY THE COMMISSIONER FOR THE REPORTING YEAR IN ACCORDANCE WITH SUBSECTION (C)(5) OF THIS SECTION; AND

(II) A SEPARATE DATA TEMPLATE FOR ANY PLANS DESCRIBED IN SUBSECTION (C)(4) OF THIS SECTION; AND

(3) POST THE DATA TEMPLATES ON THE ADMINISTRATION'S WEBSITE FOR A COMMENT PERIOD OF NOT LESS THAN 30 DAYS BEFORE ADOPTION.

(g) The reports required under ~~subsections (e) and (f) of~~ this section shall:

(1) be submitted on a standard form developed by the Commissioner **THAT** ~~**CONFORMS TO**~~ **MEETS OR EXCEEDS ANY MINIMUM REQUIREMENTS SPECIFIED IN**

THE FEDERAL REGULATIONS AND SUB–REGULATORY GUIDANCE ON NONQUANTITATIVE TREATMENT LIMITATIONS ~~COMPARATIVE ANALYSIS~~ REPORTING;

(2) be submitted by the carrier that issues or delivers the ~~health benefit plan~~ **PRODUCT**;

(3) be prepared in coordination with any entity the carrier contracts with to provide mental health benefits and substance use disorder benefits;

(4) contain a statement, signed by a corporate officer, attesting to the accuracy of the information contained in the report;

(5) be available to plan members and the public on the carrier's website in a summary form that removes confidential or proprietary information and is developed by the Commissioner in accordance with subsection **[**(m)(2)**] (N)(2)** of this section; and

(6) exclude any identifying information of any plan member.

(h) (1) A carrier submitting a report under ~~subsections (e) and (f) of~~ this section may submit a written request to the Commissioner that disclosure of specific information included in the report be denied under the Public Information Act and, if submitting a request, shall:

(i) identify the particular information the disclosure of which the carrier requests be denied; and

(ii) cite the statutory authority under the Public Information Act that authorizes denial of access to the information.

(2) The Commissioner may review a request submitted under paragraph (1) of this subsection on receipt of a request for access to the information under the Public Information Act.

(3) The Commissioner may notify the carrier that submitted the request under paragraph (1) of this subsection before granting access to information that was the subject of the request.

(4) A carrier shall disclose to a member on request any plan information contained in a report that is required to be disclosed to that member under federal or State law.

(i) **(1)** The Commissioner shall:

[(1)**]** **(I)** review each report submitted in accordance with subsections (c)**, (D),** and (f) of this section to assess each carrier's compliance with the Parity Act **FOR EACH PARITY ACT CLASSIFICATION**;

[(2)**]** **(II)** notify a carrier in writing of any noncompliance with the Parity Act before issuing an administrative order; and

[(3)**]** **(III)** within 90 days after the notice of noncompliance is issued, allow the carrier to:

[(i)**]** **1.** submit a compliance plan to the Administration to comply with the Parity Act; and

[(ii)**]** **2.** reprocess any claims that were improperly denied, in whole or in part, because of the noncompliance.

~~**(2) THE COMMISSIONER MAY EXERCISE DISCRETION TO REVIEW A SUBSET OF NONQUANTITATIVE TREATMENT LIMITATIONS FOR THE PURPOSES OF THIS SECTION IF THE COMMISSIONER:**~~

~~**(I) AFTER THE REPORTING DEADLINES ESTABLISHED UNDER SUBSECTIONS (C) AND (F) OF THIS SECTION, IDENTIFIES THE NONQUANTITATIVE TREATMENT LIMITATIONS THAT WILL BE REVIEWED BY THE COMMISSIONER;**~~

~~**(II) DESCRIBES AND POSTS ON THE ADMINISTRATION'S WEBSITE THE CRITERIA USED TO IDENTIFY THE NONQUANTITATIVE TREATMENT LIMITATIONS THAT WILL BE REVIEWED EACH YEAR;**~~

~~**(III) REVIEWS NONQUANTITATIVE TREATMENT LIMITATIONS THAT HAVE THE GREATEST EFFECT ON ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE;**~~

~~**(IV) REVIEWS THE SAME SUBSET OF NONQUANTITATIVE TREATMENT LIMITATIONS FOR EACH CARRIER REPORT;**~~

~~**(V) REVIEWS NOT LESS THAN 10 NONQUANTITATIVE TREATMENT LIMITATIONS FOR EACH CARRIER REPORT; AND**~~

~~**(VI) ISSUES A DETERMINATION IN ANY MATTER THAT IMPLICATES PARITY ACT COMPLIANCE REGARDLESS OF WHETHER A NONQUANTITATIVE TREATMENT LIMITATION AT ISSUE IN THE MATTER HAS BEEN REVIEWED UNDER THIS SECTION.**~~

(2) THE COMMISSIONER MAY REQUIRE CARRIERS TO COMPLETE DATA TEMPLATES FOR A NONQUANTITATIVE TREATMENT LIMITATION MORE FREQUENTLY THAN EVERY 2 YEARS.

(j) **(1)** If the Commissioner finds that the carrier failed to submit a complete report required under ~~subsection (c) or (f) of~~ this section, the Commissioner may**:**

(I) TAKE ACTION AUTHORIZED UNDER PARAGRAPH (2) OF THIS SUBSECTION;

(II) IN ACCORDANCE WITH § 2–208 OF THIS ARTICLE, CHARGE THE CARRIER FOR ANY ADDITIONAL EXPENSES INCURRED BY THE COMMISSIONER TO REVIEW ADDITIONAL REPORTS;

(III) IMPOSE A PENALTY FOR EACH DAY THAT THE CARRIER FAILS TO SUBMIT INFORMATION REQUIRED BY THE COMMISSIONER TO EVALUATE COMPLIANCE; OR

(IV) impose any penalty or take any action as authorized:

~~(1)~~ **1.** for an insurer, nonprofit health service plan, or any other person subject to this section, under this article; or

~~(2)~~ **2.** for a health maintenance organization, under this article or the Health – General Article.

(2) IF THE COMMISSIONER CANNOT MAKE A DETERMINATION THAT A SPECIFIC CONDUCT OR PRACTICE IS COMPLIANT WITH THE PARITY ACT BECAUSE THE CARRIER FAILED TO PROVIDE A SUFFICIENT COMPARATIVE ANALYSIS FOR A NONQUANTITATIVE TREATMENT LIMITATION, THE COMMISSIONER MAY:

(I) ISSUE AN ADMINISTRATIVE ORDER REQUIRING THE CARRIER OR AN ENTITY DELEGATED BY THE CARRIER TO TAKE THE FOLLOWING ACTION UNTIL THE COMMISSIONER CAN MAKE A DETERMINATION OF COMPLIANCE WITH THE PARITY ACT:

1. MODIFY THE CONDUCT OR PRACTICE AS SPECIFIED BY THE COMMISSIONER;

2. CEASE THE CONDUCT OR PRACTICE; OR

3. SUBMIT PERIODIC DATA RELATED TO THE CONDUCT OR PRACTICE; OR

(II) SUBJECT TO PARAGRAPH (3) OF THIS SUBSECTION, REQUIRE THE CARRIER TO PERFORM A NEW COMPARATIVE ANALYSIS.

(3) THE COMMISSIONER MAY REQUIRE THE CARRIER TO ESTABLISH SPECIFIC QUANTITATIVE THRESHOLDS FOR EVIDENTIARY STANDARDS AND CONDUCT A NEW COMPARATIVE ANALYSIS FOR A NONQUANTITATIVE TREATMENT LIMITATION IF THE COMMISSIONER DETERMINES A CARRIER FAILED TO PROVIDE A SUFFICIENT COMPARATIVE ANALYSIS BECAUSE THE CARRIER DID NOT:

(I) USE APPLICABLE QUANTITATIVE THRESHOLDS FOR THE EVIDENTIARY STANDARD; OR

(II) PROVIDE A SPECIFIC, DETAILED, AND REASONED EXPLANATION OF HOW THE CARRIER ENSURES THAT THE FACTORS FOR THE NONQUANTITATIVE TREATMENT LIMITATION ARE BEING APPLIED COMPARABLY AND NO MORE STRINGENTLY TO MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.

(4) SUBSECTION (I)(1)(III) OF THIS SECTION DOES NOT APPLY TO THE FAILURE OF A CARRIER TO SUBMIT A COMPLETE REPORT.

(k) If, as a result of the review required under subsection **[**(i)(1)**]** **(I)(1)(I)** of this section, the Commissioner finds that the carrier failed to comply with **[**the provisions of**]** the Parity Act, ~~[~~and~~]~~ did not submit a compliance plan to adequately correct the noncompliance~~, OR FAILED TO SUBMIT INFORMATION THAT IS REQUIRED TO EVALUATE COMPLIANCE WITH THE PARITY ACT~~**,** the Commissioner may:

(1) issue an administrative order that requires:

(i) the carrier or an entity delegated by the carrier to cease the noncompliant conduct or practice; ~~[~~or~~]~~

~~(II) THE CARRIER OR AN ENTITY DELEGATED BY THE CARRIER TO CEASE THE IMPLEMENTATION OF THE NONQUANTITATIVE TREATMENT LIMITATION; OR~~

~~[~~(ii)~~]~~ ~~(III)~~ the carrier to provide a payment that has been denied improperly because of the noncompliance~~, INCLUDING A FAILURE TO PROVIDE INFORMATION THAT DEMONSTRATES COMPLIANCE~~; **[**or**]**

~~(2) IMPOSE A PENALTY OF NOT LESS THAN $1,000 FOR EACH DAY IN WHICH THE CARRIER FAILS TO SUBMIT INFORMATION REQUIRED BY THE COMMISSIONER TO EVALUATE COMPLIANCE; OR~~

[(2)**]** ~~(3)~~ impose any **OTHER** penalty or take any action as authorized:

(i) for an insurer, nonprofit health service plan, or any other person subject to this section, under this article; or

(ii) for a health maintenance organization, under this article or the Health – General Article.

(L) (1) A CARRIER SHALL HAVE THE BURDEN OF PERSUASION IN DEMONSTRATING THAT ITS ~~HEALTH PLAN~~ DESIGN AND APPLICATION OF A NONQUANTITATIVE TREATMENT LIMITATION COMPLIES WITH THE PARITY ACT:

(I) IN ANY REVIEW CONDUCTED BY THE COMMISSIONER UNDER THIS SECTION; OR

(II) IN ANY ~~MATTER FILED WITH~~ COMPLAINT INVESTIGATION OR MARKET CONDUCT ACTION UNDERTAKEN BY THE COMMISSIONER THAT INVOLVES THE APPLICATION OF THE PARITY ACT.

(2) (I) A FAILURE OF A CARRIER TO SUBMIT COMPLETE PARITY ACT COMPLIANCE INFORMATION REQUIRED UNDER THIS SECTION OR IN CONNECTION WITH ~~A MATTER FILED WITH~~ AN INVESTIGATION OR EXAMINATION BY THE COMMISSIONER SHALL CONSTITUTE NONCOMPLIANCE WITH THE PARITY ACT.

(II) SUBSECTION (I)(1)(III) OF THIS SECTION DOES NOT APPLY TO A CARRIER THAT FAILS TO SUBMIT COMPLETE PARITY ACT COMPLIANCE INFORMATION.

[(l)**] (M)** In determining an appropriate penalty under subsection (j) or (k) of this section, the Commissioner shall consider the late filing of a report required under subsection (c) or (f) of this section and any parity violation to be a serious violation with a significantly deleterious effect on the public.

[(m)**] (N)** ~~On or before December 31, 2021, the~~ **THE** Commissioner shall create:

(1) a standard form for entities to submit the reports in accordance with subsection (g)(1) of this section; and

(2) a summary form for entities to post to their websites in accordance with subsection (g)(5) of this section.

[(n)**] (O)** ~~On or before December 31, **[**2021**] 2024, the~~ **THE** Commissioner shall, in consultation with interested stakeholders, adopt regulations to implement this section,

including to ensure uniform definitions and methodology for the reporting requirements established under this section.

15–1309.

(a) (1) In this section the following words have the meanings indicated.

(3) (i) "Product" means a discrete package of health benefits that are offered using a particular product network type within a geographic service area.

(ii) "Product" comprises all plans offered within the product.

Chapter 211 of the Acts of 2020

[SECTION 2. AND BE IT FURTHER ENACTED, That the standard form the Maryland Insurance Commissioner is required to develop under § 15–144(m)(1) of the Insurance Article, as enacted by Section 1 of this Act, for the report required under § 15–144(c) of the Insurance Article, as enacted by Section 1 of this Act, shall be the National Association of Insurance Commissioners' Data Collection Tool for Mental Health Parity Analysis, Nonquantitative Treatment Limitations and any amendments by the Commissioner to the tool necessary to incorporate the requirements of § 15–144(c), (d), and (e) of the Insurance Article, as enacted by Section 1 of this Act.**]**

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2020. **[**It shall remain in effect for a period of 6 years and, at the end of September 30, 2026, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.**]**

Chapter 212 of the Acts of 2020

[SECTION 2. AND BE IT FURTHER ENACTED, That the standard form the Maryland Insurance Commissioner is required to develop under § 15–144(m)(1) of the Insurance Article, as enacted by Section 1 of this Act, for the report required under § 15–144(c) of the Insurance Article, as enacted by Section 1 of this Act, shall be the National Association of Insurance Commissioners' Data Collection Tool for Mental Health Parity Analysis, Nonquantitative Treatment Limitations and any amendments by the Commissioner to the tool necessary to incorporate the requirements of § 15–144(c), (d), and (e) of the Insurance Article, as enacted by Section 1 of this Act.**]**

SECTION 4. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2020. **[**It shall remain in effect for a period of 6 years and, at the end of September 30, 2026, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.**]**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act ~~shall take effect July 1, 2024~~ is an emergency measure, is necessary for the immediate preservation of the public

health or safety, has been passed by a yea and nay vote supported by three–fifths of all the members elected to each of the two Houses of the General Assembly, and shall take effect from the date it is enacted.

Approved by the Governor, April 25, 2024.

Appendix E

2024 MHPAEA Report to Congress

Acting Secretary Julie Su
Department of Labor

Secretary Xavier Becerra
Department of Health & Human Services

Secretary Janet L. Yellen
Department of the Treasury

January 2025

Report To Congress on MHPAEA Enforcement and Implementation, 2024

Preface

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that any financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) that apply to mental health and substance use disorder (MH/SUD) benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical (M/S) benefits in a benefits classification.[1] In addition, MHPAEA prohibits separate financial requirements or treatment limitations that apply only to MH/SUD benefits. These protections are intended to ensure that participants, beneficiaries, and enrollees seeking MH/SUD benefits do not face greater limitations on access to those benefits than are imposed on M/S benefits.[2] These protections are vital for America's workers, health insurance consumers, and their families and caregivers.

The Consolidated Appropriations Act, 2021 (CAA)[3] amended MHPAEA, in part, by expressly requiring plans and issuers that provide both M/S benefits and MH/SUD benefits and

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[1] Pub. L. 110-343, 122 Stat. 3765, as amended by the Patient Protection and Affordable Care Act, Pub. L. 111-148, 12 Stat. 119, and the Consolidated Appropriations Act, 2021, Pub. L. 116-260, 134 Stat. 1182. Additionally, requirements related to mental health parity were included in the 21st Century Cures Act (Cures Act), Pub. L. 114-255, 130 Stat. 1033, as amended by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Support Act), Pub. L. 115-271, 132 Stat. 3894.

[2] In a floor statement, Representative Patrick Kennedy (D–RI), one of the chief architects of MHPAEA, made the case for its passage on the grounds that ''access to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered from discriminatory treatment at all levels of society.'' 153 Cong. Rec. S1864–5 (daily ed. Feb. 12, 2007). Cf. H. Rept. 110–374, part 3 (Mar. 4, 2008), https://www.congress.gov/congressional-report/110th-congress/house-report/374 (''The purpose of H.R. 1424, the 'Paul Wellstone Mental Health and Addiction Equity Act of 2007' is to have fairness and equity in the coverage of mental health and substance-related disorders vis-a-vis coverage for medical and surgical disorders.'').

[3] Pub. L. 116-260, 134 Stat. 1182.

that impose nonquantitative treatment limitations (NQTLs)[4] on MH/SUD benefits to perform and document comparative analyses of the design and application of NQTLs and make their analyses available to the Secretaries of the Treasury (Treasury), Health and Human Services (HHS), and Labor (DOL) (collectively, the Secretaries), as applicable, or to an applicable State authority upon request.[5] The CAA amendments to MHPAEA also require the Secretaries to report to Congress annually on the results of these NQTL comparative analyses reviews conducted by the Secretaries.[6] MHPAEA also requires the Secretary of Labor to submit a report to certain appropriate committees of Congress on MHPAEA compliance by group health plans (and issuers of health insurance coverage offered in connection with such plans) every two years.[7]

Previous Reports to Congress[8] have highlighted the parity implementation, enforcement, and outreach effort of DOL's Employee Benefits Security Administration (EBSA) and HHS' Centers for Medicare & Medicaid Services (CMS). In January 2022, Treasury, HHS, and DOL (collectively, the Departments) published the first report since the enactment of the CAA: the January 2022 MHPAEA Report to Congress, also referred to in this document as the January

[4] NQTLs are generally non-numerical limits on the scope or duration of benefits (such as prior authorization requirements, step therapy protocols, and methodologies for establishing provider reimbursement rates). For example, a treatment limitation that provides that a plan or issuer will refuse to provide coverage for a higher cost therapy until it is shown that a lower-cost therapy is not effective (also known as a fail-first policy or step therapy protocol) is an NQTL because the limitation is not expressed numerically but otherwise limits the scope or duration of benefits for treatment.

[5] Internal Revenue Code (Code) section 9812(a)(8)(A); Employee Retirement Income Security Act (ERISA) section 712(a)(8)(A); and Public Health Service Act (PHS Act) section 2726(a)(8)(A).

[6] Code section 9812(a)(8)(B)(iv); ERISA section 712(a)(8)(B)(iv); PHS Act 2726(a)(8)(B)(iv). In addition, the Secretaries were required to send Congress, over a 6-year period, an annual report on complaints and investigations concerning compliance with the requirements of MHPAEA. *See* section 13003 of the Cures Act, Pub. L. 114-255, 130 Stat. 1033, 1285, as amended by section 7182 of the SUPPORT Act, Pub. L. 115-271, 132 Stat. 3894, 4070.

[7] ERISA section 712(f).

[8] The Departments' previous Reports to Congress are available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity/tools-and-resources.

2022 Report.[9] This report highlighted that, upon initial submission, every NQTL comparative analysis reviewed was in some way insufficient to meet the requirements of Internal Revenue Code (Code) section 9812(a)(8), Employee Retirement Income Security Act (ERISA) section 712(a)(8), and Public Health Service (PHS) Act section 2726(a)(8). Similarly, the July 2023 Comparative Analysis Report to Congress,[10] also referred to in this document as the July 2023 Report, highlighted that all comparative analyses requested by DOL and HHS did not meet the requirements of Code section 9812(a)(8), ERISA section 712(a)(8) and PHS Act section 2726(a)(8) upon initial submission. The July 2023 Report was also the first to identify, by name, plans and issuers that received a final determination of noncompliance from the Departments as required pursuant to Code section 9812(a)(8)(B)(iv)(I), ERISA section 712(a)(8)(B)(iv)(I), and PHS Act section 2726(a)(8)(B)(iv)(I).

Both the January 2022 Report and the July 2023 Report also highlighted some of the results achieved by the Departments in their enforcement efforts, including the removal of a nutritional counseling exclusion that affected 1.2 million participants covered by 602 plans, elimination of exclusions for applied behavior analysis (ABA) therapy for treatment of autism spectrum disorder (ASD) for millions of participants, and the reprocessing of 3,000 previously denied claims totaling nearly $2 million by a service provider for a drug testing exclusion for MH/SUD benefits. As explained in the January 2022 Report and the July 2023 Report, between February 2021 and July 2022, 104 plans (and their service providers, such as third-party administrators, pharmacy benefit managers, etc.) and issuers overall agreed to make prospective

[9] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.
[10] *See* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.

changes to their plans addressing 135 NQTLs (71 unique NQTLs[11]) due to EBSA's enforcement efforts. These changes expanded access to MH/SUD benefits for over 4 million participants, beneficiaries, and enrollees across over 39,000 plans. Further, plans and issuers have agreed to remove impermissible treatment limitations on MH/SUD benefits that were not imposed on M/S benefits, such as limitations based on failure to demonstrate improvement/progress or to complete the full continuum of care at a treatment facility, as well as to update time and distance metrics used for provider network participation standards, as a result of CMS' enforcement efforts.

This report to Congress highlights the ongoing efforts of the Departments to strengthen and enforce the protections of MHPAEA, and better ensure comparable access to MH/SUD benefits as compared to M/S benefits for participants, beneficiaries, and enrollees during the Reporting Period.[12] This report also highlights the Departments' efforts to raise awareness of the protections of MHPAEA, including by working with Federal and State partners, and to gather feedback from interested parties on improvements needed and areas of concern. Finally, this report details efforts by the Departments to ensure parity in access to MH/SUD benefits as compared to M/S benefits for participants, beneficiaries, and enrollees, including by issuing the August 2023 proposed rules, entitled *Requirements Related to the Mental Health Parity and Addiction Equity Act: Proposed Rules* (2023 Proposed Rules),[13] and finalizing those rules with

[11] This count of "unique" NQTLs includes only NQTLs that EBSA has identified with respect to a specific plan or issuer that has defined the NQTL using different factors or evidentiary standards than other NQTLs. When a comparative analysis request is sent to an issuer with identical NQTLs that apply to many fully insured plans, EBSA similarly counts the NQTL as one unique NQTL, even though there are technically many separate NQTLs for the different plans. When EBSA learns in the course of its investigations that NQTLs previously thought to be identical are administered differently with respect to different classifications, plans, or products, EBSA changes the characterization accordingly.

[12] As explained in more detail later in this report, EBSA's Reporting Period began on August 1, 2022 and ended on July 31, 2023, and the CMS Reporting Period began on September 2, 2022 and ended on July 31, 2023.

[13] 88 FR 51552 (Aug. 3, 2023).

modifications in September 2024 in *Requirements Related to the Mental Health Parity and Addiction Equity Act: Final Rules* (2024 Final Rules).[14] The 2024 Final Rules strengthen the requirements of MHPAEA and provide detail on the NQTL comparative analysis requirements added by the CAA in order to improve the sufficiency of such analyses in the future.[15] This report fulfills the requirement under section 203 of title II of division BB of the CAA that the Departments provide an annual report to Congress on enforcement efforts related to the NQTL comparative analyses[16] and the requirement under section 712(f) of ERISA that the Secretary of Labor submit a biennial report on compliance of plans with MHPAEA.

[14] 89 FR 77586 (Sept. 23, 2024).
[15] While the 2024 Final Rules were published subsequent to the end of both the EBSA Reporting Period and the CMS Reporting Period (but prior to the publication of this report to Congress), Section IV of this report to Congress discusses the 2024 Final Rules in order to acknowledge the changes to the MHPAEA regulations made by the 2024 Final Rules and to ensure that interested parties are informed of these changes. The Departments expect that the 2024 Final Rules will positively impact access to MH/SUD benefits as compared to M/S benefits and MHPAEA compliance once they become applicable.
[16] Code section 9812(a)(8)(B)(iv); ERISA section 712(a)(8)(B)(iv); and PHS Act section 2726(a)(8)(B)(iv).

Fast Facts

EBSA enforces title I of ERISA, including the group health plan provisions added by MHPAEA, with respect to approximately 2.6 million private employment-based group health plans, which covered an estimated 136 million participants and beneficiaries during the EBSA Reporting Period.[17] CMS enforces applicable provisions of title XXVII of the PHS Act, including the provisions added by MHPAEA, with respect to approximately 91,000 non-Federal governmental group health plans nationwide and 67 issuers in the two States[18] where it was the direct enforcer of MHPAEA with respect to issuers during the reporting period from September 2, 2022, to July 31, 2023 (CMS Reporting Period).[19, 20] The following is an overview of the key enforcement actions taken by EBSA and CMS under section 203 of title II of division BB of the CAA, which are explained more fully in Sections I and II of this report.

During the EBSA Reporting Period, EBSA issued the following:

- **17 initial letters** requesting comparative analyses for **22 NQTLs (19 unique NQTLs**[21]),

[17] MHPAEA requires the submission of an annual report to Congress on the results of enforcement efforts related to the NQTL comparative analyses by October 1 of each year. Therefore, in order to provide EBSA time to collect the information necessary and draft the report, EBSA's reporting period ended on July 31, 2023. As highlighted in the Conclusion, the Departments intend to issue a report on enforcement efforts related to the NQTL comparative analyses during the subsequent reporting period (which will be August 1, 2023, through July 31, 2024) in the near future.

[18] CMS was responsible for enforcement of MHPAEA with respect to issuers in Texas and Wyoming during the CMS Reporting Period.

[19] CMS calculated the number of issuers in these two States by using 2023 medical loss ratio (MLR) data of issuers with enrollment in the individual, small group, and large group markets.

[20] The CMS Reporting Period covers the period of September 2, 2022, through July 31, 2023, due to CMS's prior reporting period in the July 2023 Report ending on September 1, 2022. In future reports, EBSA and CMS intend to align their reporting periods. The reporting period for future reports will be from August 1 through July 31 of the following year.

[21] This count of "unique" NQTLs includes only NQTLs that EBSA has identified with respect to a specific plan or issuer that has defined the NQTL using different factors or evidentiary standards than other NQTLs. For example, if

- **45 insufficiency letters** covering **over 40 NQTLs**,[22] and
- **13 initial determination letters** finding that plans and issuers had violated MHPAEA's requirements for **21 NQTLs (14 unique NQTLs**).

During the CMS Reporting Period, CMS issued the following:

- **22 initial letters** requesting comparative analyses for **22 NQTLs (12 distinct NQTLs[23])**,
- **10 insufficiency letters** covering **10 NQTLs**,
- **19 initial determination letters** finding that plans and issuers had violated MHPAEA's requirements for **19 NQTLs**, and
- **3 final determinations of noncompliance** finding an issuer violated MHPAEA's requirements for **3 NQTLs**.

a plan applies an identical prior authorization requirement NQTL to four different benefit classifications, or to four different options in the same plan, EBSA counts the NQTL as just one "unique" NQTL, even though it is technically four separate NQTLs. When a comparative analysis request is sent to an issuer with identical NQTLs that apply to many fully insured plans, EBSA similarly counts the NQTL as one unique NQTL, even though there are technically many separate NQTLs for the different plans. When EBSA learns in the course of its investigations that NQTLs previously thought to be identical are administered differently with respect to different classifications, plans, or products, EBSA changes the characterization accordingly. If EBSA took a different approach and instead counted each NQTL separately by benefit classification, plan, and product, irrespective of whether the NQTLs are administered in the same way in these different contexts, then the number of NQTLs for which EBSA requested a comparative analysis during the EBSA Reporting Period would be over 50.

[22] These insufficiency letters include NQTLs for which the comparative analyses were requested during previous reporting periods. As stated elsewhere in this report, the majority of EBSA's NQTL investigations span several years. To the extent these investigations result in initial determinations or final determinations, EBSA will provide information on these initial determinations or final determinations in future reports, as required by the CAA.

[23] This count of "distinct" NQTLs includes NQTLs that CMS has identified with respect to a specific plan or issuer for each benefits classification to which it is applied. For example, if a plan applies an identical prior authorization requirement NQTL to two different benefit classifications, CMS counts the NQTL as two "distinct" NQTLs.

I. Introduction

Mental health is crucial to the overall health and wellbeing of every person, and access to quality MH/SUD care is as essential to good health as access to quality M/S care. Currently, the United States is experiencing a MH/SUD crisis. The crisis is impacting children and adults nationwide and across demographics, with marginalized and underserved communities affected disproportionately.[24]

In 2023, almost 23 percent of adults — nearly 60 million people — are estimated to have experienced a mental illness.[25] The highest rates of mental illness were among adults aged 18 to 25 (33.8 percent), followed by adults aged 26 to 49 (29.2 percent), then by adults aged 50 or older (14.1 percent).[26] Five percent of adults had serious thoughts of suicide.[27]

Young people are experiencing mental health crises, too. In 2023, over 18 percent of adolescents aged 12 to 17 reported experiencing at least one major depressive episode, and 13.5 percent — over 3.4 million — experienced a major depressive episode with severe impairment.[28] Suicidal thoughts and behavior among young people are also prevalent, especially among marginalized communities. In 2023, 12.8 percent of adolescents had serious thoughts of suicide in the past year.[29] A 2023 survey of LGBTQ youth ages 13 to 24 found that 41 percent seriously

[24] SAMHSA. (2024). SAMHSA Releases Annual National Survey on Drug Use and Health. https://www.samhsa.gov/newsroom/press-announcements/20240730/samhsa-releases-annual-national-survey-drug-use-and-health .
[25] Substance Abuse and Mental Health Services Administration. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-21, NSDUH Series H-59). https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report.
[26] *Id*.
[27] *Id*.
[28] *Id*.
[29] *Id*.

considered attempting suicide in the past year,[30] and nearly half of multiracial LGBTQ youth seriously considered attempting suicide.[31]

Racial disparities in youth suicide prevalence during the last two decades are well-documented.[32] For example, one study reported that suicide rates increased between 1993 to 1997 and 2008 to 2012 among Black children aged 5 to 11 years (from 1.36 to 2.54 per million) but decreased among White children of the same age (from 1.14 to 0.77 per million).[33] The same 2023 survey of LGBTQ youth and young adults found that while the overall rate of young people who had attempted suicide in the past year was 17 percent, the lowest rates were among Asian American/Pacific Islander and White young people (10 and 11 percent, respectively), and the highest rates were among Native/Indigenous and Middle Eastern/North African young people (22 and 18 percent, respectively).[34]

Eating disorders, along with substance use disorders, are among the deadliest mental illnesses,[35] and in the past decade, there has been a sharp rise in eating disorders among young people. Emergency department visits for adolescent girls 12 to 17 years old with eating disorders doubled in January 2022 compared to 2019.[36] The age at which children begin experiencing

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[30] The Trevor Project. (2023). 2023 National Survey on LGBTQ Youth Mental Health. https://www.thetrevorproject.org/survey-2023/assets/static/05_TREVOR05_2023survey.pdf.
[31] *Id*.
[32] Meza, J.I., Patel, K., Bath, E. (2022). Black Youth Suicide Crisis: Prevalence Rates, Review of Risk and Protective Factors, and Current Evidence-Based Practices. https://focus.psychiatryonline.org/doi/epdf/10.1176/appi.focus.20210034.
[33] Bridge, J.A., Asti, L., Horowitz, L.M., Greenhouse, J.B., Fontanella, C.A., Sheftall, A.H., Kelleher, K.J., Campo, J.V. Suicide Trends Among Elementary School-Aged Children in the United States From 1993 to 2012. JAMA Pediatr. 2015 Jul;169(7):673-7. doi: 10.1001/jamapediatrics.2015.0465. Erratum in: JAMA Pediatr. 2015 Jul;169(7):699. doi: 10.1001/jamapediatrics.2015.1601. PMID: 25984947.
[34] The Trevor Project. (2023). 2023 National Survey on LGBTQ Youth Mental Health. https://www.thetrevorproject.org/survey-2023/.
[35] Chesney, E., Goodwin, G., Fazel, S. (2014). Risks of All-Cause and Suicide Mortality in Mental Disorders: A Meta-Review. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4102288/.
[36] Radhakrishnan L, Leeb R, Bitsko R, Carey K, Gates A, Holland K, Hartnett K, Kite-Powell A, DeVies J, Smith A, van Santen K, Crossen S, Sheppard M, Wotiz S, Lane R, Njai R, Johnson A, Winn A, Kirking H, Rodgers L, Thomas C, Soetebier K, Adjemian J, Anderson K. (2022). Pediatric Emergency Department Visits Associated with

eating disorders has been trending younger, with children as young as 9 years old seeking treatment.[37]

ASD[38] diagnoses are also increasingly prevalent. The Centers for Disease Control and Prevention's Autism and Developmental Disabilities Monitoring (ADDM) Network, which has been reviewing developmental evaluations and records from community medical and educational service providers on a biennial basis since 2000, reported that approximately 1 in 36 children aged 8 years was estimated to have ASD in 2020.[39] This report followed estimates of 1 in 44 having ASD in 2018 and 1 in 54 having ASD in 2016.[40] The ADDM Network also found that the COVID-19 pandemic had wiped out recent gains in evaluation and ASD detection, with potentially long-lasting effects.[41]

More than 17 percent of people aged 12 and older in the United States — nearly 49 million people — met the applicable Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, criteria for having a substance use disorder in 2023, including more than 27 million who had a drug use disorder and almost 29 million who had an alcohol use disorder.[42] In 2020, overdose death rates were increasing by 31 percent year over year. Today, overdose deaths

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Mental Health Conditions Before and During the COVID-19 Pandemic — United States, January 2019–January 2022. MMWR Morb Mortal Wkly Rep 2022; 71(8); 319-324. https://www.cdc.gov/mmwr/volumes/71/wr/mm7108e2.htm.

[37] Murray S, Blashill A, Calzo J. (2022). Prevalence of Disordered Eating and Associations with Sex, Pubertal Maturation, and Weight in Children in the US. https://jamanetwork.com/journals/jamapediatrics/article-abstract/2794847.

[38] As discussed in the preamble to the 2024 Final Rules, ASD is a mental health condition for purposes of MHPAEA. 89 FR 77586, 77594 (Sept. 23, 2024).

[39] Maenner MJ, Warren Z, Williams AR et al. (2023). Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2020. MMWR Morb Mortal Wkly Rep 2022; 72(2); 1-14. https://www.cdc.gov/mmwr/volumes/72/ss/ss7202a1.htm?s_cid=ss7202a1_w.

[40] Centers for Disease Control and Prevention. (2023). Data & Statistics on Autism Spectrum Disorder. https://www.cdc.gov/autism/data-research/index.html.

[41] Centers for Disease Control and Prevention (2023). Higher autism prevalence and COVID-19 disruptions. https://www.cdc.gov/autism/publications/higher-autism-prevalence-and-covid-19-disruptions.html.

[42]Substance Abuse and Mental Health Services Administration. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-21, NSDUH Series H-59). https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report.

are declining. For the 12-month period ending in July 2024, the number of overdoses is provisionally predicted to be 16.9 percent lower compared to the prior twelve-month period ending in July 2023, but there is still much work to do.[43]

The ongoing overdose epidemic has been devastating American families, as well as caregivers and communities. In 2023, an estimated 8.9 million people in the United States age 12 or older misused opioids, including heroin or prescription pain relievers.[44] Nearly 75 percent of drug overdose deaths in 2021 involved an opioid[45] — driven primarily by illicitly manufactured fentanyl, a synthetic opioid that is approximately 50 times more potent than heroin as an analgesic and approximately 100 times more potent than morphine.[46]

The number of alcohol-induced deaths in the United States, which had been increasing gradually each year since 2000, rose sharply during the first year of the COVID-19 pandemic.[47] After annual increases of 7 percent or less between 2000 and 2018, the overall age-adjusted rate[48] of alcohol-induced deaths increased 26 percent from 2019 to 2020. This steep uptick was consistent for both males and females despite differing trends in their respective rates

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[43] National Vital Statistics System. Provisional Drug Overdose Death Counts (Based on data available for analysis on November 12, 2024). https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.
[44] Substance Abuse and Mental Health Services Administration. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-21, NSDUH Series H-59). https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report.
[45] Centers for Disease Control and Prevention. Understanding the Opioid Overdose Epidemic. https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html.
[46] U.S. Drug Enforcement Administration. Drug Fact Sheet: Fentanyl. https://www.dea.gov/factsheets/fentanyl.
[47] Spencer M.R., Curtin S.C., Garnett MF. (2022). Alcohol-induced death rates in the United States, 2019-2020. NCHS Data Brief, No. 448. https://www.cdc.gov/nchs/products/databriefs/db448.htm.
[48] *See* National Library of Medicine. Common Terms and Equations: Age-Adjustment. https://www.nlm.nih.gov/nichsr/stats_tutorial/section2/mod5_age.html ("Sometimes, health statistics are used to compare different groups to assess how healthy two different groups of people are or how healthy a certain group is during two different time periods . . . [S]ince older people are more likely to get ill, and younger people are more likely to injure themselves, age-adjustment (or age standardization) can make studies more accurate . . . Age is the most common confounding variable that is adjusted or controlled for in studies . . . [A] confounder is a variable that is related to both the independent and dependent variables. . . To be able to better compare groups while adjusting for age (or any confounder), we use a process called direct standardization. When we use direct standardization, we assume both groups have the same number of people. Then we calculate the expected number of deaths and death rates in both groups. By doing this, the two populations can be directly compared, independent of the age distribution of each group.").

of alcohol-induced death since 2000. Rates of alcohol-induced deaths for males were stable from 2000 to 2009, increased 30 percent from 2009 to 2018, and increased 26 percent from 2019 to 2020.[49] Meanwhile, rates of alcohol-induced deaths for females increased each year over the entire period, with the largest annual increase (27 percent) occurring between 2019 and 2020.[50]

As with medical conditions and surgical treatment, mental health conditions and substance use disorders can be managed with timely and affordable access to quality care. Mental health conditions and substance use disorders that are left untreated can have devastating effects not only on the individuals experiencing them, but also on their families, friends, caregivers, communities, coworkers, students, patients, clients, and the behavioral health workforce.

Far too many Americans do not seek MH/SUD care because of cost, stigmatization associated with MH/SUD care, discrimination against those with mental health conditions and substance use disorders, local in-network provider shortages, geography, and other barriers. According to a survey that included data from 2021 and 2022, approximately one quarter of U.S. adults with frequent mental distress could not see a doctor due to cost.[51] The same survey found that nearly 77 percent of U.S. adults with a substance use disorder needed but did not receive treatment.[52] The barriers are particularly problematic for young adults ages 18-34, who are more likely to have poorer overall mental health than older adults.[53] Additionally, of the estimated 54.6 million people aged 12 or older needing substance use disorder treatment in 2022, only 24

[49] Spencer M.R., Curtin S.C., Garnett MF. (2022). Alcohol-induced death rates in the United States, 2019-2020. NCHS Data Brief, No. 448. National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db448.htm.
[50] *Id.*
[51] Mental Health America. (2024). The State of Mental Health in America, 2024. https://mhanational.org/sites/default/files/2024-State-of-Mental-Health-in-America-Report.pdf .
[52] *Id.*
[53] National Alliance on Mental Illness. (2021). Mood Disorder Survey Report. https://nami.org/NAMI/media/NAMI-Media/Research/NAMI-Mood-Disorder-Survey-White-Paper.pdf.

percent actually received treatment.[54] Among people aged 12 or older with an opioid use disorder, only 18.3 percent received medication-assisted treatment for opioid use.[55]

The intent of MHPAEA is to ensure that individuals' access to covered treatment for mental health conditions or substance use disorders is comparable to their access to covered treatment for M/S conditions.[56] MHPAEA enforcement is essential to ensuring parity between access to covered MH/SUD benefits and covered M/S benefits. MHPAEA prohibits financial requirements and treatment limitations applicable to MH/SUD benefits that are more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all M/S benefits. Examples of treatment limitations on MH/SUD benefits include day and visit limits, exclusions of specific treatments for covered mental health conditions or substance use disorders, disparate ways of determining reimbursement rates for MH/SUD providers as compared to M/S providers, plan practices that make it harder for MH/SUD providers to join a plan's network than the practices applied to M/S providers, and stricter prior authorization or medical necessity reviews for MH/SUD coverage. Reforming or removing impermissible limitations in accordance with MHPAEA helps to ensure that participants, beneficiaries, and enrollees have equitable access to MH/SUD benefits as compared to M/S benefits.

EBSA and CMS each have made MHPAEA a top enforcement priority. The scope of EBSA's efforts to enforce MHPAEA's NQTL requirements is significant and consistent with its

[54] Substance Abuse and Mental Health Services Administration. (2023). Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health (HHS Publication No. PEP23-07-01-006, NSDUH Series H-58). https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report. Note that the definition in the report of the need for substance use disorder treatment took into account that some people may not have met the criteria for a substance use disorder in the past year because they were receiving treatment.

[55] *Id*.

[56] *See* footnote 2 (purpose of H.R. 1424, the 'Paul Wellstone Mental Health and Addiction Equity Act of 2007' is to have fairness and equity in the coverage of mental health and substance-related disorders vis-a-vis coverage for medical and surgical disorders.").

commitment to removing illegal barriers blocking parity for MH/SUD benefits. EBSA has primary enforcement jurisdiction over MHPAEA for approximately 2.6 million private, employment-based group health plans covering roughly 136 million Americans.[57] EBSA relies on its approximately 302 investigators to review pension and welfare benefit plans for compliance with ERISA, including the group health plan provisions added by Congress in MHPAEA. EBSA is currently devoting nearly 25 percent of its enforcement program to work focusing on MHPAEA NQTLs; however, as discussed in more detail in Section V. of this report, EBSA faces serious challenges in enforcing MHPAEA's requirements due to budget constraints.

CMS enforces applicable provisions of title XXVII of the PHS Act, including the provisions added by MHPAEA, with respect to approximately 91,000 non-Federal governmental plans nationwide and 67 issuers in two States where CMS was the direct enforcer of MHPAEA with respect to issuers during the CMS Reporting Period.[58] CMS relies on its approximately 15 investigators to review plans and issuers for compliance with MHPAEA and other provisions of title XXVII of the PHS Act.

In enforcing MHPAEA, the Departments have worked assiduously using their full authority to help participants, beneficiaries, and enrollees equitably access covered MH/SUD benefits as compared to covered M/S benefits, as described in this report. Investigations into NQTL compliance, particularly complex NQTLs such as standards for network composition, increasingly require the Departments to conduct full reviews of plan and issuer operations in order to establish whether plans and issuers are in compliance with MHPAEA. This may include multiple rounds of interviews, depositions, document requests, data requests, and subpoenas,

[57] DOL, EBSA calculations using the Auxiliary Data for the March 2022 Annual Social and Economic Supplement to the Current Population.
[58] CMS was responsible for enforcement of MHPAEA with respect to issuers in Texas and Wyoming during the CMS Reporting Period.

merely to gather basic information from multiple sources. The volume and duration of this additional investigative work can be reduced if plans and issuers prepare a thorough comparative analysis with supporting documentation, as the CAA requires.

In their investigations, the Departments have aimed to resolve insufficiencies by working with plans and issuers, as well as service providers. The Departments have prioritized enforcement actions that result in facilitating parity in access to MH/SUD benefits as compared to M/S benefits, instead of simply moving to determinations of noncompliance at the earliest possible moment. Under the CAA NQTL comparative analysis review process, plans and issuers are given ample opportunity to provide additional information, and to explain and justify their NQTLs, consistent with the statute, and where appropriate, the Departments have worked with plans and issuers to help bring them into compliance.

In enforcing MHPAEA, the Departments have focused on six priority areas, including exclusions of key MH/SUD benefits and NQTLs related to network composition. The standards that govern how a network is designed present critical limitations on the availability of MH/SUD benefits under the plan or coverage, as compared to M/S benefits, and the Departments have increasingly focused on these NQTLs. DOL has uncovered troubling disparities within networks between the availability of MH/SUD providers and the availability of M/S providers, with results suggesting that, even where plans and issuers maintain robust networks on paper, in practice, these providers are not available to take new patients or may no longer be at the location or with the practice listed in the directory. Sometimes, network disparities reflect broader issues with the MH/SUD market compared with the M/S market, but too often they reflect coverage issues that impede access to MH/SUD care. In many instances, achieving parity will require that plans and issuers take steps to augment their networks and ensure access to benefits.

While more resources are needed to fully enforce MHPAEA,[59] DOL's current enforcement efforts have succeeded in ensuring comparable access to MH/SUD benefits as compared to M/S benefits for 7.6 million participants in over 72,000 plans. As compared to previous reports, some plans and issuers have also provided more detailed comparative analyses and responses during the EBSA Reporting Period and the CMS Reporting Period. The Departments hope this is an indication that plans and issuers now better understand their obligations under the law and are taking those obligations more seriously. Plans and issuers should aim to provide detailed comparative analyses and supporting documentation, and they can expect full investigations of operations related to NQTLs if they fail to do so.

The Departments also undertake a number of other activities to help ensure plans and issuers understand and comply with MHPAEA. Through direct consumer assistance, webinars and presentations, and meetings and cooperation with interested parties, the Departments have prioritized outreach, as described in this report. Specifically, EBSA has increased its emphasis on outreach to participants and beneficiaries to assist them in dealing with their health plans and has worked with Federal and State partners to make them aware of the protections of MHPAEA.

In our outreach efforts, the Departments have gathered feedback on the challenges in ensuring parity in access to MH/SUD benefits as compared to M/S benefits. The Departments have made efforts to gather feedback from a wide variety of interested parties, including plans and issuers, service providers, consumer assistance groups, health care providers, and State regulators to gain insight into these challenges. These interested parties all emphasized their commitment to ensuring parity in access to MH/SUD benefits as compared to M/S benefits, as

[59] *See* Budget of the U.S. Government, Fiscal Year, 2025, available at https://www.whitehouse.gov/wp-content/uploads/2024/03/budget_fy2025.pdf, which would include $275 million over 10 years to increase DOL's capacity to ensure that large group market health plans and issuers comply with MH/SUD requirements, and to take action against plans and issuers that do not comply.

well as the need for additional guidance to comply with the requirements of MHPAEA. These discussions have also highlighted the need to expand MH/SUD network access and the challenges in determining whether plans and issuers comply with the rules.

Drawing upon these meetings, as well as their experiences in enforcing MHPAEA, the Departments issued the 2023 Proposed Rules to further implement MHPAEA,[60] as described in this report. The 2023 Proposed Rules aimed to ensure that individuals benefit from the full protections afforded to them under MHPAEA, while providing clear standards for plans and issuers on how to comply with the law. Contemporaneously with the 2023 Proposed Rules, DOL, in collaboration with HHS and Treasury, also issued Technical Release 2023-01P,[61] which set forth principles that would allow the Departments to better understand how plans and issuers design and apply NQTLs related to network composition, and sought public comment to inform future guidance by the Departments, including a related potential enforcement safe harbor.

Following review of the comments received in response to the 2023 Proposed Rules, the Departments subsequently issued the 2024 Final Rules, which modify some provisions of the 2023 Proposed Rules.[62] The 2024 Final Rules strengthen the protections of MHPAEA and provide further details on the comparative analysis requirements added to MHPAEA by the CAA, which the Departments expect will improve the sufficiency of NQTL comparative analyses in the future. This report emphasizes the commitment of the Departments to continue their work on ensuring parity in MH/SUD benefits in compliance with the requirements of MHPAEA.

[60] 88 FR 51552 (Aug. 3, 2023).
[61] DOL Technical Release 2023-01P (July 25, 2023), available at https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/guidance/technical-releases/23-01.pdf.
[62] 89 FR 77586 (Sept. 23, 2024).

II. MHPAEA Enforcement Efforts

A. EBSA's MHPAEA Enforcement Activity Under the CAA

Since the CAA's changes to MHPAEA became effective in February 2021, EBSA has taken significant enforcement action to detect and eliminate impermissible NQTLs. EBSA has requested and reviewed comparative analyses for hundreds of NQTLs, obtained corrections that removed impermissible MH/SUD treatment barriers for more than 7.6 million participants in over 72,000 plans, and ensured payment of wrongfully denied MH/SUD claims.

Despite the law's requirement that plans and issuers perform and document comparative analyses of their NQTLs' design and application and make them available to EBSA, noncompliance remains widespread. Over the past 30 months of enforcement work, EBSA has found that comparative analyses in general have not included sufficient information for EBSA to determine compliance with the substantive requirements of MHPAEA.

As a result, EBSA has needed to look beyond the comparative analyses and use investigative techniques, such as depositions, subpoenas, interviews, and claims reviews to determine compliance with the substantive requirements of MHPAEA. These added steps delay EBSA's ability to make parity determinations and obtain meaningful corrections that expand access to care. While EBSA could focus its efforts on only citing a plan or issuer with a noncompliant comparative analysis for failing to adequately perform and document comparative analyses without undertaking additional action, EBSA has primarily focused on identifying and obtaining corrections for harmful NQTL violations, so workers and families can access needed MH/SUD benefits in parity with their ability to access M/S benefits.

Despite the difficulties inherent in these complex cases, EBSA investigators conduct investigations marked by thoroughness, expert knowledge, and close attention to detail. Their

rigorous fact-finding, painstaking data analyses, and targeted compliance assistance produced tangible results, as detailed in Section II.A.3 of this report.

EBSA is determined to continue this aggressive enforcement of MHPAEA's parity requirements, even as the lack of sufficient comparative analyses make it more difficult and time-consuming for EBSA to ensure compliance. Given the complex and ever-changing nature of the NQTL universe, much work remains to fully accomplish the CAA's and MHPAEA's objectives. Realizing the promise of parity will require many years of sustained efforts by EBSA, plans and issuers, and fellow regulators.[63]

1. EBSA's NQTL Enforcement Priorities

This section of the report covers activity during the EBSA Reporting Period (August 1, 2022 through July 31, 2023), during which EBSA continued using the enforcement tools added under ERISA section 712(a)(8) and its investigative authority under ERISA section 504 to determine whether plans and issuers comply with MHPAEA.

The July 2023 Report detailed six priority areas of NQTL enforcement.[64] These six priority areas continue to comprise the vast majority of NQTLs that are the subject of review in EBSA's enforcement cases. During the EBSA Reporting Period, EBSA deepened its focus on NQTLs relating to network composition and impermissible exclusions of key treatments for

[63] *See* Section V. of this report, which outlines the serious challenges EBSA faces in enforcing MHPAEA's requirements due to budget constraints, and reiterates the legislative recommendations outlined in the January 2022 Report.

[64] *See* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis. The six priority areas specified in the July 2023 Report are:

1. prior authorization requirements for in-network and out-of-network inpatient services,
2. concurrent care review for in-network and out-of-network inpatient and outpatient services,
3. standards for provider admission to participate in a network, including reimbursement rates,
4. out-of-network reimbursement rates (methods for determining usual, customary, and reasonable charges),
5. impermissible exclusions of key treatments for mental health conditions and substance use disorders, and
6. adequacy standards for MH/SUD provider network.

mental health conditions and substance use disorders, as further discussed in this report. EBSA continues to review comparative analyses with a focus on any disparities relating to (1) prior authorization requirements for (a) inpatient, in-network, and (b) inpatient, out-of-network services; (2) concurrent care review for (a) inpatient, in-network, (b) inpatient, out-of-network, (c) outpatient, in-network, and (d) outpatient, out-of-network services; and (3) reimbursement rates for (a) inpatient, out-of-network, and (b) outpatient, out-of-network services.

a. Focus Area 1: NQTLs Relating to Network Adequacy and Network Composition

Network adequacy refers to a health plan's or issuer's ability to provide timely access to in-network providers for the delivery of covered benefits.[65] For instance, if a participant finds that providers in their plan's network are far away or have few or no available appointments, their network may be inadequate. This report uses the term "network composition" to refer to the number, types, and identity of care providers in a network. For example, a network is usually composed of physicians, physician assistants, nurse practitioners, nurses, nurse assistants, social workers, behavioral specialists, technicians, and other categories of providers. These providers may work in different practice areas, such as obstetrics/gynecology, surgery, radiology, pediatrics, psychiatry, or counseling.

The adequacy of a plan's or issuer's provider network directly impacts access to care. When participants and beneficiaries need care but cannot find an available in-network provider, they often face a difficult choice: seek out-of-network care and incur higher out-of-pocket costs, or delay or forgo treatment altogether. A core protection of MHPAEA is to ensure parity in

[65] *Cf.* National Association of Insurance Commissioners: Network Adequacy, available at https://content.naic.org/cipr-topics/network-adequacy ("Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network primary care and specialty physicians, and all health care services included under the terms of the contract.").

NQTLs related to network composition for MH/SUD benefits as compared to M/S benefits. Furthermore, when prudently administering their plan and evaluating MHPAEA compliance, plan fiduciaries should pay close attention to how their network affects access to MH/SUD benefits relative to M/S benefits.[66] Evaluating NQTLs related to network adequacy and composition under MHPAEA is important to helping ensure that plans and issuers are taking comparable approaches to design networks for MH/SUD and M/S providers.

NQTLs related to network adequacy and network composition may include, but are not limited to:

- standards that healthcare providers must meet to be allowed to participate in the network, such as professional credentials, and processes and procedures for determining how much they will be paid for their services (reimbursement rates); and
- standards that plans or issuers use to assess the need for specific kinds of providers in the network, such as access standards, and efforts by plans and issuers to monitor the adequacy of their MH/SUD and M/S provider networks using those standards.

Provider and patient advocacy groups, as well as participants and beneficiaries, continue to tell EBSA that it is more difficult for patients to find in-network MH/SUD providers available to treat their condition or disorder than it is to find in-network M/S providers. That disparity in

[66] If a plan uses a network, its Summary Plan Description (SPD) must describe the provider network and its composition. 29 CFR 2520.102-3(j)(3). The list of providers may be distributed as a separate document that accompanies the plan's SPD if it is sent automatically and without charge and the SPD contains a statement to that effect. The list of network providers must be up to date, accurate, and complete (using reasonable efforts). *See* FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39, Q10 (Sept. 5, 2019), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf.

finding available and appropriate providers is particularly prevalent in underserved communities and rural areas.[67]

EBSA's own provider network surveys have confirmed that patients often struggle to find in-network MH/SUD providers as compared to M/S providers. Using a secret shopper[68] approach, EBSA conducted 9 surveys, calling over 4,300 randomly selected outpatient providers that plan network directories listed as accepting new patients.[69] The surveys found that an alarming proportion of providers were unresponsive or unreachable. While this was true for both MH/SUD and M/S providers, the results were consistently worse for MH/SUD providers. Under the nine surveys, the percentage of MH/SUD providers that effectively offered the caller a way to obtain the services sought ranged from 8 to 28 percent, as compared to 24 to 37 percent of M/S providers surveyed.[70] The results of EBSA's surveys of MH/SUD and M/S providers

[67] Torres Sanchez, A., Park, A.L., Chu, W., Letamendi, A., Stanick, C., Regan, J., Perez, G., Manners, D., Oh, G., Chorpita, B.F. Supporting the mental health needs of underserved communities: A qualitative study of barriers to accessing community resources. J Community Psychol. Jan. 2022; 50(1):541-552. doi: 10.1002/jcop.22633. Epub June 7, 2021. PMID: 34096626; Ricketts TC. Workforce issues in rural areas: a focus on policy equity. *American Journal of Public Health* 2005; 95: 42–48. doi: 10.2105/AJPH.2004.047597.

[68] Secret shopper means EBSA representatives contacted random samples of providers selected from network directories provided by plans or issuers. The EBSA representatives called the providers and used scripts to pose as participants seeking care.

[69] During the EBSA Reporting Period, EBSA conducted surveys of outpatient care providers listed in network directories produced by plans and service providers in nine open investigations. EBSA drew a random sample of 296 to 1,511 providers from each directory, and secret shopper surveyors called each provider using scripts designed to mimic the experience of a participant or beneficiary seeking care. Callers sought information confirming the provider's phone number, network status, address, specialty type, ability to accept new patients, and wait time for an appointment. Voicemails seeking a callback were left for providers who did not respond to calls. Callers also made up to three call attempts to contact providers who did not respond. Such call attempts were made on different days and times.

[70] EBSA classified a provider as effectively offering a way to obtain the services sought only when all of the following occurred:

- a live person responded to the call or eventually responded to the call after up to three attempts;
- the M/S or MH/SUD services were offered at the listed location by any provider in the listed M/S or MH/SUD specialty;
- an appointment was available within a month of the call; and
- the provider was in-network and accepting new patients.

mirrored the findings of other surveys examining the availability of MH/SUD providers listed in directories.[71]

At this time, EBSA is analyzing NQTLs related to network adequacy and network composition in over 25 investigations of plans and service providers. EBSA examines the efforts that plans and their service providers make in evaluating network composition and its impact on access. While NQTL investigations cover plans and issuers of varying sizes, the NQTL investigations related to network adequacy and network composition involve some of the largest service providers in the benefits industry.

b. Focus Area 2: Impermissible Exclusions of Key Treatments for Mental Health Conditions and Substance Use Disorders

During the EBSA Reporting Period, EBSA continued to investigate plans and service providers that exclude key treatments for covered mental health conditions and substance use disorders. These kinds of exclusions are impermissible when a plan or issuer does not apply a comparable limitation to benefits for M/S conditions. Examples include exclusions of:

- ABA therapy for ASD,
- medication-assisted treatment (MAT), or medication for opioid use disorder, and
- nutritional counseling for eating disorders.

[71] *See* Senate Committee on Finance, Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks, May 3, 2023, https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf, (finding 82 percent of the listed in-network mental health providers surveyed unreachable, not accepting new patients, or not in-network. *See also* New York State Attorney General, Inaccurate and Inadequate: Health plans' mental health provider network directories, Dec. 7, 2023, https://ag.ny.gov/sites/default/files/reports/mental-health-report_0.pdf (finding 86 percent of the listed in-network mental health providers unreachable, not in network, or not accepting new patients).

During the EBSA Reporting Period, EBSA made progress toward eliminating these impermissible exclusions across the industry. However, EBSA continues to find plans and issuers impermissibly excluding key treatments in plan document language or in practice by denying related claims. EBSA also found that plans and issuers are rarely able to provide a complete comparative analysis detailing these exclusions or offer any justification for the exclusions. When EBSA's investigators ask for basic information, plans and issuers will often remove, rather than justify, the exclusions to come into compliance with MHPAEA.

2. EBSA's Approach to Implementing Its NQTL Enforcement Priorities

EBSA uses its limited investigative resources[72] to target potential violations that, if corrected, will have the greatest impact on participants' and beneficiaries' MH/SUD benefits.

In general, for all NQTL areas, EBSA develops investigative leads by carefully reviewing plan documents in its open health case inventory and examining plan operations. EBSA also gathers leads from other sources, such as State and Federal regulatory partners, media reports, private litigation, participant or beneficiary complaints, professional associations, and patient advocacy groups.

EBSA continues to prioritize potential violations that stem from service providers that serve hundreds or thousands of plans. When EBSA finds NQTL violations in a plan, it examines the role of each service provider in the design and administration of each NQTL to determine if the service provider has implemented the same impermissible NQTL for other plans it serves.

As described in more detail below, EBSA's different approaches to addressing the two focus areas are tailored to reflect the challenges and complexities of each focus area.

[72] *See* Section V. of this report, which outlines the serious challenges EBSA faces in enforcing MHPAEA's requirements due to budget constraints, and reiterates the legislative recommendations outlined in the January 2022 Report.

a. EBSA's Approach to NQTLs Related to Network Adequacy and Network Composition

For NQTLs related to network composition, EBSA closely examines how plans and issuers create and monitor their networks and how they measure those processes' impact on access to MH/SUD benefits as compared to M/S benefits. Processes for constructing and monitoring a network are often complex and varied. Among other things, EBSA reviews how plans and issuers design standards used to monitor network adequacy and network composition and how those standards are applied in practice. EBSA also looks at any actions that plans and issuers take to identify and remedy gaps in their network. At each step, EBSA considers how the plan's or issuer's actions impede a patient's ability to obtain needed MH/SUD care, as compared to M/S care.

The statutory process for reviewing a comparative analysis and identifying deficiencies is a helpful tool in NQTL investigations. However, EBSA has found that while review of a comparative analysis can be a starting point, these cases often require a full investigation in order to more thoroughly delve into operations related to network development and monitoring. The comparative analysis review process involves exchanging analyses, insufficiency letters, and written questions and responses. Network adequacy and network composition investigations typically involve multiple interviews of plan officials and service provider representatives, claims data analysis, and extensive document review.

The following five subsections detail EBSA's early findings and key aspects of EBSA's approach to reviewing NQTLs related to network adequacy and network composition:

- EBSA examined out-of-network utilization and other outcomes reflecting access to care,

- EBSA identified disparities in access standards and processes for monitoring network adequacy and composition,
- EBSA's secret shopper surveys found troubling results about disparate access to services,
- EBSA found disparities in network provider reimbursement rates and found that plans and issuers could not explain methodologies resulting in reimbursement rate disparities, and
- Plans and issuers offered unsupported conclusions to explain how they complied with MHPAEA's parity requirements.

i. EBSA Examined Out-of-Network Utilization and Other Outcomes Reflecting Access to Care

While outcomes alone are not determinative of compliance with MHPAEA's parity requirements, outcomes can show what is happening in operation and inform how an NQTL affects access to MH/SUD care relative to M/S care. In cases focusing on NQTLs related to network adequacy and composition, EBSA looks at the processes, strategies, evidentiary standards, and other factors a plan uses to design and monitor its networks; examines the application of these factors; and reviews outcomes, to better understand the potential harm caused by the NQTLs and validity of a plan's assertion of operational compliance. EBSA also may look at reimbursement rates, provider availability, member complaints, and other data to inform its analysis. As noted above, EBSA also uses a secret shopper survey approach to gather information about the availability of network providers from a participant's point of view.

EBSA considers it a red flag when participants go out of network much more often for MH/SUD treatments than for M/S treatments. Disproportionate out-of-network utilization is a

potential sign that participants looking for care cannot find an appropriate and available in-network provider for MH/SUD treatment as compared to M/S treatment.

Because EBSA views high out-of-network utilization for MH/SUD services compared to M/S services as an indicator of concern, EBSA reviews out-of-network utilization data in all its cases investigating NQTLs related to network composition. Specifically, EBSA reviews plan data on how often participants and beneficiaries go to out-of-network providers for care. It also compares claim volume and dollars paid for MH/SUD benefits as compared to M/S benefits, often looking closely at data broken out by provider or service type, to identify potential patterns that might point to lack of parity.

Some plans and issuers minimize the importance of out-of-network utilization as a red flag by arguing that participants and beneficiaries seek out-of-network providers by choice. EBSA acknowledges that some people may, at times, prefer out-of-network providers. Still, plans and issuers have failed to explain how these preferences alone could account for the vast disparities in out-of-network utilization for MH/SUD providers as compared to M/S providers that EBSA has seen in some of its investigations, and generally have failed to explain how they have ensured their NQTLs comply with parity requirements.

For example, in one investigation, data showed that plan participants used out-of-network providers significantly more often for MH/SUD benefits than for M/S benefits. Claims data spanning multiple years showed that 73 percent of total dollar amounts paid for substance use disorder care and 42 percent of total dollar amounts paid for mental health care were paid to out-of-network providers. By contrast, only 17 percent of total dollar amounts paid for M/S care was paid to out-of-network providers.[73] In light of the specific disparities in processes, strategies,

[73] Under the terms of this plan, participants and beneficiaries pay a higher coinsurance percentage for services from an out-of-network provider, as compared to a lower coinsurance when they go to an in-network provider.

evidentiary standards, and other factors, as well as the out-of-network utilization rates that suggest potential disparity and noncompliance in operation, EBSA issued an initial determination letter citing the plan for violating MHPAEA's NQTL requirements. EBSA is working with the plan to develop a corrective action plan (CAP).

ii. EBSA Identified Disparities in Access Standards and Processes for Monitoring Adequacy of Networks

EBSA looks for potential issues with the processes, strategies, evidentiary standards, and other factors used to apply NQTLs. Early findings in investigations that were ongoing during the EBSA Reporting Period show troubling disparities in how plans and issuers measured network adequacy and set reimbursement rates.

Whether an individual seeking MH/SUD care has comparable access to services (as compared to those who seek M/S care) may depend on the coverage the plan provides, the services it offers, the timeliness with which care can be provided, and the presence of healthcare providers with the appropriate expertise. Many plans and issuers pointed to access standards as a large part of how they monitor and ensure network parity. These standards varied, but often took the form of:

- provider-to-member ratios (e.g., 1 provider to 2,000 members),
- time and distance standards (e.g., 1 provider within 15 minutes or 30 miles), and
- maximum wait times (e.g., initial appointment within 10 days, follow-up appointment within 20 days of initial appointment).

Plans and issuers have imposed standards that appear to require fewer MH/SUD providers in their network (without consideration of other factors, such as the need of the plan

population relative to the number of providers available in the relative geographic location) and may result in less access to MH/SUD treatment than to M/S treatment. These plans and issuers have repeatedly failed to explain how these standards comply with parity. For example, many plans and issuers appear to require participants to travel farther distances or endure longer travel times to reach fewer MH/SUD providers per member, as compared to M/S providers, and fail to adequately explain how their network adequacy and composition NQTLs comply with the parity rules. Such disparate standards have included:

- a goal of 1 obstetrician or gynecologist for every 500 participants versus goals of only 1 psychiatrist for every 2,000 participants and only 1 psychologist for every 3,000 participants,
- a goal of 95 percent of participants in urban areas within 10 miles of two pediatricians versus a goal of 85 percent of participants in urban areas within 10 miles of a single psychiatrist who will treat children, and
- a goal of 90 percent of participants in metro areas within 20 miles of an ophthalmologist versus a goal of 90 percent of participants in metro areas within 30 miles of a psychiatrist.

No plan or issuer provided a plausible explanation of how these standards could have been established in compliance with MHPAEA.

Several plans and issuers also used special access standards to track the availability in their network of categories of M/S providers they identified as “high-impact” or “high-volume.” However, they did not similarly evaluate or track any categories of MH/SUD providers in the network that might also be “high-impact” or “high-volume.” The lack of a process for evaluating

or tracking these types of MH/SUD providers is not comparable to the process applied to M/S providers.

Access standard disparities were made worse when plans and issuers bundled many different types of MH/SUD providers in the network under a single standard for all "behavioral health providers" in the network but tracked M/S providers separately by specialty, each with its own access standard. For instance, one plan used provider-to-member ratios of 1 provider to 2,000 members to measure network adequacy. The plan separately measured each M/S specialty against this standard, such as requiring 1 cardiologist for every 2,000 members, 1 nephrologist for every 2,000 members, and so forth, resulting in many different types of M/S providers for every 2,000 members. However, when applying the ratio to MH/SUD providers, the plan combined all MH/SUD providers into a single category, requiring 1 "behavioral health provider" of any behavioral health specialty or training for every 2,000 members. The plan did not apply a comparable level of specificity and separate tracking by provider type when applying the provider-to-member ratio to MH/SUD providers. While it could be asserted that the plan applied the "same" provider-to-member ratio, the plan constructed the ratio in a very different manner. The plan used evidentiary standards that are not comparable, which does not comply with MHPAEA. These standards also resulted in the plan having far fewer MH/SUD providers than M/S providers in its network, which illustrates the potential impact of such disparate standards.

EBSA also found disparities in whether and how the availability of pediatric MH/SUD providers in the network was tracked as compared to the availability of pediatric M/S providers in the network, which plans and issuers were unable to justify. These differences were another common example of how some plans and issuers may not be applying comparable processes, strategies, evidentiary standards, and other factors to maintain adequate numbers of MH/SUD

providers in relevant specialties as compared to M/S providers. For example, EBSA found that many plans and issuers separately evaluate access to pediatric M/S providers but do not also separately evaluate access to MH/SUD providers who treat children or adolescents, and are unable to demonstrate how these processes, strategies, evidentiary standards, and other factors are comparable.

Not only has EBSA found that plans and issuers were unable to demonstrate that evidentiary standards as written for MH/SUD benefits were comparable to, and applied no more stringently than, those for M/S benefits, but the way the plans and issuers applied the evidentiary standards in practice was often problematic. For instance, some plans aimed to meet their access standard for 90 percent of participants and beneficiaries for M/S services, but only 80 to 85 percent for MH/SUD services, which is a red flag for a potential violation of MHPAEA.

Furthermore, EBSA found disparities in the level of effort that plans and issuers took to identify and address concerns with their network. Some plans and service providers routinely collected data on the adequacy of their M/S networks and then used that information to develop action plans to fill gaps. Targeted actions to address identified M/S provider gaps included recruiting specific kinds of providers in identified geographic areas. However, those same plans and service providers did not have a comparable process to identify and address measurable deficiencies in their MH/SUD networks.

For example, a national issuer developed specific "Action Plans" to address access gaps with respect to certain M/S specialties in nine different States for the following provider types: dermatologists, ophthalmologists, pulmonologists, cardiologists, infectious disease specialists, hematologists/oncologists, and neurologists. The "Action Plans" included specific strategies to recruit additional providers in the respective geographic locations and increase the percentage of

participants within the required time and distance from a low of 54 percent to the required 90 percent. The issuer also developed "Action Plans" to fill M/S gaps in geographic locations that failed the required time and distance standards by less than a percentage point. However, despite having multiple States with fewer than 20 percent of participants within the required time and distance of certain MH/SUD provider types, the issuer did not create any similar "Action Plans" to address access gaps with respect to MH/SUD provider types. Those MH/SUD gaps occurred in 25 States for the following MH/SUD provider types: Masters-level clinicians, psychologists, psychiatrists, mental health inpatient facilities, MH/SUD residential facilities, or other MH/SUD ambulatory programs.

iii. EBSA's Secret Shopper Surveys Found Troubling Results about Disparity in Access to Services

EBSA was particularly troubled by its secret shopper survey results that indicated many providers listed in network directories were not available for an appointment. As highlighted in Section II.A.1.a, only 8 to 28 percent of MH/SUD providers in each survey effectively offered the caller a way to obtain the services sought as compared to 24 to 37 percent of M/S providers.

Moreover, if plans and issuers use their own inaccurate directory data that does not reflect the actual availability of their providers to patients to assess whether they meet network adequacy metrics, then those assessments may have little bearing on actual access to care under the plan. For example, a provider listed with an incorrect address may skew whether a plan meets its time and distance access standards for participants in a given ZIP Code having access to a provider within 30 miles or 60 minutes. Similarly, a provider who has retired and is no longer seeing patients but remains in the directory will erroneously improve reported provider-to-

member ratios. Directory data that does not reflect the availability of providers can make it seem that care is reasonably accessible when it is not.

iv. Plans and Issuers Could Not Explain Methodologies Resulting in Disparate Network Provider Reimbursement Rates

EBSA also reviewed the methodologies for reimbursement rates for network providers as part of its investigations into NQTLs related to network composition. Plans and issuers use reimbursement rates to encourage provider participation in a network. A plan or issuer can raise rates to increase the number of healthcare providers (or the proportion of healthcare providers) who are in-network in an area, which increases access to specific services, including MH/SUD services. EBSA found that, generally, plans and issuers did not adequately explain the processes, strategies, evidentiary standards, and other factors used to derive network reimbursement rate methodologies for MH/SUD benefits to show that they are comparable to, and no more stringently applied than, those used to derive network reimbursement rate methodologies for M/S benefits.

EBSA frequently found disparities when measuring rates against a benchmark. One issuer noted that its MH/SUD and M/S reimbursement rates were similarly set based on a formula tied to Medicare rates. However, EBSA's review of a sample of claims paid showed that the issuer paid M/S claims at 120 to 123 percent of Medicare's rates but paid MH/SUD claims at 88 to 98 percent of Medicare's rates. The issuer could not explain how the methodology generated disparate rates.

EBSA looked at reimbursement rate disparities in the context of other aspects of how the plan or issuer developed and monitored its network composition. Plans and issuers generally indicated that they rely on network adequacy concerns as a factor in determining whether

reimbursement rates are sufficient, yet could not explain whether and how they considered network adequacy concerns during the rate-setting process, including in rate negotiations with providers.

Additionally, EBSA has identified instances where a plan or service provider has actively increased reimbursement rates for certain M/S providers as a strategy to attract and retain service providers when there is a detected gap in the network. However, the plan or service provider did not use similar strategies to increase reimbursement rates for MH/SUD providers when they detected gaps in the MH/SUD network.

v. Plans and Issuers Unable to Show Compliance Instead Offered Unsupported Conclusions

During the EBSA Reporting Period, EBSA found that plans' and issuers' comparative analyses for NQTLs related to network adequacy and network composition were inadequate to demonstrate MHPAEA compliance, especially in light of measured disparities in outcomes. When EBSA identified such disparities, EBSA worked with each plan and issuer to seek clarifying information about the differences in processes, strategies, evidentiary standards, and other factors used to apply an NQTL to MH/SUD benefits as compared to M/S benefits, as well as in outcomes that are red flags for potential violations of MHPAEA.

Plans and issuers often responded with general justifications. When EBSA asked plans and issuers about aspects of plan design like disparate access standards, those plans and issuers, where they offered a justification, generally pointed to industry practice or external entities not otherwise subject to MHPAEA as the source of their standards. Some plans and issuers responded by minimizing the role of access metrics in shaping network composition.

When EBSA asked about disparate reimbursement rates and unexplained processes for developing those rates, many plans and issuers pointed to general concepts like "market dynamics," "supply and demand," and "bargaining power" to justify paying M/S providers a higher rate than MH/SUD providers. However, they did not explain how factors such as "supply and demand" were used to apply their NQTLs to MH/SUD and M/S benefits in comparable ways. They also failed to address how a high demand for M/S services leads to higher reimbursement rates for M/S providers, while high demand (and low numbers of specific types of MH/SUD providers) does not lead to higher reimbursement rates.

Many plans and issuers also cited MH/SUD provider shortages as a justification for the disparities EBSA identified. EBSA recognizes that provider shortages exist and affect access for both MH/SUD and M/S treatments. However, in its investigations, EBSA sees plans and issuers take affirmative measures to address shortages of M/S providers, but has not observed plans and issuers taking equal measures to address shortages of MH/SUD providers. If plans and issuers take affirmative measures to address shortages of M/S providers, MH/SUD provider shortages should prompt similar efforts by plans and issuers to attract and retain MH/SUD providers in their networks, not serve as justification for a lack of additional efforts on the part of plans and issuers. Instead, plans and issuers seem focused on justifying their longstanding practices and giving unsupported conclusions for not making changes to their processes, strategies, evidentiary standards, and other factors to ensure compliance with MHPAEA's requirements.

Plans and issuers that make these arguments fail to demonstrate that they utilize comparable processes, strategies, evidentiary standards, and other factors to apply NQTLs related to network composition, such as documented, comparable efforts to address network gaps. For an example of specific actions that plans and issuers can take to address network

adequacy concerns, see Example #1 in Section II.A.3.a.i below and a settlement agreement in Appendix A.[74]

Overall, explanations provided by plans and issuers fell far short of providing reasonable justifications for disparities in outcomes. EBSA has begun citing plans and issuers with violations for impermissible NQTLs related to network adequacy and network composition. EBSA issued two such initial determinations of noncompliance during the EBSA Reporting Period and expects to issue more in future reporting periods as appropriate.

b. EBSA's Approach to Impermissible Exclusions of Key Treatments for Mental Health Conditions and Substance Use Disorders

During the EBSA Reporting Period, EBSA continued to expand its initiative to target impermissible exclusions of key treatments for mental health conditions and substance use disorders. Under this initiative, EBSA works directly with the service providers administering plan benefits before contacting the plans they serve. Once potentially impermissible exclusions are flagged, the service provider identifies plan clients that have the exclusions, and EBSA gathers information from the service provider about any compliance analyses. Depending on the circumstances, EBSA may need to issue comparative analysis requests to some or all of the service provider's plan clients. EBSA aims to work with the service provider and plans to correct any impermissible exclusions across many plans at once. Corrections may include:

- amending written plan terms to remove improper exclusion language,
- re-adjudicating previously denied claims resulting from the exclusion,
- processing claims incurred due to the exclusion,
- providing notice to participants and beneficiaries,

[74] *See also* 26 CFR 54.9812-1(c)(4)(iii)(C); 29 CFR 2590.712(c)(4)(iii)(C); 45 CFR 146.136(c)(4)(iii)(C) of the 2024 Final Rules (providing additional examples of actions plans and issuers may take).

- changing practices at the plan and service provider levels, and
- ensuring any wrongly denied claims are paid.

EBSA continues to find that working directly with service providers efficiently and effectively addresses impermissible exclusions. EBSA used this approach in 10 new NQTL inquiries during the EBSA Reporting Period and in more than 20 inquiries prior to the EBSA Reporting Period. These cases are ongoing, and many service providers are removing common exclusions applied across many plans without EBSA needing to issue comparative analysis requests to their plan clients with respect to those exclusions. These service providers range in size from some of the largest national service providers to smaller, regional ones.

EBSA also has expanded use of this approach to address exclusions beyond ABA therapy for ASD, medication for opioid use disorder, and nutritional counseling for eating disorders. EBSA uses this approach for categorical limitations of other key MH/SUD benefits for which comparable treatment limitations are not applied to M/S benefits in the relevant benefits classification, such as exclusions of:

- residential treatment for mental health conditions and substance use disorders,
- partial hospitalization for mental health conditions and substance use disorders,
- speech therapy for mental health conditions, and
- ASD treatment based on age.

EBSA expects plans, issuers, and service providers across the healthcare industry to proactively address treatment limitations that apply only to MH/SUD benefits, including exclusions, prior to EBSA initiating an investigation.

3. Impact of EBSA's Enforcement Results

EBSA measures its success based on how much its efforts have expanded access to MH/SUD benefits for participants and beneficiaries—and EBSA's efforts have had a powerful effect over the past few years. **Since February 2021 through the end of the EBSA Reporting Period, EBSA's efforts under the CAA have cumulatively resulted in corrections that have benefited directly more than 7.6 million participants in more than 72,000 plans.**

During the EBSA Reporting Period, EBSA worked closely with plans and issuers to correct MHPAEA violations and increase access to MH/SUD care. Appropriate correction varied based on the kind of NQTL at issue and its application in practice. EBSA routinely sought corrections that involved changes to written plan provisions and policies, changes to practices and procedures, disclosures to participants, and re-adjudication and payment of affected claims. To achieve full correction, EBSA worked with plans and issuers to identify affected claims, which required EBSA to gain a deep understanding of multiple claims processing systems and data tracking practices.

EBSA achieved corrective results at all NQTL review stages, meaning not all NQTL corrections required an initial or final determination of noncompliance. During the EBSA Reporting Period, EBSA issued the following:

- **17 initial letters** requesting comparative analyses for **22 NQTLs (19 unique NQTLs)**,
- **45 insufficiency letters** covering over **40 NQTLs**, and
- **13 initial determination letters** finding that plans and issuers had violated MHPAEA's requirements for **21 NQTLs (14 unique NQTLs)**.

NQTL investigations are complex and routinely span multiple reporting periods, so it is helpful to review these numbers in the context of EBSA's NQTL enforcement work since the CAA's amendments to MHPAEA took effect. Over the 30 months since February 2021, EBSA has issued:

- **199 initial request letters** for **over 480 NQTLs (over 290 unique NQTLs)**,
- **183 insufficiency letters** covering **over 330 NQTLs**,
- **66 initial determination letters** finding that plans and issuers had violated MHPAEA's requirements for **97 NQTLs (70 unique NQTLs)**, and
- **3 final determinations of noncompliance** finding MHPAEA violations for **3 NQTLs (3 unique NQTLs)**.

Since February 2021, EBSA has increasingly found that plans and issuers are motivated to correct potentially problematic NQTLs earlier in the comparative analysis review process in order to avoid receiving an initial or final determination of noncompliance. **EBSA has obtained the majority of the corrections under the CAA process without the need to issue determinations of noncompliance**. Some plans and issuers even corrected potential MHPAEA violations in response to EBSA's questions before EBSA issued a comparative analysis request. Others corrected potential MHPAEA violations after receiving a comparative analysis request or subsequent insufficiency letter. This increased responsiveness to EBSA's initial fact-finding efforts, or to an initial determination of noncompliance, resulted in EBSA issuing no final determinations of noncompliance for the EBSA Reporting Period.

a. Examples of the Impact of EBSA's Enforcement Results Under the CAA

The following are examples of EBSA's successes and their impact on participants and beneficiaries who now have greater access to MH/SUD care. These examples result from

EBSA's activity during the EBSA Reporting Period as well as ongoing efforts that began beforehand.

i. Example of Corrections for NQTLs Related to Network Composition

Example #1 –Monitoring of Network Composition for Gaps, with Special Assistance for Those Who Have Difficulty Finding Network Care

Issue: A large self-funded plan covering over 17,000 participants uses a network from a large national network administrator. EBSA's Kansas City Regional Office found disparities in the percentage of times participants received out-of-network MH/SUD benefits as compared to out-of-network M/S benefits. Specifically, participants used out-of-network benefits for MH/SUD services 37 to 50 percent of the time; however, out-of-network utilization for the plan was just over 4 percent overall. The plan's out-of-network utilization disparities warranted further examination to determine whether the processes, strategies, evidentiary standards, and other factors related to network composition were comparable for the relevant NQTLs. EBSA found additional disparities between access to MH/SUD benefits and M/S benefits in the form of:

- the standards the plan used to measure access to providers,
- how the plan assessed network adequacy,
- how often the plan's service provider met its own adequacy standards for in-network providers,[75]

[75] The service provider frequently met its own internally set access standard goals for M/S providers but failed to meet its standards for MH/SUD providers.

- the plan's network provider reimbursement levels,[76] and
- the kinds of actions the plan and its network administrator took to address identified network inadequacies.[77]

Action: The Kansas City Regional Office issued an initial determination letter citing the plan for violating MHPAEA because the processes, strategies, evidentiary standards, and other factors it used to evaluate the adequacy of its network for MH/SUD benefits were not comparable to, and were applied more stringently than, those used to evaluate the adequacy of its network for M/S benefits. This non-comparability and more stringent application resulted in more limited access to MH/SUD services as compared to M/S services. The letter also cited the plan for its deficient comparative analysis.

Result: In response to EBSA's initial determination letter, the plan took quick action to ensure its participants have access to MH/SUD care that is more comparable to access to M/S care. The plan committed to taking significant steps toward actively monitoring its network composition and filling gaps. The plan's next steps included:

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[76] As described in Appendix II to the MHPAEA Self-Compliance Tool (https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf), EBSA compared specific CPT codes against FAIR Health rates as a benchmark. (CPT stands for Current Procedural Terminology. These numeric codes are used to identify different medical services, procedures, and items.) Healthcare providers use CPT codes to bill FAIR Health. EBSA found disparities between MH/SUD and M/S provider reimbursement rates relative to FAIR Health. The disparities ranged from 25 to 32 percentage points, with MH/SUD providers being paid less than M/S providers for the same service.

[77] When the service provider failed any access standard for M/S services, it created action plans to address the deficiencies in the network. No similar action plans were found for the failed access standards for MH/SUD services, of which there were many. For instance, analysis by the plan's service provider showed the network failed access standards for psychiatrists, MH/SUD inpatient facilities, and MH/SUD residential facilities, but did not fail any access standards any M/S provider types measured. Between 98 and 100 percent of all ZIP Codes met time and distance standards for M/S providers, but only 88 to 96 percent of all ZIP Codes met time and distance standards for MH/SUD providers. When viewed on a State level, 11 to 25 States had between 18 and 89 percent of their ZIP Codes meeting time and distance standards for MH/SUD masters level clinicians, psychologists, psychiatrists, MH/SUD inpatient facilities, and MH/SUD residential facilities. The plan also had special procedures allowing out-of-network claims to be processed as in-network claims when there were network gaps. However, the plan applied these special procedures almost exclusively to M/S claims and to very few MH/SUD claims.

- live support for participants who have difficulty finding available in-network providers,
- arrangements for the plan to pay for out-of-network care when in-network providers are not available,
- identifying network gaps through ongoing review of network composition and utilization data, including appointment wait times and out-of-network provider use,
- affirmative steps to close network gaps, such as targeted provider recruitment,
- measuring progress to close network gaps using the same data-based measures used to identify them,
- expanding telehealth services,
- expanding a supplemental network of substance use disorder treatment facilities, and
- soliciting proposals to evaluate the suitability of other networks and network administrators outside of the plan's then-current network administrator.

EBSA applauds the plan's commitment to parity and its efforts to ensure its participants and beneficiaries have meaningful access to MH/SUD benefits as compared to M/S benefits. The plan's response was constructive because it focused on processes, strategies, evidentiary standards, and other factors (including resources) it could control to address access disparities, rather than simply pointing to provider shortages, general arguments about market forces, or how its network administrator controlled many aspects of network composition. **Other plans and issuers should take note of the types of activities this plan is undertaking to monitor and address disparities in access to providers.**

See Appendix A for more details on the actions the plan is taking.

ii. Examples of Corrections for NQTLs Imposed on Treatment for ASD

Example #2 – Removal of ABA Therapy Exclusion and Reprocessing of Claims

Issue: A self-funded union plan covering more than 2,500 participants excluded benefits for ABA therapy to treat ASD in the outpatient, in-network and outpatient, out-of-network benefit classifications, despite covering ASD under the terms of the plan. The plan did not apply any comparable categorical exclusion to benefits for M/S conditions in those benefit classifications.

Action: EBSA's Chicago Regional Office issued an initial determination letter citing the plan for imposing an impermissible NQTL that was applicable only to MH/SUD benefits in the classification with respect to the ABA therapy exclusion.

Result: In the prior reporting period, the plan removed the ABA therapy exclusion. In this EBSA Reporting Period, the plan re-adjudicated over 1,100 claims, resulting in over $250,000 in claims payments, over $290,000 in network discounts being applied, and over $5,500 in premiums being returned to participants who bought supplemental coverage to pay for their child's ABA therapy.

Example #3 – Removal of ABA Therapy Age Limit at Early Stage of Inquiry

Issue: A self-funded plan covering more than 16,000 participants excluded benefits for ABA therapy to treat ASD for participants after age 18.

Action: EBSA's Cincinnati Regional Office asked the plan about this exclusion in preparation for issuing a comparative analysis request to determine whether any benefits for M/S conditions were subject to a comparable limitation in those benefit classifications.

Result: The plan removed the ABA therapy exclusion for participants after age 18 due to EBSA's questions. The plan re-adjudicated affected claims, resulting in claims payments of over $60,000.

Example #4 – Removal of ABA Therapy Exclusion at Service Provider Level

Issue: A large, national service provider and its subsidiary administered self-funded plans, some of which covered ASD but excluded benefits for ABA therapy. The service provider did not apply any comparable NQTL to benefits for M/S conditions in the outpatient, in-network and outpatient, out-of-network benefit classifications.

Action: EBSA's Boston Regional Office requested documents from the service provider to determine which self-funded plan clients were affected by the exclusion. In preparation for requesting comparative analyses from the service provider's ERISA plan clients, investigators also reviewed claims to understand how the service provider processed claims and how the ABA therapy exclusion worked in practice.

Result: The service provider took steps to remove the exclusion without the need for EBSA to issue a comparative analysis request. Working with the service provider and one of its subsidiaries, the Boston Regional Office identified over 50 plans and over 190,000 participants who were potentially adversely affected by the exclusion. EBSA is still working with the service provider and its subsidiary, which removed the exclusion from the plans, to identify and re-adjudicate wrongfully denied claims for ABA therapy.

Example #5 – Removal of Speech Therapy Exclusion at Early Stage of Inquiry

Issue: A self-funded plan excluded benefits for speech therapy to treat mental health conditions in the outpatient, in-network; outpatient, out-of-network; inpatient, in-network; and

inpatient, out-of-network benefit classifications. The plan did not apply any comparable NQTL to benefits for M/S conditions in those benefit classifications.

Action: EBSA's Chicago Regional Office asked the plan about this exclusion in preparation for issuing a comparative analysis request.

Result: As a result of EBSA's questions, the plan removed the speech therapy exclusion. The plan also reviewed claims and found no participants or beneficiaries were adversely affected.

Example #6 – Removal of Age Limits for ASD Treatments at Service Provider Level

Issue: A service provider administering many self-funded plans had 31 group health plan clients that imposed age limits for some or all ASD treatments.[78] The service provider did not assert that there were any age limits imposed on comparable M/S treatments. These limitations affected plans covering 17,077 participants and beneficiaries. This service provider was one of the three identified in the July 2023 Report as part of EBSA's expansion of its service provider approach to addressing exclusions.[79]

Action: EBSA's Cincinnati Regional Office worked with the service provider to investigate the age limits and how many plans imposed them. The office also obtained data on claims that were denied as a result.

Result: The service provider facilitated the removal of the age limit on ASD treatments from 30 of 31 plan clients. The remaining plan client is in the process of removing the limit. The service provider is in the process of correcting its internal processes to ensure no ASD claims

[78] For example, several plans specified that ASD treatments were only for "covered persons up to age 21."
[79] *See* page 29 of the July 2023 Report.

will be denied in the future based on age limits. It also identified the affected claims and is in the process of reprocessing and paying wrongfully denied claims.

iii. Examples of Corrections to NQTLs Specific to Substance Use Disorder Benefits

Example #7 – Removal of Exclusions for Substance Use Disorder Care

Issue: A self-funded multiple employer welfare arrangement (MEWA) plan covering 2,930 participants covered methadone as a medication to treat pain arising from M/S conditions. The plan, however, excluded coverage for methadone maintenance to treat opioid use disorder. The plan's written provisions also excluded coverage of inpatient, partial hospitalization, and intensive outpatient admissions in instances where such treatment was the result of "continued noncompliance " with specified aftercare or outpatient substance use disorder treatment requirements. Written plan provisions also noted that participation in a designated aftercare program of up to two years may be required for a participant to be eligible for further substance use disorder benefit coverage. The plan did not have a similar compliance requirement for M/S benefits in their respective benefit classifications.

Action: EBSA's San Francisco Regional Office issued an initial determination letter citing the plan for two impermissible NQTLs:

- an exclusion based on continued noncompliance with specified aftercare and outpatient treatment requirements for mental health conditions and substance use disorders, and
- an exclusion of methadone or narcotic maintenance treatment for MH/SUD conditions that is an impermissible separate treatment limitation because it

applied only to MH/SUD benefits and not to M/S benefits in the same benefit classifications.

Result: The plan removed both exclusions. The plan also reviewed claims to ensure no participants were adversely affected by the exclusions.

Example #8 – Removal of Opioid Treatment Program Exclusion and Reprocessing of Claims at Service Provider Level

Issue: A service provider that is also an issuer to fully insured plans processed claims for its client plans in a way that excluded methadone for treatment of opioid use disorder, despite plan language offering coverage of methadone treatment for opioid use disorder.

Action: EBSA's Philadelphia Regional Office issued a comparative analysis request to the service provider.

Result: The service provider acknowledged that claims from fully insured plan participants for methadone treatment had been incorrectly denied as an excluded benefit. EBSA's Philadelphia Regional Office worked with the service provider to identify over 800 improperly denied claims. The service provider took corrective action by removing the impermissible operational exclusion and reprocessing and paying all claims that had been wrongfully denied.

Example #9 – Removal of Exclusion for Medication-Assisted Treatment at the Service Provider Level

Issue: A third-party service provider administered benefits for many self-funded plans. This service provider was one of the three identified in the July 2023 Report as part of EBSA's expansion of its service provider approach to addressing exclusions.[80] One of the service

[80] *See* page 29 of the July 2023 Report.

provider's plan clients excluded ABA therapy, and four of its plan clients excluded MAT for substance use disorders, in the in-network and out-of-network, inpatient and outpatient benefit classifications. The plan did not apply any comparable NQTLs to benefits for M/S conditions in those benefit classifications.

Action: EBSA's Dallas Regional Office sent a letter to the service provider asking about specific exclusions, including for ABA therapy and MAT. The service provider identified the clients that imposed these exclusions.

Result: After discussions with EBSA, the service provider worked with affected plans to eliminate the ABA therapy and MAT exclusions. The ABA therapy exclusion affected coverage for 160 participants and beneficiaries, and the MAT exclusion affected coverage for approximately 5,000 participants and beneficiaries. The service provider removed the exclusions from practices and plan provisions going forward, then worked with EBSA to review claims to ensure no participants or beneficiaries were adversely affected in the past.

iv. Examples of Corrections to NQTLs Imposed on Various MH/SUD Benefits

Example #10 – Ending the Use of an Employee Assistance Program as a Gatekeeper for MH/SUD Services

Issue: A large self-funded plan's written provisions advised that participants should contact the plan's Employee Assistance Program (EAP) provider before seeking treatment for "mental or nervous disorders" under the plan. The limitation was applied more stringently to MH/SUD conditions than to M/S conditions because the plan required contacting the EAP for all MH/SUD benefits in the outpatient (in-network and out-of-network) benefit classifications, but only for a few M/S benefits in the benefit classifications.

Action: EBSA's Cincinnati Regional Office requested and reviewed the plan's comparative analysis for the NQTL, then issued an initial determination letter citing the plan for imposing an impermissible NQTL by using the EAP as a gatekeeper for accessing only some M/S benefits, but all MH/SUD benefits.[81]

Result: The plan modified its summary plan description (SPD) and mailed a summary of material modifications to over 850 participants and beneficiaries to inform them that they could receive MH/SUD benefits without first using the EAP.

Example #11 – Removal of Prior Authorization Requirement on Certain MH/SUD Services

Issue: A self-funded plan covering over 3,000 participants required prior authorization for many in-network, outpatient benefits. In its comparative analysis for that NQTL, the plan identified several quantitative factors and referenced thresholds it used to determine which benefits require prior authorization. However, the comparative analysis and supplemental information provided by the plan in response to EBSA's insufficiency letter did not sufficiently define quantitative standards used to apply specific factors, such as "elasticity of demand," "high outlier cost," and "high utilization relative to benchmark." The plan also excluded MAT for substance use disorders in the in-network and out-of-network, inpatient and outpatient benefit classifications and did not apply any comparable NQTL to benefits for M/S conditions in those benefit classifications.

Action: EBSA's New York Regional Office issued initial determination letters citing the plan for:

[81] *See* 26 CFR 54.9812-1(c)(4)(iii), Ex. 6, 29 CFR 2590.712(c)(4)(iii), Ex. 6, and 45 CFR 146.136(c)(4)(iii), Ex. 6 of the 2013 final rules. *See also* 26 CFR 549812-1(c)(4)(vi)(K), 29 CFR 2590.712(c)(4)(vi)(K), and 45 CFR 146.136(c)(4)(vi)(K) of the 2024 Final Rules.

- imposing an impermissible separate NQTL for the exclusion of MAT applicable only to MH/SUD benefits in the benefits classifications, and
- not adequately defining the factors and standards used to apply the prior authorization NQTL.

Result: In the prior reporting period, the plan's service provider removed the MAT exclusion from all plans it administered. The service provider had played a role in applying the MAT exclusion, and therefore EBSA worked directly with the service provider to correct the violation. The service provider removed the MAT exclusion from 10 plans and re-adjudicated and paid over $9,000 in claims that had been wrongfully denied because of the MAT exclusion. In this EBSA Reporting Period, the service provider paid an additional $1,700 in claims that had been wrongfully denied as a result of the exclusion.

Also during this EBSA Reporting Period, the plan and its service provider removed the prior authorization requirement from select MH/SUD services (electroconvulsive therapy, transcranial magnetic stimulation, and psychological testing). The correction by the service provider impacted 135 plans covering over 770,000 participants.

Example #12 – Removal of Nutritional Counseling Exclusion

Issue: A self-funded plan covering more than 200 participants excluded benefits for nutritional counseling to treat mental health conditions in the inpatient, in-network; inpatient, out-of-network; outpatient, in-network; and outpatient out-of-network benefit classifications. The plan did not apply any comparable NQTL to benefits for M/S conditions in those benefit classifications.

Action: EBSA's Dallas Regional Office issued an initial determination letter citing the plan for imposing an impermissible separate NQTL applicable only to MH/SUD benefits in the benefits classifications.

Result: The plan eliminated the nutritional counseling exclusion. EBSA also reviewed claims to ensure no participants or beneficiaries were adversely affected.

4. Looking to the Future: Challenges Remain to Fulfill MHPAEA's Promise

EBSA has made significant strides in ensuring parity for participants and beneficiaries, and some plans and issuers have made some improvements in their documentation and compliance efforts, but much more work is needed to fulfill MHPAEA's promise. Over the 30 months since February 2021, EBSA has substantially increased its MHPAEA enforcement efforts nationwide and made progress in eliminating certain NQTLs, such as exclusions of key treatments for mental health conditions and substance use disorders, that are not in parity with NQTLs imposed on M/S benefits. These successes are due, in part, to the increase in supplemental funding Congress provided EBSA as part of the CAA. Progress toward meaningful change for other more complex NQTLs, such as those related to network adequacy and network composition, has been slower. Nearly 3 years of reviewing comparative analyses has shown EBSA that the comparative analysis review process itself is a valuable enforcement tool because plans and issuers are motivated to make corrections during EBSA's enforcement process and avoid a final determination of noncompliance. However, EBSA's experience has also shown the limits of the statutory process for reviewing comparative analyses. Despite its limited resources, EBSA has worked with plans and issuers throughout the comparative analysis review process, affording them multiple opportunities to supplement their responses and take corrective action prior to issuing a final determination of noncompliance. However, the review of comparative

analyses is not a substitute for investigative work to understand the complexities of plan or issuer operations and the processes, strategies, evidentiary standards, and other factors they employed in applying NQTLs to MH/SUD benefits and M/S benefits. For more complex NQTLs that may be the result of the application of multiple complex processes, strategies, evidentiary standards, and other factors, such as NQTLs related to network composition, this investigative work is essential. Unfortunately, EBSA has found that plans' and issuers' explanations of the processes, strategies, evidentiary standards, and other factors shifts with each submission, and may not accurately reflect the actual design and application of the NQTLs. EBSA reminds plans and issuers that a thorough comparative analysis with supporting documentation that accurately reflects the design and application of an NQTL, as required by the CAA, will reduce the investigative burden for both plans and issuers and the Departments.

5. EBSA's Statutory Reporting Requirements

a. EBSA's Summary of Requests and Identification of Noncompliant Plans and Issuers

During the EBSA Reporting Period, EBSA issued 17 letters requesting comparative analyses—11 to plans and 6 to issuers—for 22 NQTLs (19 unique NQTLs), as shown in the table below. In total, between April 9, 2021, and July 31, 2023, and across 116 investigations, EBSA issued 199 letters to plans and issuers requesting comparative analyses for over 480 NQTLs (over 290 unique NQTLs).

The following table summarizes the types of NQTLs for which EBSA requested a comparative analysis during the EBSA Reporting Period.

Type of NQTL Covered by New Requests in EBSA Reporting Period	Number of Comparative Analysis Requests Issued

Network admission standards, including reimbursement rates and network adequacy	6
Exclusion of ABA, intensive behavioral, rehabilitative/habilitative, or cognitive therapy to treat MH/SUD conditions	5
Restriction on access to out-of-network providers	3
Prior authorization, precertification, or prior notification	2
Limitations based on likelihood of improvement or progress	1
Exclusion of nutritional or dietary counseling for mental health conditions	1
Exclusion of telehealth for mental health conditions	1
Exclusion of residential care or partial hospitalization for mental health conditions or substance use disorders	1
Limitation on services rendered by associates, interns, psychological and/or physician assistants	1
Requirement to bill through another provider	1
Total	**22**

EBSA did not issue any final determinations of noncompliance during the EBSA Reporting Period. EBSA's rigorous investigations and targeted compliance assistance produced tangible results. As noted above, many plans and issuers were highly motivated to avoid a final determination of noncompliance, and they corrected potential NQTL violations at earlier stages of EBSA's NQTL inquiries than in previous reporting periods.

b. EBSA's Conclusions Regarding Sufficiency of Responses

EBSA thoroughly reviews the information provided in a comparative analysis to evaluate a plan's or issuer's compliance with MHPAEA. The Secretary's comparative analysis request is an opportunity for plans and issuers to demonstrate how they assessed processes, strategies, evidentiary standards, and other factors used in an NQTL's design or application to MH/SUD benefits and M/S benefits. It is a chance for plans and issuers to show how and why the NQTLs they chose to impose comply with MHPAEA, so comparative analyses should be detailed and include meaningful comparisons with supporting documentation.

i. Some Improvements, But Many Comparative Analyses Still Deficient

EBSA has seen some bright spots of improvement in comparative analyses during the EBSA Reporting Period. A few plans and issuers provided more detailed comparative analyses upon initial request during the EBSA Reporting Period, and a growing number provided relevant data and more detailed explanations in response to insufficiency letters. The additional information has often been sufficient to remedy identified deficiencies.

As described in the July 2023 Report, some responses from plans and issuers amount to a "green flag" that the NQTL in question does not appear to be applied more stringently to MH/SUD benefits relative to M/S benefits. In these instances, those responses allow EBSA to resolve its inquiry.

Despite some improvements, EBSA continues to receive deficient comparative analyses and inadequate responses to insufficiency letters. As noted above, EBSA's efforts to afford plans and issuers ample opportunity to supplement deficient responses usually lead to unhelpful exchanges that do not explain what a plan did or is doing in practice. Plans and issuers frequently named new factors and evidentiary standards when asked about existing factors and evidentiary standards from their prior responses, emphasizing in many cases that the initial comparative analysis was deficient. It is often unclear which set of factors, if any, accurately reflect what the plan or issuer actually considered when designing or applying an NQTL.

The same deficiencies and trends noted in the January 2022 Report and July 2023 Report are commonly reflected in comparative analyses reviewed during the EBSA Reporting Period:

- failure to document a comparative analysis before designing and applying the NQTL,

- conclusory assertions lacking specific supporting evidence or detailed explanation,
- lack of meaningful comparison or analysis,
- nonresponsive comparative analysis,
- documents provided without adequate explanation,
- failure to identify the specific MH/SUD and M/S benefits or MHPAEA benefit classifications affected by an NQTL, and
- focusing only on similarities—rather than explaining differences—to show parity.

EBSA attributes these deficiencies mainly to the following two factors, which were noted in the July 2023 Report:

- inadequate preparation by plans and issuers, and
- plans and issuers attempting to justify practices that were adopted without MHPAEA compliance in mind.

Given that MHPAEA's requirements extend to NQTLs both as written and in operation, EBSA must often request and evaluate supplemental operational data and supporting information to assess compliance. Data on what happens when a plan or issuer applies an NQTL is relevant to understanding operations. When plans and issuers provide data to supplement their responses, the submissions often involve unexplained calculations, undefined inputs, or unclear methodologies. This leads to additional exchanges about the information and its meaning.

When plans submit deficient comparative analyses, EBSA generally issues insufficiency letters notifying the plan or issuer of the deficiencies. These letters list specific additional information or supporting documentation that the plan or issuer should provide to supplement its submission or to cure the deficiency. EBSA's insufficiency letters often include pointed

questions to draw attention to a particular part of the comparative analysis. Each letter is unique to the plan or issuer and NQTL and includes multiple follow-up questions or addresses problems related to the comparative analysis and supporting documents.

As explained in section IV.E below, the Departments are currently developing a sample comparative analysis, informed by comparative analyses received to date, which will include helpful details that, if provided by a plan or issuer in an NQTL investigation, would greatly expedite EBSA's review. To assist plans and issuers in performing and documenting sufficiently detailed comparative analyses, the fictional sample comparative analysis will reflect a combination of the kinds of information that EBSA investigators found helpful in investigations of similar NQTLs and will comply with the requirements of the 2024 Final Rules.,.

ii. NQTL Compliance Determinations Increasingly Require Full, Resource-Intensive Investigations of Plan Operations

As noted above, EBSA has found that the comparative analysis review process is not a substitute for investigative work. NQTL investigations typically span multiple years and involve numerous interviews, document requests, and data reviews. Deficient comparative analyses prolong the investigative process. These investigations are both resource-intensive and time-consuming; the overwhelming majority of EBSA's NQTL investigations span several years.

c. EBSA's Conclusions Regarding Compliance with Disclosure Requirements[82]

i. Initial Determinations by the Numbers

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

Since February 2021, EBSA has obtained sufficient information to make initial determinations of noncompliance for 66 plans and issuers in connection with 97 NQTLs (70 unique NQTLs). Of those, 13 were issued during the EBSA Reporting Period in connection with 21 NQTLs (14 unique NQTLs).

These initial determination letters involved the following NQTLs. EBSA's review of other NQTLs and comparative analyses requested during this and prior reporting periods is ongoing.

Type of NQTL	**Number of Initial Determinations of Noncompliance Issued**	
	Total Issued Since February 2021	**Issued During the EBSA Reporting Period**
Prior authorization, precertification	23	13
Exclusion of ABA therapy, cognitive, intensive behavioral, habilitative, or rehabilitative interventions to treat MH/SUD	20	1
Exclusion of medication-assisted treatment for opioid use disorder	8	1
Provider billing restrictions	7	0
Exclusion of nutritional counseling for mental health conditions	7	1
Provider experience requirement beyond licensure	4	0
Exclusion of residential care or partial hospitalization for MH/SUD conditions	3	0
Treatment plan requirement	3	1
Concurrent care review	3	1
Exclusion of speech therapy for mental health conditions	3	1
Exclusion of telehealth/virtual visits	2	0
EAP referral/exhaustion requirement	2	0
Case manager or "care manager" requirement	2	0
Network admission standards, including reimbursement rates and network adequacy	2	2
Out-of-network provider reimbursement methodology/usual, customary, and reasonable (UCR) calculation	1	0
Fail-first policies	1	0

Exclusion based on likelihood of improvement or "treatability" of MH/SUD	1	0
Exclusion based on chronic or long-term conditions, chronicity	1	0
Formulary design	1	0
Other	3	0
Total	**97**	**21**

The reduction in the number of initial determinations of noncompliance issued during the EBSA Reporting Period reflects increased efforts by plans and issuers to avoid or correct deficiencies before an initial determination of noncompliance is issued, as well as the commitment by EBSA to work with plans and issuers to achieve meaningful corrections for participants and beneficiaries.

ii. EBSA's Enforcement Efforts Have Led to Improvements in Parity Compliance

Many plans and issuers changed their practices and removed NQTLs as a result of EBSA's efforts. During the EBSA Reporting Period, EBSA received CAPs from 16 plans and issuers in response to initial determination letters.[83] These CAPs addressed 25 NQTLs (18 unique NQTLs). Some corrections are complete, and some are pending as EBSA awaits proof of completion.

However, as noted above, EBSA achieved impactful results from plans and issuers at every stage of its NQTL inquiries. Plans and issuers were motivated to avoid an initial and final determination of noncompliance, and many corrected potential NQTL violations without EBSA needing to issue a determination of noncompliance.

[83] Many of these corrective action plans related to NQTLs that EBSA cited in the EBSA Reporting Period.

As a result of EBSA's efforts since February 2021, plans and issuers have completed corrections improving access to MH/SUD benefits for more than 7.6 million participants and beneficiaries across more than 72,000 plans. Examples of these corrections are detailed in Section II.A.3 above.

d. EBSA's Specifications Regarding Sufficiency of Responses

Since February 2021, EBSA has sent 199 letters requesting comparative analyses and, subsequently, 183 insufficiency letters noting that plans and issuers have failed to provide sufficient information in response. These requests covered over 330 NQTLs.

As explained above, some plan or issuer responses were deficient because they did not have a comparative analysis available to provide (despite the requirement in the CAA for plans and issuers to have prepared comparative analyses for NQTLs applied to MH/SUD benefits that reflect the current terms of the plan or coverage by February 10, 2021, and to provide these comparative analyses to the relevant Secretary or applicable State authority upon request).[84] Additionally, there were many instances where a comparative analysis was missing key information required by statute. EBSA's specifications regarding the sufficiency of responses, which reflect the statutory requirements of ERISA section 712(a)(8), are detailed above in Section II.A.5.b (EBSA's Conclusions Regarding Sufficiency of Responses).

e. EBSA's Specifications Regarding Compliance

Because of plans' and issuers' remedial efforts, EBSA did not need to issue any final determinations of noncompliance during the EBSA Reporting Period. Plans and issuers that received initial determinations of noncompliance were highly motivated to avoid receiving a final determination of noncompliance, since the CAA, among other things, requires the

[84] Code section 9812(a)(8)(A), ERISA section 712(a)(8)(A), and PHS Act section 2726(a)(8)(A).

Departments to publicly identify plans and issuers that receive such determinations. Accordingly, plans and issuers proactively worked to correct violations. EBSA closely monitored the status of corrective actions taken by plans and issuers that received initial determinations of noncompliance.

B. CMS' MHPAEA Enforcement Activity under the CAA

CMS, on behalf of HHS, enforces applicable requirements of title XXVII of the PHS Act, including MHPAEA, with respect to issuers selling products in the individual and fully insured group markets in States that fail to substantially enforce MHPAEA or another PHS Act provision (referred to as direct enforcement States) and with respect to non-Federal governmental plans nationwide.[85, 86] CMS requested 22 comparative analyses from 8 plans and issuers during the CMS Reporting Period.[87, 88]

CMS reviewed the comparative analyses from each of the 8 plans and issuers for completeness and made requests for information when submissions were insufficient, identified areas of noncompliance, and issued initial determinations of noncompliance to applicable plans

[85] CMS is responsible for enforcement of MHPAEA with respect to non-Federal governmental plans in all 50 States, the District of Columbia, and the territories. See section 2723(b)(1)(B) of the PHS Act. In the 2023 Plan Year, CMS was responsible for enforcement of MHPAEA with regard to issuers in Texas and Wyoming. In addition, six States (Alabama, Florida, Louisiana, Montana, Oklahoma, and Wisconsin) have entered into collaborative enforcement agreements with CMS that include MHPAEA enforcement. The States with collaborative enforcement agreements with CMS perform State regulatory and oversight functions with respect to MHPAEA; however, if the State finds a potential violation and is unable to obtain compliance by an issuer, the State will refer the matter to CMS for possible enforcement action.

[86] Sponsors of self-funded non-Federal governmental plans previously could elect to exempt those plans from (opt out of) certain requirements of title XXVII of the PHS Act, including MHPAEA. *See* former PHS Act section 2722(a)(2). The Consolidated Appropriations Act, 2023 amended PHS Act section 2722(a)(2) such that sponsors of self-funded non-Federal governmental plans generally can no longer opt out of MHPAEA. The 2024 final rules also include provisions related to the sunset of the ability of self-funded non-Federal governmental plans to opt out of compliance with MHPAEA. 45 CFR 146.180.

[87] Multiple NQTL comparative analyses were requested from some plans and issuers, resulting in 22 total comparative analyses requested and 22 comparative analysis reviews.

[88] The CMS Reporting Period is September 2, 2022, through July 31, 2023. CMS intends to align its reporting period with EBSA's reporting period in subsequent years. The reporting period for future reports will be from August 1 through July 31 of the following year.

and issuers. Plans and issuers that received an initial determination of noncompliance were required to provide a CAP and an additional comparative analysis demonstrating compliance within 45 calendar days of the date of the initial determination letter.[89] CMS provided information and technical assistance to plans and issuers regarding CAP submissions upon request. Plans and issuers were expected to:

- provide sufficient information for CMS to assess compliance with the NQTL requirements under MHPAEA (for example, providing factors, sources, evidentiary standards, and guidelines used in the design and application of the NQTL); and
- correct identified instances of noncompliance (for example, revising utilization management policies to have comparable written processes and standards between MH/SUD benefits and M/S benefits).

If the initial CAPs submitted by the plan or issuer did not sufficiently address or correct the identified instances of noncompliance, CMS' final determination letter included updated corrective actions outlining the steps required to achieve MHPAEA compliance.

The CMS Reporting Period included reviews of comparative analyses for plan years starting in 2021, 2022, and 2023, covering the time period between September 2, 2022, and July 31, 2023. CMS issued three final determinations of noncompliance to one issuer during the CMS Reporting Period (as detailed in Section II.B.4.b.iv). Forty-five comparative analysis reviews were ongoing at the end of the CMS Reporting Period.[90] CMS continues to work with plans and issuers to finalize determinations and ensure corrective actions are taken when warranted. For those reviews that are ongoing, CMS will include its findings in future reports to Congress.

[89] *See* PHS Act section 2726(a)(8)(B)(iii)(I)(aa).
[90] This number includes comparative analysis reviews initiated during prior reporting periods.

In its third year of implementing the CAA amendments to MHPAEA, CMS has not seen a marked improvement in the sufficiency of initial NQTL comparative analyses provided by plans and issuers. However, a few plans and issuers provided more detailed comparative analyses as part of their initial submissions, and a growing number provided relevant data and more detailed explanations in response to insufficiency letters and initial determinations of noncompliance. Deficiencies and trends identified during the CMS Reporting Period are consistent with those noted in the July 2023 Report. CMS determined that 10 comparative analyses were insufficient upon initial review. The sufficiency determination for the remaining reviews is in progress. In 2023, CMS added a secondary Insufficient Data Request step to the review process to allow for more guidance to plans and issuers to improve the sufficiency of NQTL comparative analyses prior to issuing initial determinations. Plans and issuers are working with CMS to provide additional information about identified NQTLs, complete CAPs, and provide additional comparative analyses demonstrating compliance. CMS will also include findings for the remaining reviews in future reports to Congress.

1. CMS' NQTL Enforcement Priorities

During the CMS Reporting Period, CMS requested a total of 22 comparative analyses for 12 distinct NQTLs. Notably, CMS placed a new emphasis in this Reporting Period on comparative analyses for provider reimbursement treatment limitations and pharmacy benefit formulary design (including step therapy and quantity limits [91]). CMS reviewed NQTLs as follows:

[91] For this purpose, a "quantity limit" refers to how the plan designs and applies its standards for setting quantity limits on prescription drugs, including any processes or requirements for receiving approval to exceed the quantity limit. For guidance on quantity (or dosage) limits, see FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39 (Sept. 5, 2019), Q3, available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/faqs-mental-health-

- Eight reviews focused on prior authorization NQTLs in the inpatient, in-network; inpatient, out-of-network; outpatient, in-network; and outpatient, out-of-network benefit classifications;
- Five reviews focused on concurrent review NQTLs in the inpatient, in-network; outpatient, in-network; and outpatient, out-of-network benefit classifications;
- Two reviews focused on specific NQTLs and exclusions of key treatments for covered conditions and disorders (e.g., exclusions of ABA for ASD) in the outpatient, in-network benefit classification;
- Three reviews focused on provider reimbursement NQTLs in the outpatient, in-network benefit classification;
- Two reviews focused on formulary design in the prescription drug benefit classification; and
- Two reviews focused on prior authorization requirements, step therapy, and quantity limits in the prescription drug benefit classification.

2. CMS' Approach to Implementing Its NQTL Enforcement Priorities

CMS maximized MHPAEA enforcement efforts by basing its NQTL comparative analysis requests on previous indicators of MHPAEA noncompliance in market conduct examinations, form reviews, non-Federal governmental plan investigations, and consumer complaints. CMS supplemented its risk-based requests with a random selection of issuers in direct enforcement States.

After sending the initial comparative analysis request, CMS held entrance conferences with each plan and issuer to discuss the review process and the elements of a sufficient

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substance-use-parity-implementation-cures-act-2019.pdf and https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/faqs-part-39.pdf.

comparative analysis submission. In addition to entrance conferences, CMS met with plans and issuers to discuss initial determinations of insufficiency, initial determinations of noncompliance, and final determinations of noncompliance, when applicable. Upon request, CMS also provided technical assistance throughout the review process, clarifying the review stages and/or determinations with plans and issuers.

3. CMS' Enforcement Results Under the CAA and Their Impact

Plans and issuers completed various corrective actions based on CMS' initial and final determinations of noncompliance. The issuer for which CMS made a final determination of noncompliance was required to notify all individuals enrolled in the plan or coverage, within 7 days of the final determination, that the plan or coverage was determined to be not in compliance with MHPAEA.[92] This requirement ensured that affected consumers were informed of their issuer's violation.

a. Examples of Corrective Actions Taken for Insufficient Comparative Analyses

In many instances of noncompliance, the plan or issuer provided an insufficient comparative analysis, insufficient supporting documentation, or insufficient supplemental information in response to CMS' comparative analysis request and insufficient data requests. As a result of CMS' determinations of insufficiency, plans and issuers provided additional information and documentation to support their comparative analyses. This resulted in a more thorough evaluation of the processes, strategies, evidentiary standards, and other factors used in the design and application (as written and in operation) of NQTLs to MH/SUD benefits and M/S benefits in the same benefits classification. Examples of corrective actions taken in response to

[92] *See* PHS Act section 2726(a)(8)(B)(iii)(I)(bb).

CMS' initial and final determinations of noncompliance related to insufficient comparative analyses include:

- One plan implemented a new annual review of inpatient utilization data as part of its updated comparative analysis to demonstrate the comparability and relative stringency of the application of prior authorization requirements for inpatient, in-network services to MH/SUD benefits and M/S benefits.
- Ten plans and issuers provided additional operational metrics with detailed explanations as part of their CAP submissions. Plans and issuers used operational metrics to assess the comparability and relative stringency of the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits and M/S benefits. For example, one issuer provided updated operational metrics to use the same metric (e.g., percentage format) for turnaround-time for prior authorization and concurrent review decisions for both MH/SUD and M/S data. The issuer confirmed the updated metrics were included in its NQTL comparative analysis.
- Seventeen plans and issuers submitted additional evidence and supporting documentation to substantiate statements made in initial comparative analysis submissions and supplemental responses. The additional supporting documentation helped plans and issuers demonstrate the comparability and stringency of the standards, processes, sources, and factors utilized in the design and application of an NQTL, as written and in operation. For example, one issuer provided supporting documentation that considered each MH/SUD and M/S service under review, outlining how each factor, including the supporting

rationale used by the issuer's decision makers and experts, is used in the design and application of the NQTL.

- An issuer provided supporting documentation demonstrating how factors are defined and applied to MH/SUD services and M/S services subject to the NQTL. This included describing which factor is applied to each MH/SUD service and M/S service and clarifying how the factors are measured.
- An issuer provided updated documentation for all committees involved in the design and application of the NQTL, to include pertinent information about the structure and composition of the committees (e.g., qualifications and clinical specialties).

b. Examples of Corrective Actions Taken for Comparability and Relative Stringency

When CMS issued an initial determination that a plan or issuer failed to demonstrate comparability and relative stringency of the processes, strategies, evidentiary standards, and other factors used to design or apply an NQTL to MH/SUD benefits and M/S benefits, plans and issuers removed the limitation and/or updated their written policies and procedures. Two examples are described below:

Example #1 – Failure to demonstrate comparability and relative stringency of prior authorization and approval timelines pertaining to ABA therapy as compared to M/S benefits.

Issue: The plan limited the length of prior authorization approval for ABA therapy for outpatient, in-network services to a 6-month time period, but there was no such limitation for M/S benefits in the classification.

Action: CMS issued an initial determination letter citing the plan's failure to demonstrate comparability and relative stringency of any processes, strategies, evidentiary standards, or other factors used in applying prior authorization in the outpatient, in-network classification with respect to MH/SUD benefits and M/S benefits, as written and in operation.

Result: After receiving CMS' initial determination letter, the plan removed all prior authorization requirements for outpatient, in-network MH/SUD services. The plan confirmed that a prior authorization requirement would no longer be imposed on MH/SUD benefits in the outpatient, in-network classification and provided supporting documentation of this corrective action.

Example #2 - Failure to demonstrate comparability and relative stringency of the NQTL pertaining to benefits approval timeframes for MH/SUD benefits as compared to M/S benefits.

Issue: Multiple issuers whose comparative analyses were reviewed had prior authorization approval timeframe standards for elective outpatient MH/SUD benefits that were not comparable to, and were more stringent than, the prior authorization approval timeframe standards used for elective outpatient M/S benefits. Specifically, prior authorization approvals for elective M/S benefits were valid for 6-month timeframes, while prior authorization approvals for MH/SUD benefits were only valid for specified dates. Because MH/SUD benefits could only be approved for specified dates, elective MH/SUD services could have been approved for an amount of time less than 6 months. As a result, the allowed length of approvals for elective MH/SUD services was more restrictive than the length of approvals for elective M/S benefits.

Action: CMS issued initial determination letters citing these issuers' failure to demonstrate comparability and relative stringency, as written and in operation, of any processes,

strategies, evidentiary standards, or other factors used in applying prior authorization in the outpatient, in-network classification with respect to MH/SUD benefits and M/S benefits.

Result: After receiving CMS' initial determination letters, the issuers submitted CAPs to make the 6-month prior authorization approval timeframe applicable to both MH/SUD benefits and M/S benefits. The issuers also removed written policy and procedure language noting that prior authorization approvals for MH/SUD benefits were only valid for specified dates. As part of the CAPs, the issuers provided CMS with revised policy and procedure documents verifying the stated revisions.

4. CMS' Statutory Reporting Requirements

a. CMS' Summary of Requests and Identification of Non-Compliant Plans and Issuers[93]

During the CMS Reporting Period, CMS requested a total of 22 comparative analyses across 12 distinct NQTLs. The following is a comprehensive list of the NQTLs for which CMS requested a comparative analysis during the CMS Reporting Period, organized by benefit category.

Type of NQTL Covered by New Requests in CMS Reporting Period	Number of Comparative Analysis Requests Issued
Prior Authorization	8
Prior authorization treatment limitations for outpatient, in-network services	4
Prior authorization treatment limitations for inpatient, in-network services	1
Prior authorization treatment limitations for outpatient, out-of-network services	2

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

Prior authorization treatment limitations for inpatient, out-of-network services	1
Concurrent Review	5
Concurrent review treatment limitations for inpatient, in-network services	1
Concurrent review treatment limitations for outpatient, in-network services	3
Concurrent review treatment limitations for outpatient, out-of-network services	1
Treatment Limitations and Exclusions	2
Treatment limitations on outpatient, in-network MH/SUD services, such as requirements for treatment plans and other treatment authorization requirements, compared to outpatient, in-network M/S services	1
Limitations or exclusions of services to treat MH/SUD as compared to limitations or exclusions to treat M/S conditions in the in-network, outpatient classification	1
Provider Reimbursement	3
Provider reimbursement treatment limitations for outpatient, in-network providers	3
Limitations on Prescription Drug Benefits	4
Prescription drug benefits - formulary design	2
Prescription drug benefits - prior authorization requirements, step therapy, quantity limits	2
Total:	**22**

CMS conducted 48 comparative analysis reviews during the CMS Reporting Period.[94] Three reviews resulted in final determinations of noncompliance (as detailed in Section II.B.4.b.iv). Forty-five comparative analysis reviews remained ongoing at the end of this CMS

[94] This number includes comparative analysis reviews that were initiated during prior reporting periods.

Reporting Period.[95] CMS continues to review these comparative analyses, including CAPs and supplemental materials, as well as engage with plans and issuers to assess compliance. Future reports to Congress will include the results of these reviews.

b. CMS' Conclusions Regarding Sufficiency of Responses[96]

After reviewing initial comparative analysis submissions, CMS sent plans and issuers requests for additional information needed to complete the reviews. CMS was available to respond to questions and provide additional assistance. CMS provided up to two opportunities for the submission of additional information before making an initial compliance determination. During the CMS Reporting Period, CMS requested and received supplemental responses with respect to 10 reviews. CMS continues to review plans' and issuers' initial and supplemental submissions.[97]

i. Examples of Corrective Actions

For any instances of noncompliance found in during the CMS Reporting Period, CMS sent an initial determination letter to the plan or issuer describing each instance of noncompliance. The initial determination letters also requested that the plan or issuer submit a CAP within 45 calendar days of the date of the letter, as required under Section 2726(a)(8)(B)(iii) of the PHS Act. CMS requested that the CAP include actions taken or in progress to correct the instances of noncompliance described in the initial determination letter, a timeline for completion, evidence of corrective action implementation or completion, and a

[95] These numbers apply to the CMS Reporting Period. CMS has since made final determinations for two Plan Year 2021 reviews and six Plan Year 2022 reviews. At this time, CMS is evaluating compliance for 15 Plan Year 2022 reviews, 24 Plan Year 2023 reviews, and 21 Plan Year 2024 reviews. The results of these reviews will be detailed in future reports.

[96] PHS Act section 2726(a).

[97] During the CMS Reporting Period, 10 comparative analyses were reviewed and determined to be insufficient. As of the date of publication of this report, all 22 comparative analyses requested during the CMS Reporting Period were determined to be insufficient.

revised NQTL comparative analysis demonstrating compliance based on the corrective actions identified in the CAP.

As a result of CMS' initial determination letters, plans and issuers implemented changes to correct instances of noncompliance and to more proactively and thoroughly assess compliance with MHPAEA. Examples of these changes are described below:

Example #1 – Removal of Prior Authorization Requirements for MH/SUD Benefits

One plan reviewed had a prior authorization approval timeframe in place for an outpatient MH/SUD benefit that was not comparable to and was more stringent than prior authorization approval timeframes used for outpatient M/S benefits. Specifically, the plan limited prior authorization approval for ABA therapy to a 6-month period, while no M/S benefits were subject to this limit. After receiving CMS' initial determination letter, the plan submitted a CAP that removed all prior authorization requirements for outpatient MH/SUD benefits for in-network and out-of-network services, including ABA therapy. As part of the CAP, the plan provided CMS with updated documentation verifying the removal of prior authorization requirements for outpatient MH/SUD benefits.

Example #2 – Increased Assessment and Reasoned Discussion of Operational Comparability and Stringency

Many of the reviews lacked a sufficient assessment or reasoned discussion to demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits were comparable to, and no more stringently applied than, those applied to M/S benefits, as written and in operation. This kind of noncompliance was found in 16 reviews during the CMS Reporting Period. After receiving CMS' initial determination letter,

plans and issuers submitted additional operational metrics with a detailed explanation as part of their CAP submissions. As a result:

- One plan is implementing a new annual review of inpatient utilization analytics reports.
- Ten plans and issuers provided updated operational metrics analyses to assess the comparability and relative stringency of the processes, strategies, evidentiary standards, and other factors used to apply the applicable NQTL to MH/SUD benefits and M/S benefits. Operational metrics included items such as average approval-length time periods for prior authorization requests, approval and denial rates for prior authorization and concurrent review requests, and average decision turnaround-time rates for prior authorization and concurrent review determinations, compared between MH/SUD benefits and M/S benefits.
- Separate operational metrics were provided by six issuers to demonstrate comparability and relative stringency of different processes used to apply the NQTL under review, such as "standard" vs. "urgent" prior authorization processes.

Example #3 – Additional Supporting Documentation Provided

Failure to provide sufficient information was the most common instance of noncompliance and was found in 19 reviews during the CMS Reporting Period. Plans and issuers in their initial submissions and supplemental responses often made assertions regarding the standards, processes, sources, or factors used in the design and application of the applicable NQTL without providing supporting documentation to verify the assertions made. Furthermore, some plans and issuers provided conclusory statements regarding their compliance with MHPAEA without providing supporting evidence demonstrating compliance. In response to CMS' initial determinations that comparative analyses were insufficient, plans and issuers

submitted additional evidence and supporting documentation to support statements made in their initial comparative analysis submissions and supplemental responses. The additional supporting documentation helped plans and issuers ensure the comparability and stringency of the standards, processes, sources, and factors utilized in the design and application of an NQTL. For example, 11 issuers provided additional supporting documentation pertaining to the design and application of the NQTLs under review concerning utilization management standards (e.g., medical necessity review process, utilization management review guidelines, and peer-to-peer review process).

ii. CMS' Conclusions Regarding Compliance with Disclosure Requirements

1. Initial Determinations by the Numbers

Since February 2021, CMS has obtained sufficient information to make 34 initial determinations of noncompliance for 20 plans and issuers in connection with 34 NQTLs (11 distinct NQTLs). Nineteen of those were issued during the CMS Reporting Period in connection with 19 NQTLs (6 distinct NQTLs).

These initial determination letters involved the following NQTLs. CMS' review of other NQTLs and comparative analyses requested during the CMS Reporting Period and prior reporting periods is ongoing.

Type of NQTL	**Number of Initial Determinations of Noncompliance Issued**	
	Total Issued Since February 2021	**Issued During the CMS Reporting Period**
Prior authorization for outpatient, in-network services	8	7

Prior authorization for inpatient, in-network services	4	3
Prior authorization for outpatient, out-of-network services	2	1
Prior authorization for inpatient, out-of-network services	1	1
Concurrent review for outpatient, in-network services	9	6
Concurrent review for outpatient, out-of-network services	1	-
Concurrent review for inpatient, out-of-network services	1	-
Treatment certification requirements for inpatient, in-network services	1	-
Credentialing standards to qualify as an inpatient, in-network provider	3	-
Credentialing standards to qualify as an outpatient, in-network provider	3	-
Prescription drug exclusions of specific treatments for certain conditions	1	1
Total	**34**	**19**

iii. CMS' Specifications Regarding Sufficiency of Responses

Since February 2021, CMS has sent 48 letters requesting comparative analyses and, subsequently, 45 insufficiency letters noting that plans and issuers have failed to provide sufficient information in response.[98] CMS' specifications regarding the sufficiency of responses are detailed above in Section II.B.4.b (CMS' Conclusions Regarding Sufficiency of Responses).

iv. CMS' Specifications Regarding Compliance[99]

[98] Of the 48 letters requesting comparative analyses, three of the Reviews were closed prior to any further analysis of their responses. Reasons for closure included confirmation after sending the call letter of a plan's HIPAA opt-out from MHPAEA requirements; and a plan's initial submission providing evidence that the identified NQTLs were not being applied. Therefore, only 45 insufficiency letters were sent. All 45 comparative analyses provided by 24 plans and issuers evaluated for compliance with the MHPAEA NQTL requirements failed to provide sufficient information in response to the initial call letter.

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

CMS is required to identify the non-Federal governmental plans and health insurance issuers that were issued a final determination of noncompliance.[100] During the CMS Reporting Period, CMS determined that the issuer listed below was not in compliance with MHPAEA based on a review of comparative analyses of three NQTLs.

Issuer	NQTL(s)
Community Health Choice of Texas	• Provider network participation requirements for inpatient, in-network providers; • Provider network participation requirements for outpatient, in-network providers; and • Prior authorization treatment limitations for outpatient, in-network services.

This issuer was required, within 7 days of the final determination, to notify all individuals enrolled under the impacted plans that such coverage was determined to be out of compliance with MHPAEA.[101] CMS also requires plans and issuers that receive a final determination of noncompliance to verify that they have completed their stated corrective actions. This issuer fulfilled the notification obligation in a timely manner, and the completion of corrective actions was in progress at the end of the CMS Reporting Period.[102]

As detailed below, Community Health Choice of Texas (CHC) received final determinations of noncompliance due to insufficient information and supporting documentation. Without sufficient information and supporting documentation, the issuer was unable to demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply

[100] PHS Act section 2726(a)(8)(B)(iv)(I).
[101] *See* PHS Act section 2726(a)(8)(B)(iii)(I)(bb).
[102] Review of the corrective actions was still in progress during the CMS Reporting Period. As of the date of publication of this report, the issuer has completed their corrective actions, and CMS has closed this Review.

the NQTLs to MH/SUD benefits were comparable to and no more stringently applied than those applied to M/S benefits, as written and in operation.

CHC –Provider network participation requirements for inpatient, in-network providers and provider network participation requirements for outpatient, in-network providers.

The issuer failed to provide a sufficient comparative analysis for the NQTLs under review to demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits in the relevant benefits classifications were comparable to, and applied no more stringently than, those used to apply the NQTLs to M/S benefits in the classification in operation. Additionally, the issuer did not provide a stringency assessment of the application of the NQTLs required by PHS Act section 2726(a)(8)(A)(iv) and (v). CMS reviewed CHC's CAP submission and made a final determination of its adequacy in addressing the instances of noncompliance. CMS concluded that the comparative analysis still did not demonstrate how the issuer determined whether the processes, strategies, evidentiary standards and other factors used to apply the provider network participation requirements NQTL to MH/SUD benefits were comparable to and no more stringently applied than those applied to M/S benefits in operation.

The stringency assessment provided in the CAP response included metrics regarding average credentialing time, provider reimbursement rates, liability insurance amount, admitting privileges, participation requirements, geographic access, specialty requirements, specialty exclusions, whether the network is open to new applicants, facility participation requirements, average facility credentialing time, and facility reimbursement. However, the stringency assessment did not include a reasoned discussion to support the application of various standards

to the NQTLs. For example, there was a disparity in the average facility credentialing turnaround times for MH/SUD and M/S facilities, but the stringency assessment did not include any explanation. Therefore, on their own, the metrics demonstrated that the average facility credentialing time for MH/SUD facilities resulted in longer application times as compared to the average facility credentialing time for M/S facilities. In addition, the assessment failed to clarify the units of measurement used to calculate average facility credentialing time as well as the geographic access standard of "75 miles" that was reported in the stringency assessment for both MH/SUD and M/S providers. It was unclear whether "75 miles" was a minimum, maximum, or average data metric and whether this was a standard or an observed metric.

CMS provided the following corrective actions instructions to the issuer in its final determination of noncompliance letter:

- Provide a reasoned discussion of the findings or conclusions regarding comparability and stringency of the NQTLs and associated processes, strategies, evidentiary standards, and other factors. The discussion should include an analysis of the categories/metrics that were provided in the issuer's CAP submission;
- Provide an explanation to define the "75 miles" metric included in the "Geo Access" category of the stringency assessment;
- Provide the units of measurement used to measure average provider and facility credentialing times as provided in the stringency assessment; and
- Provide additional comparative analyses demonstrating compliance for the NQTLs under review.

The issuer took the following corrective actions to address the remaining instances of noncompliance:

- The issuer provided a reasoned discussion of the conclusions regarding comparability and stringency of the NQTL and its associated processes, strategies, evidentiary standards, and other factors. The discussion included an analysis of the categories/metrics that were provided in the issuer's CAP submission;
- The issuer provided an explanation to define the "75 miles" metrics in the revised NQTL comparative analysis;
- The issuer provided the units of measurement used to measure average provider and facility credentialing times; and
- The issuer provided a revised NQTL comparative analysis.

No further compliance concerns regarding MHPAEA for the coverage under review were identified.

CHC –Prior authorization treatment limitations for outpatient, in-network services

The issuer did not provide sufficient information as required by PHS Act section 2726(a)(8)(A)(ii) regarding the processes, strategies, evidentiary standards, or other factors considered in the design and application of the NQTL, including those used in determining which MH/SUD benefits and M/S benefits are subject to the NQTL. Additionally, the issuer did not provide a sufficient comparative analysis, including a sufficient stringency assessment and reasoned discussion as required by PHS Act section 2726(a)(8)(A)(ii) and (v), for the NQTL under review.

CMS reviewed the issuer's CAP submission and made a final determination of its adequacy in addressing the instances of noncompliance. CMS concluded that the issuer did not provide sufficient information and supporting documentation regarding the factors considered in

the design and application of the NQTL. The issuer's comparative analysis did not adequately demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits were comparable to and no more stringently applied than those applied to M/S benefits.

The issuer initially identified five factors used to determine the outpatient, in-network MH/SUD services and M/S services subject to the NQTL. In its CAP response, the issuer identified two additional factors, thus raising uncertainty about which of the seven total factors submitted were used in the design and application of the NQTL. The issuer did not provide sufficient definitions for all factors or an explanation of how quantitative measures of its factors had been established, applied, and assessed. Furthermore, it was unclear which factors applied to each MH/SUD service and M/S service.

For example, the issuer provided prior authorization approval and denial rates for MH/SUD outpatient, in-network services and M/S outpatient, in-network services in the CAP for its stringency assessment. Though the data metrics indicated a higher prior authorization approval rate and a lower prior authorization denial rate for MH/SUD services as compared to M/S services, rates alone did not explain how the processes, strategies, evidentiary standards, or other factors used were comparable and no more stringently applied to MH/SUD benefits. The issuer did not include a sufficient reasoned discussion of findings and conclusions as to the comparability and relative stringency of all processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD services as compared to M/S services, as written and in operation.

CMS provided the following corrective action instructions to the issuer in its final determination of noncompliance letter:

- Provide a complete list of factors utilized to determine which MH/SUD services and M/S services are subject to prior authorization. This list should identify which factors apply to each MH/SUD service and M/S service;
- Provide concise definitions for each factor identified above;
- To the extent the issuer defines any of the factors in a quantitative manner, identify and provide quantitative measures or thresholds for each factor identified above. Provide supporting information regarding the methodology and sources used in establishing the quantitative measure or threshold and affirmatively state if quantitative thresholds are used;
- Provide the qualifications and applicable clinical specialties of the decision makers and experts pertaining to the "clinical review" factors, if still applicable;
- Provide a complete stringency assessment demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL are no more stringently applied to MH/SUD outpatient in-network benefits compared to outpatient, in-network M/S benefits. The stringency assessment should demonstrate that the written processes used to apply the NQTL are no more stringently applied in operation. The assessment should include, at a minimum, an assessment of the following metrics:
    - Outpatient, in-network prior authorization appeal data for MH/SUD benefits and M/S benefits, including the total number of appeals submitted, the number of appeals for which the denial was upheld, and the number of overturned appeals; and
    - Outpatient, in-network prior authorization decision timeliness for MH/SUD benefits and M/S benefits; and

- Include the results and analysis of the completed stringency assessment in a reasoned discussion of the findings or conclusions regarding the comparability and stringency of the NQTL and its associated processes, strategies, evidentiary standards, and other factors.

As of the end of the CMS Reporting Period, these corrective actions were in progress.[103]

III. Outreach and Consumer and Compliance Assistance Efforts

In assisting consumers and seeking voluntary compliance, EBSA relies on its benefits advisors. EBSA's benefits advisors answer questions and attempt to informally resolve benefits complaints from participants and beneficiaries in ERISA plans. These inquiries and complaints come to EBSA's benefits advisors through the agency's toll-free telephone line; from its web portal, Ask EBSA;[104] and via mail sent to EBSA offices. The benefits advisors provide expert assistance about mental health parity to participants and beneficiaries across the country who have questions or complaints related to their health plan's compliance with MHPAEA. If an individual's inquiry or complaint suggests that there may be violations of the law, including improper benefit denials, a benefits advisor will seek voluntary compliance by working with the individual and their health plan to determine if there is such a violation and, if so, to help obtain the benefits to which they are entitled. If a plan-wide problem cannot be resolved by the benefits advisors, they will refer the plan to EBSA's investigators. Benefits advisors also provide compliance assistance to employers and other stakeholders. In fiscal years 2022 and 2023, EBSA received 362 inquiries from participants and beneficiaries in connection with MHPAEA.

[103] These corrective actions had not been received as of July 31, 2023. Since the end of the CMS Reporting Period, these corrective actions have been completed to CMS' satisfaction. Future reports to Congress will include the results of these corrective actions.
[104] Ask EBSA, available at https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. Click on "Message Us."

A. Benefits Advisor Results

The valuable assistance EBSA's benefits advisors provide to participants and beneficiaries is exemplified by their work on inquiries to resolve problems for participants and beneficiaries. One example originates from EBSA's Kansas City Regional Office, where a benefits advisor assisted a participant whose 3-year-old son's speech therapy claims were denied on the grounds that the plan only covered speech therapy for restoration of speech lost due to illness or injury, but did not cover speech therapy for treatment of developmental delay, a mental health condition under the plan. A benefits advisor obtained relevant documents and contacted the plan to ask for review of the speech therapy claims. The plan reversed the denials and paid $1,045 for eight speech therapy sessions.

Likewise, a benefits advisor in EBSA's New York Regional Office assisted a patient who was denied ABA therapy. After the benefits advisor contacted the plan about the denied claims and explained the requirements of ERISA, including MHPAEA, the plan reprocessed the claims and paid $3,750 for the ABA therapy claims. Similarly, a benefits advisor in EBSA's Chicago Regional Office also assisted a patient who had a claim denied for ABA therapy. The benefits advisor contacted the health plan to request a review of the denied claims after the claims were referred to EBSA from the Wisconsin Office of the Commissioner of Insurance. After review, the health plan determined that the claims were denied due to a processing error, which the plan corrected by issuing a payment of $5,373 to the patient.

EBSA's benefits advisors also play a valuable role in identifying leads that merit further investigation by EBSA's regional offices. Where the agency's benefits advisors find potential MHPAEA violations that impact an entire plan, they can refer the inquiry to an EBSA

investigator. Here are some examples where benefits advisors have made such referrals during the Reporting Period:

- A benefits advisor in EBSA's Chicago Regional Office was contacted by a multiemployer health plan beneficiary whose claims for outpatient psychotherapy treatment were being denied on the grounds that they were not medically necessary. The beneficiary had been given confusing information about how to appeal the claim denials. The benefits advisor reviewed the SPD and plan denial. The benefits advisor referred the issue to enforcement and the regional office opened an investigation on the plan.
- A participant contacted the Boston Regional Office because her son's inpatient mental health treatment was not being covered by the plan. During the course of the benefits advisor's attempts to assist, the plan changed its rationale for denying the claims; the plan initially indicated it would not cover the claims because the facility did not have a nurse on duty 24/7, and then later stated that the claims were not covered because the plan considered the inpatient care to be "maintenance care" rather than treatment. The benefits advisor referred the matter to enforcement and the Boston office opened an investigation.
- A benefits advisor in EBSA's Philadelphia Regional Office referred a complaint to enforcement after being contacted by a participant whose claims for medical nutritional therapy for her eating disorder were denied by the plan based on visit limits that appeared to apply only to mental health treatment. An investigation was opened based on the complaint.
- While assisting a participant with a health plan eligibility issue, a Los Angeles Regional Office benefits advisor spotted potential MHPAEA violations with respect to patient cost sharing in plan documents she was reviewing and referred the plan to enforcement. The

Los Angeles office opened an investigation based on the potential problems uncovered by the benefits advisor.

While EBSA's benefits advisors continue to work tirelessly to inform participants and beneficiaries, as well as plans and issuers, about the requirements of MHPAEA, many patients might not realize when a claim denial or benefit limitation could be a potential MHPAEA concern, or that they have rights under MHPAEA and that EBSA can help. EBSA encourages the public to contact the agency through our website, Ask EBSA,[105] or by calling 1-866-444-3272 to talk to a benefits advisor about concerns they have.

B. Partnerships with Other Interested Parties

Collaboration with interested parties is a vital component to facilitating mental health and substance use disorder parity. With EBSA's limited resources, it is imperative to focus agency resources on the areas where such efforts are most needed, and where the greatest impact can be achieved. Those representing participants and beneficiaries, as well as other interested parties, are often in the best position to provide this information, which aids EBSA in ensuring that MHPAEA's full protections are realized. Consumer advocacy groups and provider organizations are uniquely positioned to communicate the challenges that consumers still face in realizing parity. EBSA recognizes efforts by plans and issuers to move toward full parity compliance and values their input. EBSA therefore seeks opportunities to work with all interested parties to ensure compliance with MHPAEA, raise awareness of the law's protections, and seek feedback on what else may be needed to ensure the full protections of MHPAEA.

[105] Ask EBSA, available at https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. Click on "Message Us."

1. EBSA Leadership's Dedicated Focus on Outreach and Education Regarding MH/SUD Parity

Acting Secretary of Labor Julie A. Su and EBSA's leadership are deeply committed to MHPAEA and has made this increased emphasis a high priority. Starting in May 2023, EBSA used Mental Health Awareness Month as an opportunity to launch its MHPAEA Outreach campaign, through which it made concerted efforts to increase awareness about both MHPAEA rights and obligations as well as EBSA's role in MHPAEA education, assistance, and enforcement. EBSA centered its campaign on a redesign of its MHPAEA webpage, increased media outreach and exposure, and increased outreach to and collaboration with Members of Congress, mental health advocates, and plan and issuer representatives to increase awareness about MHPAEA and EBSA.

Since her Senate confirmation in late September 2022, EBSA Assistant Secretary Lisa M. Gomez has engaged in outreach to raise awareness of MHPAEA and gather feedback from interested parties. Assistant Secretary Gomez has engaged in outreach in various settings including podcast interviews, D.C. office visits and in-district events with Members of Congress and their constituents, collaboration with ONDCP and SAMHSA during National Recovery Month and other activities, interviews with national publications, meetings with healthcare providers, and national conferences and roundtables focused on mental health.

Other members of EBSA's leadership, including Timothy Hauser, Deputy Assistant Secretary for Program Operations; and Ali Khawar, Principal Deputy Assistant Secretary, also participated in this outreach to raise awareness of MHPAEA. In addition to these engagements, EBSA leadership used DOL's blog during the Reporting Period to effectively communicate with participants and beneficiaries in plain language and make them aware of the protections of MHPAEA.

2. Other Efforts

In June 2023, EBSA published a guide for participants and beneficiaries titled "Understanding Your Mental Health and Substance Use Disorder Benefits."[106] This guide was designed in a consumer-friendly format to help workers and their families understand their rights to mental health and substance use disorder benefits covered under their plan in compliance with parity requirements. The guide also highlighted that, to the extent readers had questions or needed help with their benefits, they could call an EBSA benefits advisor to assist without cost to them.

In the January 2022 Report, EBSA highlighted efforts by regional offices to cooperate with other stakeholders to further MHPAEA compliance. These regional offices have continued their work with partners in their areas of the country. For example, over the last fiscal year, EBSA's Boston Regional Office met quarterly with the Insurance Resource Center for Autism and Behavioral Health at the University of Massachusetts Chan Medical School's Eunice Kennedy Shriver Center to discuss obstacles faced by patients and parents when seeking ABA therapy and ways to collaborate to increase treatment access for patients with ASD.

The Cincinnati Regional Office met advocacy groups across the region to discuss EBSA's outreach program and current priorities related to underserved populations and MHPAEA. In November 2022, two Senior Advisors for Health Investigations met with several representatives of the Appalachian Children Coalition, an advocacy coalition located in southeast Ohio focusing on the improvement of children's health and wellbeing in that area.

In December 2022 and September 2023, EBSA's Cincinnati Regional Office met with various members of the Steering Committee for the Southwest Ohio Hub of the Mental Health &

[106] Available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-mental-health-and-substance-use-disorder-benefits.

Addiction Advocacy Coalition (MHAC), an advocacy and research organization focusing on mental health and addiction issues. These meetings focused on EBSA's MHPAEA enforcement program and provided an overview of MHPAEA's rules regarding financial requirements, quantitative treatment limitations (QTLs), and NQTLs, as well as the NQTL comparative analysis requirement under the CAA.

In February 2023, the Cincinnati Regional Office also met with members of the Ohio Parity Coalition, an organization led by the Ohio Council of Behavioral Health and Family Service Providers, a trade and advocacy organization that works to ensure effective enforcement of MHPAEA, to discuss EBSA's role in enforcing Federal mental health parity rules, as well as EBSA's jurisdiction and structure and highlights from the January 2022 Report.

EBSA's Philadelphia Regional Office had frequent engagement with the National Alliance on Mental Illness (NAMI) and its regional affiliates during the EBSA Reporting Period. For example, in May 2023, the regional office participated in two of NAMI's awareness walks in which the regional office's members delivered agency publications, answered questions, provided the toll-free number to call for assistance from EBSA's benefits advisors, and shared online resources about MHPAEA. There were 375 attendees at the walk in Landsdale, Pennsylvania, and 859 attendees at the walk in Baltimore, Maryland. In July 2023, the Acting Regional Director of EBSA's Philadelphia Regional Office met with the Executive Director of NAMI Maryland to discuss MHPAEA generally, as well as partnering to conduct future workshops focused on mental health benefits.

In June 2023, the Cincinnati Regional Office met with the Ohio Suicide Prevention Foundation to discuss EBSA's role in enforcing MHPAEA's protections, EBSA's jurisdiction and structure, and the January 2022 Report. The non-profit organization is dedicated to suicide

prevention by reducing stigma, promoting other evidence-based prevention strategies, and raising awareness about how mental illness and alcohol and substance use impacts suicide risk.

Also in June 2023, a Senior Advisor for Health Investigations from the Los Angeles Regional Office was interviewed by Radio Bilingüe for the live Alerta radio program. The interview was conducted in Spanish, and the live broadcast was heard by approximately 10,000 listeners. In July 2023, another Senior Advisor for Health Investigations from the Los Angeles Regional Office appeared as a guest on OC Health & Education, a program sponsored by the Orange County Autism Foundation that aired on Little Saigon TV. The interview was conducted in both English and Vietnamese and was broadcast to an audience of about 250,000 people.

In September 2023, a Senior Advisor for Health Investigations from the Cincinnati Regional Office presented at the membership meeting of the Southwest Ohio Hub of MHAC. The MHPAEA-focused presentation discussed EBSA's MHPAEA enforcement efforts and the NQTL comparative analysis requirement under the CAA. Similarly, staff from the Cincinnati Regional Office also met with representatives of Interact for Health, an Ohio-based non-profit organization that focuses on ensuring access to health resources. This meeting also included members of MHAC leadership and focused on many of the same topics as discussed in the meetings with MHAC.

The Boston Regional Office met with the Harvard Law School Center for Health Law and Policy Innovation to discuss coordination of outreach efforts relating to MHPAEA. The Boston Regional Office staff also met with a number of ABA therapy providers in order to gain a better understanding of the obstacles faced by families seeking ABA therapy for their children and the challenges faced by providers when working with health insurance issuers, as well as to

gain insight on coverage of ASD-related services in the area. The providers were affiliated with the Little Leaves Behavioral Services, Bierman Autism Centers, and League School.

C. Presentations and Webinars

EBSA conducts outreach and education programs to ensure that plans, issuers, participants and beneficiaries, health care providers, and State regulators understand MHPAEA's requirements and protections. These initiatives include webcasts, in-person seminars, and nationwide compliance outreach events for the regulated community. During fiscal year 2023, EBSA launched a fully integrated, multi-channel outreach campaign focused on educating and engaging target audiences nationwide on what the agency does and informing them of programs and resources that EBSA provides. EBSA updated how agency content available to the public is delivered digitally to raise awareness, increase usability, and improve the public's understanding of complex technical information regarding MHPAEA. The agency focused on reaching the broad multicultural audience it supports. EBSA modified its website pages, and developed videos, social media content, and a toolkit on MHPAEA in multiple languages.

From June 29, 2023, to September 22, 2023, EBSA ran a MHPAEA-related outreach campaign through the use of paid, earned, and organic social media. Despite its short duration, the campaign performed extremely well, exceeding industry benchmarks. As a result of EBSA's efforts:

- More than 700 assets were created for social media in 13 languages;
- More than 75 million impressions[107] were delivered;

[107] Impressions are the total number of exposures to an advertisement. One person can receive multiple exposures over time. If one person is exposed to an advertisement five times, that would count as five impressions.

- More than half a million page views were delivered; and
- Monthly traffic to the MHPAEA web page increased by 67 percent.

EBSA also used DOL's social media accounts, including on Facebook, X, and LinkedIn, with 29 postings resulting in 298,922 impressions for fiscal year 2023.

EBSA also participated in 24 interviews highlighting its priority initiative of mental health parity. Interviews were delivered on radio, newspapers, online publications, podcasts, television, and Facebook Live and Instagram Live. Consistent with agency initiatives to reach diverse and underserved communities, 11 of the interviews were targeted at the African American, Hispanic/Latino, and Asian American and Native American Pacific Islander communities. Four interviews (newspaper, radio, and television) were conducted in languages other than English, namely Spanish and Vietnamese.

In fiscal years 2022 and 2023, EBSA conducted 170 compliance assistance outreach events nationwide that covered MH/SUD parity, which were attended by employers, employee benefit plan administrators, attorneys, accountants, and other plan officials. These events educated attendees about their responsibilities under Federal laws affecting group health plans, including MHPAEA. EBSA also conducted 419 participant assistance and public awareness events, such as those listed above, that educated workers and other stakeholders about their MHPAEA rights.

In furtherance of the goal of improving understanding of MHPAEA and the 2023 Proposed Rules, on September 7, 2023, EBSA hosted a webinar updating employers, employee benefit plan administrators, attorneys, accountants, and other plan officials on the 2023 Proposed Rules. There were over 700 participants in the live webcast, and the archived recording of the webcast has been posted on EBSA's website since the live session. Through the webinar, EBSA

provided an overview of MHPAEA, including a brief summary of financial requirements, QTLs, NQTLs, and information regarding new and updated requirements under the 2023 Proposed Rules.

Similarly, EBSA's regional offices have consistently emphasized mental health parity in their webinars and presentations. In December 2022, EBSA's Boston Regional Office participated in the "Autism and Behavioral Health Insurance Update" seminar hosted by the Insurance Resource Center for Autism and Behavioral Health of the Eunice Kennedy Shriver Center at the University of Massachusetts Chan Medical School which was attended by 77 service providers in the medical field.

The Senior Advisors for Health Investigations for EBSA's Dallas Regional Office participated in three workshops held by the Southwest Benefit Administration in both Texas and Oklahoma during the months of March and April 2023. The Dallas Regional Office's presentation covered MHPAEA with a focus on NQTLs and the CAA comparative analysis review process, and included a discussion of EBSA's enforcement efforts, findings, and results in this area.

In May 2023, a Senior Advisor for Health Investigations from EBSA's Cincinnati Regional Office participated in a webinar entitled "Understanding Mental Health Insurance Benefits for Healthcare Professionals" hosted by the Ohio Department of Insurance. The discussion focused on the requirements on group health plans under ERISA and MHPAEA, and also on EBSA's role enforcing those requirements. This outreach effort was geared toward helping health professionals and other members of the public understand MH/SUD benefits under MHPAEA and how to contact EBSA with questions or concerns.

EBSA's Los Angeles Regional Office conducted a number of presentations on various health laws, including MHPAEA enforcement. In July 2023, it conducted a presentation on key health benefits protections for women (including the protections under MHPAEA) during a meeting sponsored by the Cancer Support Community in South Bay, California.

EBSA's Los Angeles Regional Office presented at the Health Benefits Education Conference in August 2023. The conference's attendees included plan sponsors, attorneys, service providers, and representatives of the Arizona Department of Insurance. The office also conducted a webinar presentation entitled "Health Benefits and Women's Rights" in collaboration with the DOL's Wage and Hour Division and Women's Bureau, as well as the Small Business Administration, which provided information about a number of topics, including MHPAEA compliance. The webinar was open to the general public but was specifically targeted toward small businesses. Attendees included small business owners and human resources personnel as well as the staff of several business development centers, including the Patsy T. Mink Center for Business and Leadership, the Enterprising Women of Color Business Center, and the Veterans Business Outreach Center.

Senior Advisors for Health Investigations from the Boston Regional Office presented a webinar entitled "Compliance Assistance on Mental Health Parity" on August 10, 2023, and again on September 15, 2023. The purpose of the webinar was to help employers, service providers, and benefit professionals understand how the provisions of MHPAEA apply to employer-sponsored group health plans and provide information on how to avoid common problems.

In late September 2023, the Los Angeles Regional Office also conducted a webinar for the newly hired directors, benefits manager, and human resources staff of the Law Offices of

Hugo Gamez in Los Angeles. The presentation was given in Spanish and was intended to better enable attendees to assist low-income members of the Hispanic community with issues involving their benefits, including mental health parity.

EBSA's Philadelphia Regional Office presented a series of workshops in a webinar to employers and service providers entitled "What to Expect in an EBSA Health Investigation," which gave an overview of health plan investigations, included information for health plans on the Voluntary Fiduciary Compliance Program, and discussed the ERISA Part 7 and MHPAEA Compliance Checklists and related online tools. A total of 274 employers and service providers attended these workshops.

D. Cooperation with State and Federal Agencies

1. Cooperation with Federal Partners

EBSA frequently coordinates with other Federal agencies to ensure that MHPAEA is interpreted consistently, to provide education and to improve enforcement of parity requirements. EBSA, along with CMS and Treasury, worked with HHS' Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance on a trio of resources on parity published in April 2022. These resources, discussed in more detail below, are intended to help participants, families and caregivers, and policymakers understand the protections and requirements of the law.

EBSA, CMS, and Treasury provided technical assistance on two publications for consumers. The first was an updated copy of "Know Your Rights: Parity for Mental Health and

Substance Use Disorder Benefits,"[108] which introduces essential information on MHPAEA, including that any limits applied to MH/SUD benefits must be no more restrictive than the limits applied to M/S benefits and that participants and beneficiaries in group health plans have a right to appeal denied claims. EBSA, CMS, and Treasury also provided technical assistance on a 10-page pamphlet providing useful information and guidance to families and caregivers of individuals seeking MH/SUD plan benefits. The publication entitled "Understanding Parity: A Guide to Resources for Families and Caregivers"[109] explains what parity means in the context of a plan's MH/SUD benefits, identifies which plans are subject to MHPAEA and which are not, informs readers about a plan's obligation to provide explanatory information about plan benefits, and provides additional informational resources. The Guide includes short summaries of mental health parity requirements and notes that most health plans are subject to them. The Guide also includes examples to illustrate how parity protections are beneficial to families and caregivers. Throughout the Guide are links to additional resources from the Departments on the topics covered.

EBSA, along with CMS and Treasury, also provided technical assistance on the publication "The Essential Aspects of Parity: A Training Tool for Policymakers,"[110] a 28-page resource designed to educate State policymakers, public health professionals, and others about MHPAEA. The training tool reviews the relevant statutory and regulatory provisions and discusses their impact on health plans and interaction with State law. The publication details how parity is evaluated, outlines plans' disclosure obligations to both participants and regulators, and

[108] SAMHSA (2022). Retrieved from https://store.samhsa.gov/product/know-your-rights-parity-for-mental-health-substance-use-disorder-benefits/pep21-05-00-003?referer=from_search_result.
[109] SAMHSA (2022). Retrieved from https://store.samhsa.gov/product/understanding-parity-guide-to-resources-for-families-caregivers/pep21-05-00-002.
[110] SAMHSA (2022). Retrieved from https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001.

describes parity enforcement mechanisms. The training tool explains the parity requirements that apply to financial requirements, lifetime and annual dollar limits, QTLs and NQTLs, and the tests for determining compliance, and includes charts providing eligibility information, definitions, and analytical examples. Finally, it also provides ample links to source materials and additional educational resources.

EBSA also works with other parts of the Federal government through its work on the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC), first authorized by the Cures Act.[111] ISMICC works to enhance coordination across Federal agencies to improve service access and delivery of care for people with serious mental illness. DOL has been an active ISMICC participant since the committee's inception, serving on the Financing Work Group with colleagues from CMS and SAMHSA.

2. Cooperation with State Partners

EBSA is also committed to working with States as partners in carrying out its obligations to regulate group health plans. In addition to EBSA's enforcement jurisdiction over private-sector employer-sponsored group health plans, whether self-insured or fully-insured, the States generally have primary enforcement responsibility and authority over health insurance issuers for the requirements of title XXVII of the PHS Act, including MHPAEA. Additionally, many group health plan requirements included in ERISA create a Federal floor, and States may be more protective of consumers in carrying out their obligations that relate to health insurance issuers under parallel provisions in the PHS Act, to the extent State requirements do not prevent the application of the Federal requirements.

[111] Pub. L. 114- 255, 130 Stat. 1033.

As part of their work with States, EBSA and CMS participate in regular and ongoing dialogue with the National Association of Insurance Commissioners (NAIC). EBSA and CMS staff also attend national NAIC meetings to engage State regulators on MHPAEA implementation and enforcement efforts. As part of this dialogue, EBSA and CMS provides technical assistance to State regulators on complex parity issues. EBSA, CMS, and the States exchange ideas to help inform EBSA and CMS about State parity implementation and to promote greater uniformity in parity implementation and enforcement efforts. In addition to the quarterly meetings, EBSA, along with CMS, participates in regular conference calls with State regulators through the NAIC to address discrete issues that arise between the quarterly meetings.

Similarly, EBSA's regional offices have focused on working with State partners to advance EBSA's efforts on mental health parity. For example, EBSA's Cincinnati Regional Office has diligently worked to strengthen its existing relationships with various State partners. In October and November 2022, the regional office met with representatives from the Michigan Department of Insurance and Financial Services to discuss outreach priorities related to MHPAEA and underserved populations, EBSA's jurisdiction and structure, and enforcement activities related to the reviews of NQTL comparative analyses required under the CAA. They also shared highlights from the January 2022 Report. The regional office also met with the newly created Mental Health Insurance Assistance Office of the Ohio Department of Insurance to discuss opportunities to collaborate on enforcement and outreach with regard to MHPAEA between EBSA and the newly established office. Finally, the Cincinnati Regional Office conducted a briefing for nine representatives of the Kentucky Department of Insurance, which provided a refresher on EBSA's structure, role, and jurisdiction and discussed current EBSA enforcement priorities, including MHPAEA.

EBSA's Boston Regional Office bolstered its existing relationship with the Massachusetts Division of Insurance Office by meeting quarterly to discuss EBSA's mission and mental health parity, including NQTL issues relating to reimbursement rates and network adequacy and network directory accuracy as they impact the coverage of autism.

EBSA's regional offices also collaborate with one another in outreach efforts to State partners. For example, in May 2023, EBSA's New York and Boston Regional Offices conducted a joint outreach presentation for the Healthcare Bureau of the New York Attorney General's Office. The virtual presentation covered MHPAEA, with a specific emphasis on NQTLs and the ways in which the offices can collaborate in the future. In September 2023, EBSA's Cincinnati and Chicago Regional Offices jointly met with three representatives from the Indiana Department of Insurance to discuss EBSA's enforcement priorities, including MHPAEA NQTL compliance.

E. MHPAEA Listening Session

During the EBSA Reporting Period, on September 23, 2022, DOL hosted a listening session with consumer advocates, group health plan representatives, health insurance issuers, managed behavioral health organizations, State and Federal regulators, and other interested parties. This listening session focused on (1) access to care and network adequacy through the lens of parity, including how the COVID-19 pandemic affected the need for treatment; and (2) improving compliance with the CAA amendments to MHPAEA, including lessons learned and challenges experienced from performing and documenting comparative analyses, such as compiling the necessary data, and best practices for demonstrating compliance with the CAA. This event allowed a range of organizations to come together to discuss some of the enduring challenges to realizing parity, and opportunities to increase access to MH/SUD benefits.

Interested parties noted the need to expand network access to accommodate demand, especially in rural areas where there are often fewer providers and a higher stigma for seeking MH/SUD treatment and for specific mental health conditions, such as ASD and eating disorders. Some attendees also noted the increase in telehealth benefits, which they cautioned was not a panacea. Health insurance issuers highlighted some of the steps they have taken to increase access over the past few years. State regulators noted the difficulty in ensuring that providers listed as in-network are actually available to the people who are enrolled in the health plan. Consumer advocacy organizations highlighted the problems of ghost networks, where listed in-network providers are not actually available under the plan, and emphasized that the Departments should look at how plans adjust their reimbursement rates when they know they have a shortage on the M/S side to inform what steps can be taken to address MH/SUD provider shortages.

Interested parties also noted the challenges in measuring operational compliance but emphasized the value in having to go through the comparative analysis process to bring disparities to light. Issuers highlighted their desire for specificity on data needed for parity compliance and the benefit of providing something specific and quantifiable to measure mental health parity. Service providers requested more guidance on a uniform assessment and process for analyzing NQTLs, including for those NQTLs related to reimbursement rates. Interested parties requested examples of specific complaints and general best practices of NQTLs. Interested parties also requested a list of NQTLs, though it was noted that an exhaustive list of NQTLs might encourage new types of limitations to be created that may not be subject to the existing requirements for NQTLs because they would not be included in the exhaustive list. Lastly, interested parties noted that certain treatments, such as ABA therapy for ASD, or

nutritional counseling for eating disorders, are being excluded despite being a fundamental part of treatment for the respective conditions.

IV. Efforts to Provide Updated and Additional Regulations and Guidance[112]

A. CAA Amendments to MHPAEA

The CAA amended MHPAEA to strengthen the enforcement of parity requirements in the application of NQTLs to M/S benefits and MH/SUD benefits. The regulations implementing MHPAEA prior to enactment of the CAA (2013 final rules)[113] made clear that the parity requirements apply both to QTLs that are expressed numerically (such as caps on the number of days of coverage or office visits), and to NQTLs, which are generally non-numerical requirements that limit the scope or duration of benefits (such as prior authorization requirements, step therapy, and methodologies for establishing provider reimbursement rates). To comply with the 2013 final rules, plans and issuers must ensure that the processes, strategies, evidentiary standards, and other factors used when applying an NQTL to MH/SUD benefits are, both as written and in operation, comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the same benefits classifications.

To strengthen compliance with that requirement, the CAA amended MHPAEA to require plans and issuers that provide both M/S benefits and MH/SUD benefits and that impose NQTLs

[112] While some of the efforts described in this section of the Report relate to materials that were published subsequent to the end of both the EBSA Reporting Period and the CMS Reporting Period (but prior to the publication of this report to Congress), discussion of the MHPAEA NPRM, Technical Release 2023-01P, and the 2024 Final Rules is included here in order to acknowledge the changes to the MHPAEA regulations made by the 2024 Final Rules and to ensure that interested parties are informed of these changes. The Departments expect that the 2024 Final Rules will positively impact access to MH/SUD benefits as compared to M/S benefits and MHPAEA compliance once they become applicable.

[113] 78 FR 68240 (Nov. 13, 2013).

on MH/SUD benefits to perform and document comparative analyses of the design and application of each NQTL imposed under a plan or coverage and to make these analyses available to the applicable Secretary or applicable State authorities upon request.[114] These analyses must include the following information:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs, and a description of all MH/SUD and M/S benefits to which each term applies in each benefit classification;[115]
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and M/S benefits;[116]
3. The evidentiary standards used to develop the identified factors, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD and M/S benefits;[117]
4. A demonstration that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to M/S benefits in the benefits classification;[118] and

[114] Code section 9812(a)(8)(A), ERISA section 712(a)(8)(A), and PHS Act section 2726(a)(8)(A).
[115] Code section 9812(a)(8)(A)(i), ERISA section 712(a)(8)(A)(i), and PHS Act section 2726(a)(8)(A)(i).
[116] Code section 9812(a)(8)(A)(ii), ERISA section 712(a)(8)(A)(ii), and PHS Act section 2726(a)(8)(A)(ii).
[117] Code section 9812(a)(8)(A)(iii), ERISA section 712(a)(8)(A)(iii), and PHS Act section 2726(a)(8)(A)(iii).
[118] Code section 9812(a)(8)(A)(iv), ERISA section 712(a)(8)(A)(iv), and PHS Act section 2726(a)(8)(A)(iv).

5. The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with MHPAEA's requirements.[119]

The CAA provides a mechanism for the Departments to request NQTL comparative analyses to examine whether the plans or issuers are in compliance with MHPAEA's NQTL requirements. Plans and issuers that the Departments determine are not in compliance must specify the corrective actions they will take to come into compliance and provide additional comparative analyses that demonstrate compliance not later than 45 days after the initial noncompliance determination.[120] Following the 45-day corrective action period, if the Departments make a final determination that the plan or issuer still is not in compliance, the plan or issuer must notify all enrolled individuals of the noncompliance finding no later than seven days after a final determination.[121] On April 2, 2021, the Departments issued *FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45* (FAQs Part 45) to provide guidance on the amendments to MHPAEA made by the CAA.[122]

B. MHPAEA NPRM

Under the Biden-Harris Administration, the Departments made an unprecedented commitment to advancing parity for MH/SUD benefits. The Departments have also engaged

[119] Code section 9812(a)(8)(A)(v), ERISA section 712(a)(8)(A)(v), and PHS Act section 2726(a)(8)(A)(v).
[120] Code section 9812(a)(8)(B)(iii)(I)(aa), ERISA section 712(a)(8) (B)(iii)(I)(aa), and PHS Act section 2726(a)(8) (B)(iii)(I)(aa).
[121] Code section 9812(a)(8)(B)(iii)(I)(bb), ERISA section 712(a)(8) (B)(iii)(I)(bb), and PHS Act section 2726(a)(8) (B)(iii)(I)(bb).
[122] *See* FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (Apr. 2, 2021), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

with interested parties to help increase awareness of MHPAEA's requirements and ensure that participants, beneficiaries, and enrollees benefit from them, as well as providing extensive guidance and compliance assistance materials to regulated entities.[123] However, the Departments' experiences, as underlined by DOL's September 23, 2022, listening session, have made clear that many years after the enactment of MHPAEA, participants, beneficiaries, and enrollees are not realizing the full benefit of the protections afforded by MHPAEA. Therefore, on August 3, 2023, the Departments issued the 2023 Proposed Rules.[124] The 2023 Proposed Rules focused on changes intended to prevent plans and issuers from designing and implementing NQTLs that impose greater limits on access to MH/SUD benefits than on M/S benefits, while adding needed clarity to the statutory requirements for the regulated community and other interested parties.

C. Technical Release 2023-01P

In addition to the 2023 Proposed Rules, DOL, in collaboration with HHS and Treasury, released Technical Release 2023-01P (Technical Release).[125] The Technical Release set forth principles regarding the relevant data that group health plans and health insurance issuers would be required to collect and evaluate for NQTLs related to network composition to demonstrate compliance with MHPAEA. The Technical Release also sought public comment to inform future guidance with respect to required data submissions for NQTLs related to network composition and a potential enforcement safe harbor. The Technical Release sought comment on the potential enforcement safe harbor, for a specified period of time, for plans and issuers that include data in their comparative analyses that demonstrate they meet or exceed all the standards with respect to

[123] *See* 88 FR 51552, 51555-56 (Aug. 3, 2023).
[124] *See* 88 FR 51552 (Aug. 3, 2023).
[125] DOL Technical Release 2023-01P (July 25, 2023), available at https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/guidance/technical-releases/23-01.pdf.

NQTLs related to network composition. While the Departments continue to consider the comments received in response to the Technical Release, the below discussion focuses on the 2024 Final Rules.[126]

D. 2024 Final Rules

The Departments received 9,503 comments on the 2023 Proposed Rules during the comment period.[127] These comments were submitted by a wide variety of interested parties, including private citizens; consumer and advocacy organizations; employers, employee organizations, and other plan sponsors; Federal, State, and local officials; health care providers and facilities and health systems; health insurance issuers; service providers, including managed behavioral health organizations, third party administrators (TPAs), and pharmacy benefit managers; trade and professional associations; and researchers. On September 23, 2024 (subsequent to the DOL and CMS Reporting Periods), after considering the comments received on the 2023 Proposed Rules, the Departments published the 2024 Final Rules.[128] The 2024 Final Rules aim to strengthen consumer protections consistent with MHPAEA's fundamental purpose—to ensure that individuals in group health plans (or with group or individual health insurance coverage) that cover MH/SUD benefits are not subject to more restrictive aggregate lifetime or annual dollar limits, financial requirements, or treatment limitations with respect to those benefits than the predominant dollar limits, financial requirements, or treatment limitations that are applied to substantially all M/S benefits covered by the plan (or coverage) in the same classification. In conjunction with the 2024 Final Rules, the Departments also developed a fact

[126] The preamble to the 2024 Final Rules notes that plans and issuers would be allowed adequate time to conform to any future guidance on the type, form, and manner of collection and evaluation for the relevant data required under the 2024 Final Rules. 89 FR 77586, 77589 n.40.
[127] The original comment period for the proposed rules was extended by 15 days to October 17, 2023.
[128] This section provides a brief, high-level summary of the 2024 Final Rules at 89 FR 77586 (Sept. 23, 2024).

sheet,[129] and resources for participants and beneficiaries, providers, and plans and issuers,[130] which highlight the protections found in the 2024 Final Rules.

1. Amendments to Existing MHPAEA Rules

The 2024 Final Rules add a purpose section to the MHPAEA regulations, which emphasizes that plans and issuers must not design or apply financial requirements and treatment limitations that impose a greater burden on access (that is, are more restrictive) to MH/SUD benefits under the plan than they impose on access to M/S benefits in the same classification of benefits, and note that MHPAEA and its implementing regulations should be interpreted in a manner consistent with the purpose section.

The 2024 Final Rules also revise and clarify several definitions in the 2013 final rules.[131] The 2024 Final Rules amend the definitions of the terms "medical/surgical benefits," "mental health benefits," and "substance use disorder benefits" by removing a reference to State guidelines.[132] Additionally, any condition, disorder, or procedure defined by the plan or coverage as being or as not being a mental health condition, SUD, medical condition, or surgical

[129] Available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/final-rules-under-the-mental-health-parity-and-addiction-equity-act-mhpaea.
[130] Available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/new-mhpaea-rules-what-they-mean-for-participants-and-beneficiaries, https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/new-mhpaea-rules-what-they-mean-for-providers, and https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/new-mhpaea-rules-what-they-mean-for-plans-and-issuers.
[131] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 FR 68240 (Nov. 13, 2013).
[132] The 2013 final rules generally provide that a plan's or coverage's definition of a condition as being (or not being) a medical/surgical condition, mental health condition, or substance use disorder must be consistent with generally recognized independent standards of current medical practice. The 2013 final rules further provide that generally recognized independent standards of current medical practice could include the most current version of the Diagnostic and Statistical Manual of Mental Disorders, the most current version of the International Classification of Diseases, or State guidelines. The 2024 Final Rules remove this reference to State guidelines. As the Departments noted in the preamble to the 2024 Final Rules, removing the reference to State guidelines minimizes situations where differences between generally recognized independent standards of current medical practice and State guidelines create conflicts and improperly limit protections under MHPAEA. *See* 89 FR 77586, 77591 (Sept. 23, 2024).

procedure must be defined consistent with generally recognized independent standards of current medical practice. For this purpose, a plan's or issuer's definition of mental health benefits or substance use disorder benefits must include all conditions or disorders that fall under the relevant categories or chapters of the most current version of the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders. If generally recognized independent standards of current medical practice do not address how to define a condition, disorder, or procedure, plans and issuers may define it in accordance with applicable Federal and State law.

The 2024 Final Rules also define several key terms used in the rules for NQTLs under MHPAEA. "Evidentiary standards" are generally defined to include any evidence, sources, or standards that a plan or issuer considered or relied upon in designing or applying a factor with respect to an NQTL. "Factors" are all information, including processes and strategies (but not evidentiary standards), that a plan or issuer considered or relied upon to design an NQTL or to determine whether or how the NQTL applies to benefits under the plan or coverage. The 2024 Final Rules also add specific definitions to make clear that "processes" are actions, steps, or procedures that a plan or issuer uses to *apply* an NQTL, whereas "strategies" are practices, methods, or internal metrics that a plan or issuer considers, reviews, or uses to *design* an NQTL.

The 2024 Final Rules strengthen the requirement under the 2013 final rules that, if a plan (or health insurance coverage) provides any benefits for a mental health condition or substance use disorder in any classification of benefits, it must provide benefits for that condition or disorder in every classification in which M/S benefits are provided. The "meaningful benefits" standard in the 2024 Final Rules aims to ensure that, when plans and issuers cover benefits for a range of services or treatments for M/S conditions in a classification, plans and issuers cannot

provide, for example, only one limited benefit for a covered mental health condition or substance use disorder in that classification. Therefore, if a plan or coverage provides any benefits for a mental health condition or substance use disorder in any benefits classification, the 2024 Final Rules state that it must provide meaningful benefits for that condition or disorder in every classification in which meaningful M/S benefits are provided. Whether the benefits provided are meaningful is determined in comparison to the benefits provided for M/S conditions in the same classification. Under the 2024 Final Rules, to be considered to provide meaningful benefits, a plan or issuer generally must cover a core treatment for a covered mental health condition or substance use disorder in each classification in which the plan or coverage provides benefits for a core treatment for one or more medical conditions or surgical procedures.

The 2024 Final Rules add a new general rule for NQTLs, which states that, consistent with the fundamental purpose of MHPAEA, a plan or coverage may not impose any NQTL with respect to MH/SUD benefits in any classification that is more restrictive, as written or in operation, than the predominant NQTL that applies to substantially all M/S benefits in the same classification. To demonstrate compliance with this general rule, a plan or issuer is required under the 2024 Final Rules to satisfy: (1) the design and application requirements and (2) the relevant data evaluation requirements, each of which is discussed in more detail below.

Under the design and application requirements, the 2024 Final Rules add to the existing NQTL compliance standard focused on the processes, strategies, evidentiary standards, and other factors used to design and apply NQTLs, to prohibit plans and issuers from relying on discriminatory factors and evidentiary standards to design NQTLs. For this purpose, a factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which it is based are biased or not objective in a manner that discriminates against MH/SUD

benefits as compared to M/S benefits. Whether information, evidence, sources, or standards are considered to be biased or not objective is based on all the relevant facts and circumstances and whether they systematically disfavor or are specifically designed to disfavor access to MH/SUD benefits as compared to M/S benefits. Under the 2024 Final Rules, plans and issuers may take the steps necessary to correct, cure, or supplement information, evidence, sources, or standards that are biased or not objective. Additionally, generally recognized independent professional medical or clinical standards and carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH/SUD benefits are not biased and are objective.

Additionally, the relevant data evaluation requirements of the 2024 Final Rules require the collection and evaluation of outcomes data in order to ensure that, in operation, any NQTL applicable to MH/SUD benefits in a classification is no more restrictive than the predominant NQTL applied to substantially all M/S benefits in the same classification (the "relevant data evaluation requirements"). To do so, plans and issuers must collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on relevant outcomes related to access to MH/SUD benefits and M/S benefits, and carefully consider the impact. For NQTLs related to network composition standards, a plan or issuer must collect and evaluate relevant data in a manner reasonably designed to assess the NQTLs' aggregate impact on relevant outcomes related to access to MH/SUD benefits and M/S benefits.

As the relevant data for any given NQTL depend on the facts and circumstances, the 2024 Final Rules provide both flexibility for plans and issuers to determine what data should be collected and evaluated, and guidance for when data are either temporarily unavailable for a newly imposed NQTL or when no data exist to reasonably assess any relevant impact on access.

However, the Departments or applicable State authorities may also request other data in addition to what a plan or issuer determines to be relevant data for any particular NQTL included in its comparative analyses. The 2024 Final Rules also list examples of relevant data for all NQTLs and additional relevant data for NQTLs related to network composition standards.

To the extent the evaluated relevant data suggest that the NQTL contributes to material differences in access to MH/SUD benefits as compared to M/S benefits, that is considered a strong indicator of a MHPAEA violation. Differences in access are material if, based on all relevant facts and circumstances, the difference in the data suggest that the NQTL is likely to have a negative impact on access to MH/SUD benefits as compared to M/S benefits. Where the relevant data suggest that the NQTL contributes to material differences in access to MH/SUD benefits, plans and issuers must take reasonable action, as necessary, to address the material differences to ensure compliance, in operation, with MHPAEA. The 2024 Final Rules provide examples of actions plans and issuers can take to address material differences in access as a result of the application of NQTLs related to network composition. Differences in access to MH/SUD benefits are not treated as material if they are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect, prevent, or prove fraud and abuse.

Finally, building on the provisions of the CAA that require the Departments to specify the steps a plan or issuer must take to be in compliance with MHPAEA after a final determination of noncompliance, the 2024 Final Rules specify that, if a plan or issuer receives a final determination that any NQTL is not in compliance with the comparative analysis requirements, including because the plan or issuer has not submitted a sufficient comparative analysis to demonstrate compliance, the relevant Department may direct the plan or issuer to not

impose the NQTL with respect to MH/SUD benefits unless and until the plan or issuer demonstrates compliance or takes appropriate action to remedy the violation.

2. New Regulations on Comparative Analysis Requirements

The 2024 Final Rules also include new regulations that set forth the content requirements of the NQTL comparative analyses required under MHPAEA, as amended by the CAA.[133] Plans and issuers that cover both M/S benefits and MH/SUD benefits and impose NQTLs on MH/SUD benefits must perform and document a comparative analysis of the design and application of each applicable NQTL. The 2024 Final Rules require the comparative analysis to contain, at a minimum, six content elements:

1. a description of the NQTL, including identification of benefits subject to the NQTL;
2. identification and definition of the factors and evidentiary standards used to design or apply the NQTL;
3. a description of how factors are used in the design or application of the NQTL;
4. a demonstration of comparability and stringency, as written;
5. a demonstration of comparability and stringency, in operation, including the required data, evaluation of that data, explanation of any material differences in access, and description of reasonable actions taken to address such differences; and
6. findings and conclusions.

ERISA-covered group health plans must also include in their comparative analyses a certification by one or more named fiduciaries that they have engaged in a prudent process to select one or more qualified service providers to perform and document a comparative analysis in connection with the imposition of any NQTLs that apply to MH/SUD benefits under the plan in accordance

[133] 26 CFR 54.9812-2, 29 CFR 2590.712-1, and 45 CFR 146.137.

with applicable law and regulations, and have satisfied their duty to monitor those service providers as required under Part 4 of ERISA.

This new regulatory provision finalized in the 2024 Final Rules also sets forth the steps the Departments will follow to request and review a plan's or issuer's comparative analysis of an NQTL. After an initial request for a comparative analysis, the plan or issuer must submit it to the relevant Secretary within 10 business days (or an additional period of time specified by the relevant Secretary). If the Secretary determines the comparative analysis is insufficient, the Secretary will specify the additional information necessary, which must be provided by the plan or issuer within 10 business days (or an additional period of time specified by the relevant Secretary). If the Secretary makes an initial determination of noncompliance, the plan or issuer has 45 calendar days to specify the actions it will take to comply and provide additional comparative analyses.

The 2024 Final Rules also implement the CAA's added requirement to MHPAEA to notify participants and beneficiaries of any final determination of noncompliance. If the Secretary makes a final determination of noncompliance, the plan or issuer must notify all participants, beneficiaries, and enrollees enrolled in the plan or coverage not later than 7 business days after the Secretary's determination. The 2024 Final Rules set forth specific content for this notice and require that a copy of the notice be provided to the Secretary and relevant service providers and fiduciaries. Additionally, plans and issuers must make a copy of the comparative analysis available when requested by any applicable State authority, a participant, beneficiary, or enrollee who has received an adverse benefit determination related to MH/SUD benefits, and participants and beneficiaries in ERISA plans at any time.

3. **Sunset of MHPAEA Opt-out**

In the 2024 Final Rules, HHS finalized regulatory amendments to implement the sunset provision for self-funded non-Federal governmental plan elections to opt out of compliance with MHPAEA, as adopted in the Consolidated Appropriations Act, 2023.

4. Applicability Dates

For group health plans and health insurance issuers offering group health insurance coverage, the 2024 Final Rules generally apply starting with the first plan year beginning on or after January 1, 2025; except the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the provisions requiring the comparative analysis to demonstrate comparability and stringency in operation (with respect to those relevant data evaluation requirements), which apply starting with the first plan year beginning on or after January 1, 2026. For health insurance issuers offering individual health insurance coverage, the 2024 Final Rules apply for policy years beginning on or after January 1, 2026.

E. Future Guidance

The Departments intend to issue additional guidance in the future to provide more information on MHPAEA's requirements. For example, the Departments intend to issue future guidance on the type, form and manner of collection and evaluation for the data required and the lists of examples of data that are relevant across the majority of NQTLs, as well as additional relevant data for NQTLs related to network composition. DOL also intends to update the MHPAEA Self-Compliance Tool to provide a robust framework and roadmap for plans and issuers to determine which data to collect and evaluate, and to assist plans and issuers as they work to comply with the 2024 Final Rules.

Additionally, the Departments intend to make available a sample comparative analysis that uses written explanation with supporting documents to demonstrate how a plan applied factors and standards in the design of an NQTL, consistent with the requirements of the 2024 Final Rules. The sample comparative analysis will evaluate multiple aspects of how the NQTL is designed and applied in order to examine whether, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to M/S benefits, and therefore are not more restrictive with respect to MH/SUD benefits as compared to M/S benefits.

V. Conclusion

EBSA continues to make MH/SUD parity a top priority, as reflected in EBSA's enforcement actions, outreach, regulations and guidance. Over the next two years, EBSA expects to continue its enforcement efforts, including its focus on network composition. EBSA also will continue to raise awareness of the agency and its mission, as well as the protections of MHPAEA.

However, EBSA faces serious challenges in its role in enforcing mental health parity. The agency oversees roughly 2.6 million private-sector health,[134] 801,000 retirement,[135] and 514,000 welfare benefit plans[136] covering 156 million workers and retirees.[137] Budget constraints

[134] DOL, EBSA calculations using the 2023 Medical Expenditure Panel Survey, Insurance Component (MEPS-IC), Form 5500 filings, and the 2021 Census Bureau County Business Patterns.
[135] DOL, EBSA. Private Pension Plan Bulletin: Abstract of 2022 Form 5500 Annual Reports.
[136] DOL, EBSA calculations using non-health welfare plan Form 5500 filings and projecting non-filers using estimates based on the non-filing health universe.
[137] DOL, EBSA calculations using the Auxiliary Data for the March 2022 Census Bureau Annual Social and Economic Supplement of the Current Population Survey.

have left the agency with an enforcement capacity of roughly one investigator for every 13,900 plans it regulates at current staffing levels. As highlighted by the Government Accountability Office (GAO), over the 2013 to 2021 period, EBSA's annual appropriations have declined when accounting for inflation.[138] This has happened despite EBSA's increased role in overseeing health plans and implementing new protections in the CAA. EBSA also has experienced a decline in staffing over this period, that has only been partially reversed due to supplemental funding for CAA implementation. EBSA relies on this temporary supplemental funding from the CAA to expand its MHPAEA enforcement program. This funding was set to expire at the end of calendar year 2024. While the date by which the funding could be used was subsequently extended to September 30, 2025, the amount of funding was not increased, such that the extension solely gave the Departments additional time to use any amounts remaining in the fund, and did not provide any additional funding. Nevertheless, the amount remaining in the fund is insufficient and its full depletion will likely have catastrophic effects on EBSA's ability to aggressively enforce MHPAEA's NQTL provisions. If the supplemental funding is not fully replenished or permanent resources otherwise appropriated, EBSA ultimately will be forced to manage with 120 fewer full-time employees and will be unable to sustain the current volume and pace of MHPAEA enforcement activity. DOL's Solicitor's Office will separately be forced to manage with 30 fewer full-time employees, which means losing lawyers who can help develop cases and ultimately bring lawsuits when needed. The Solicitor's Office will no longer be able to provide the same level of support towards covered enforcement efforts under MHPAEA. Existing NQTL investigations will move much more slowly to resolution, and EBSA will not be able to engage in such protracted efforts to allow plans and issuers time to correct violations and

[138] Employee Benefits Security Administration: Systematic Process Needed to Better Manage Priorities and Increased Responsibilities, pg. 4, available at https://www.gao.gov/products/gao-24-105667.

deficiencies prior to issuing a final determination of noncompliance. EBSA will have fewer staff available to answer questions from the public and to pursue voluntary correction for individuals who are inappropriately denied MH/SUD benefits, and will be less able to respond to new leads regarding potential NQTL violations. Because EBSA is committed to prioritizing MHPAEA enforcement, the end of supplemental funding also will negatively impact EBSA's ability to enforce other parts of ERISA that apply to welfare and pension plans. Despite these challenges, EBSA will continue to advocate for participants and beneficiaries, and for mental health parity, to the best of its ability and to the limit of its resources.

Another persistent challenge EBSA faces is the mismatch between the parties who commonly drive NQTL violations and EBSA's authority to pursue them directly for NQTL violations. Plan sponsors often rely on service providers to administer their plan's MH/SUD benefits and design and implement any NQTLs in a manner that is compliant with MHPAEA. Certain NQTLs, including those related to network adequacy and network composition, are typically driven by processes and decisions made at the service provider level. Service providers are usually well-situated to efficiently address concerns across many plans at once. EBSA has leveraged its existing enforcement tools to achieve some success when addressing concerns at the service provider level, but EBSA could have an even greater impact if it had full authority to pursue service providers directly.

In light of these challenges, EBSA renews its legislative recommendations outlined in the January 2022 Report. EBSA also notes the critical importance of the President's Budget Request for fiscal year 2025 (Budget), which would require all health plans to cover MH/SUD benefits; ensure that plans have an adequate network of behavioral health providers; and improve DOL's

ability to enforce the law.[139] Additionally, the Budget would include $275 million over 10 years to increase DOL's capacity to ensure that large group market health plans and issuers comply with MH/SUD requirements, and to take action against plans and issuers that do not comply.[140]

The Departments are firmly committed to facilitating parity in access to MH/SUD benefits as compared to M/S benefits. This report outlines how the Departments continue to rigorously enforce MHPAEA, engage with interested parties, and provide additional guidance and regulations to improve compliance with MHPAEA and parity in access to MH/SUD benefits as compared to M/S benefits. The Departments are hopeful that, as a result of these efforts, individuals will receive the benefits of parity protections intended under the law. The Departments look forward to working with interested parties, other regulators, and Congress to achieve the shared goal of ensuring meaningful MH/SUD parity for individuals. The Departments continue to prioritize enforcement of MHPAEA and following the issuance of this report, intend to publish a report on their enforcement efforts related to NQTL comparative analyses for the subsequent reporting period in the near future.

[139] Budget of the U.S. Government, Fiscal Year, 2025, available at https://www.whitehouse.gov/wp-content/uploads/2024/03/budget_fy2025.pdf.
[140] *Id.*

Appendix A – Sample Settlement Agreement

The following is a settlement agreement between EBSA and a group health plan to address MHPAEA violations related to an NQTL relating to network composition and network adequacy. The terms of this settlement agreement address the specific violation and facts of this case. Other plans and issuers should take note of the types of activities this plan is undertaking to monitor and address disparities in access to providers.

SETTLEMENT AGREEMENT AND RELEASE

THIS AGREEMENT AND RELEASE (the "Agreement") is made and entered into by and between the United States Department of Labor, Employee Benefits Security Administration ("EBSA") and the Boilermakers National Health & Welfare Fund (the "Fund"). EBSA and the Fund are referred to collectively as the "Parties." The Agreement is effective as of the date it is signed by the last Party to execute the Agreement (the "Effective Date").

WHEREAS, the Fund is an ERISA-covered Taft-Hartley multiemployer health plan that provides benefits for members of the International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmiths, Forgers, and Helpers, and their families;

WHEREAS, on August 4, 2021, EBSA requested a comparative analysis and supporting documentation (the "Comparative Analysis") regarding the Fund's application of the following non-quantitative treatment limitation: "standards for provider admission to participate in a network, including reimbursement rates, for in-network inpatient and in-network outpatient services" (the "NQTL") pursuant to section 712(a)(8)(B) of ERISA, 29 U.S.C. § 1185(a)(8)(B);

WHEREAS, the Fund produced a Comparative Analysis and supporting documentation in response to EBSA's request;

WHEREAS, the Fund, as of the Effective Date of this Agreement, contracts with Cigna Health and Life Insurance Company ("Cigna") to provide in-network healthcare services to its participants and beneficiaries;

WHEREAS, EBSA issued an Initial Determination Letter (the "IDL") on January 24, 2023, determining that the Fund failed to comply with ERISA § 712(a)(3), 29 U.S.C. § 1185(a)(3), with respect to the NQTL, because (1) the Fund, through Cigna, uses different, non-comparable processes and evidentiary standards to evaluate the adequacy of its medical/surgical ("M/S") and

mental health/substance use disorder ("MH/SUD") networks; (2) the Fund, through Cigna, does not respond comparably to identified deficiencies in its M/S and MH/SUD Networks; and (3) the Fund's own practices for addressing deficiencies in its Network are not applied comparably to M/S and MH/SUD benefits. EBSA also found that the Fund failed to produce a statutorily sufficient Comparative Analysis, in violation of ERISA § 712(a)(8)(A), 29 U.S.C. § 1185(a)(8)(A) (collectively, the "IDL Violations");

WHEREAS, the Fund neither admits nor denies the IDL Violations, has responded to EBSA in a letter dated March 10, 2023, and has agreed to resolve the alleged IDL Violations, as described in this Agreement;

WHEREAS, EBSA is concerned about the adequacy of Cigna's MH/SUD Network and the Fund's disparate rate of out-of-network ("OON") utilization for MH/SUD services as compared to M/S services;

WHEREAS, the Parties have engaged in good-faith negotiations, including the submission of proposed Corrective Action Plans;

WHEREAS, the Fund is committed to ensuring that its plan participants and beneficiaries have comparable access to in-network MH/SUD benefits as they have to in-network M/S benefits, and is committed to working with its Network Administrator towards making its MH/SUD Networks as robust and accessible as its M/S Networks;

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, it is agreed as follows:

I. Definitions. The following definitions apply to the terms of this Agreement:

A. **"Collaborative Care Model" ("CoCM")** means an integrated approach that involves the collaboration between patients and primary care physicians within physician groups that

include care for mental health conditions and substance use disorders, particularly including the addition of two key services to the "usual" primary care: (1) care management support for patients receiving behavioral treatment; and (2) regular psychiatric inter-specialty consultation to the primary care team, especially for patients whose conditions are not improving;

B. **"Monitoring Period"** means an 18-month period of time starting on the Effective Date of this Agreement;

C. **"Network"** means the facilities, providers, and suppliers contracted to provide healthcare services;

D. **"Network Administrator"** means an entity which has established a Network and which offers that Network to health plans for a fee;

E. **"Network Gap"** refers to a deficiency of in-network provider(s), facilities, or suppliers within the MH/SUD Network as compared to the M/S Network;

F. **"Preferred Facility"** is defined in Paragraph 107 of Article 28 of the 2023 Boilermakers Summary Plan Description;

G. **"Request for Information" ("RFI")** means the process outlined on page 8 of the Fund's updated Corrective Action Plan, dated June 16, 2023; and

H. **"Substance Abuse Treatment Program"** means the program described in Section 4.17 of the 2023 Boilermakers Summary Plan Description.

II. The Fund agrees to complete the following actions (the "Negotiated Corrections"):

A. **Measurement and Improvement of the Network Administrator's Network**

1. Within 90 days of the Effective Date, the Fund will:

a. Define "High-Volume Specialists" as the top five categories of M/S specialists and the top five categories of MH/SUD specialists (as measured by claims

volume) used by the Fund's participants and beneficiaries;

b. Define "High Impact Specialists" by using the Fund's claims and cost data to identify the top five M/S and the top five MH/SUD specialists treating conditions that either have a high mortality/morbidity rate or require significant resources (i.e., cost of treatment exceeds $10,000);

c. The Fund will use the definitions of "High-Volume Specialists" and "High-Impact Specialists" in evaluating the Network Administrator's Network adequacy standards applied to M/S and MH/SUD specialists.

d. Provide EBSA with documentation of the Fund's evaluation noted in 1.c above.

e. Provide EBSA with documentation to demonstrate the changes noted in 1.a and 1.b above.

2. On a quarterly basis during the Monitoring Period, the Fund will evaluate the comparative adequacy of its Network Administrator's Network as applied to M/S and MH/SUD providers generally, as well as the adequacy of the Network with respect to "High-Volume Specialists" and "High Impact Specialists" in particular. The Fund will identify any Network Gaps, and will work with its Network Administrator to take affirmative, documented steps that are reasonably designed to close the gaps within the Monitoring Period.

3. The Fund will perform six quarterly reviews of its Network Administrator's Network during the Monitoring Period. In each quarterly review, the Fund will collect and evaluate the following data and measurements, in addition to any other information the Fund elects to consider, to identify Network Gaps:

a. *Out-of-Network Utilization*: These measurements require the collection and completion of the data elements and calculations set forth in Attachment A,

Table 1. The data used in this measurement should be based on the claims incurred date, breaking the data out by year and by category, for the previous two years prior to each quarterly review.

i. The Fund will also request and review, on a quarterly basis, reports from the Fund's Network Administrator addressing Network Gaps. For example, it will request and review Cigna's "Gaps in Care" and Medical Snapshot Report ID 068. If the Fund's Network Administrator fails to timely provide the requested information to the Fund, the Fund will immediately notify EBSA of the Network Administrator's failure, so that EBSA can take appropriate action to protect the interests of Fund participants and beneficiaries.

ii. The Fund will also request from its Network Administrator and review, on a quarterly basis, a list of all provider specialties and sub-specialties for which participants and beneficiaries submitted claims for OON MH/SUD services. If the Fund's Network Administrator fails to timely provide the requested information to the Fund, the Fund will immediately notify EBSA of the Network Administrator's failure, so that EBSA may take appropriate action to protect the interests of the Fund's participants and beneficiaries.

b. *Network Providers Actively Submitting Claims:* These measurements require the collection and completion of the data elements and calculations specified in Attachment A, Table 2, for the six months prior to each quarterly review. Providers not actively submitting claims will be removed from the data provided. These measurements may be based on the Network Administrator's

book of business, as opposed to the Fund-specific data, provided that the Network Administrator uses the same Network for the Fund as for other benefit plans or group policies, and the Fund has no reason to believe that data based on the Network Administrator's book of business is unrepresentative of the Fund's experience.

c. *Wait Times for New and Existing Patients:* These measurements require the collection and completion of the data elements and calculations set forth in Attachment A, Table 3. These measurements may be based on the Network Administrator's book of business, as opposed to the Fund-specific data, provided that the Network Administrator uses the same network for the Fund as for other benefit plans or group policies, and the Fund has no reason to believe that data based on the Network Administrator's book of business is unrepresentative of the Fund's experience.

d. *Time and Distance Measurements:* These measurements require the collection and completion of the data elements and calculations set forth in Attachment A, Table 4. The Fund will request that the Network Administrator identify the actual number of providers that are counted in the standard measured, not just whether the standard was met or the percentage meeting the standard. The standards will not be treated as meeting the requirements of this Agreement if they contemplate greater times or distances for MH/SUD claimants than for M/S claimants. These measurements may be based on the Network Administrator's book of business, as opposed to the Fund-specific data, provided that the Network Administrator uses the same network for the Fund as for other benefit plans or group policies, and the Fund has no reason to believe that data based

on the Network Administrator's book of business is unrepresentative of the Fund's experience. If the Fund's Network Administrator fails to timely provide the requested information to the Fund, the Fund will immediately notify EBSA of the Network Administrator's failure, so that it can take appropriate action to protect the interests of the Fund's participants and beneficiaries.

e. *Provider-To-Member Ratios:* These measurements require the collection and completion of the data elements and calculations set forth in Attachment A, Table 5. The Fund will request that the Network Administrator identify the actual number of providers that are counted in the standard measured, not just whether the standard was met or the percentage meeting the standard. If the Fund's Network Administrator fails to timely provide the requested information to the Fund, the Fund will immediately notify EBSA of the Network Administrator's failure, so that EBSA can take appropriate action to protect the interests of the Fund's participants and beneficiaries. If unable to obtain this data from the Network Administrator regarding the Network Administrator's book of business, the Fund will collect and utilize the Fund's data to the best of its ability (i.e., relying on all claims data and reporting capabilities available to the Fund) as related to the Fund's Network.

f. *Retention and Loss of Network Providers:* These measurements require the collection and completion of the data elements and calculations set forth in Attachment A, Table 6, for the two years preceding each quarterly review. These measurements may be based on the Network Administrator's book of business, as opposed to the Fund-specific data, provided that the Network Administrator uses the same network for the Fund as for other benefit plans or

group policies, and the Fund has no reason to believe that data based on the Network Administrator's book of business is unrepresentative of the Fund's experience.

g. *Telehealth:* The Fund will perform quarterly monitoring of the following aspects of telehealth utilization during the Monitoring Period:

   i. average wait times for appointments,

   ii. gaps in telehealth Network, and

   iii. member complaints.

4. For each of the six quarterly reviews conducted during the Monitoring Period, the Fund will provide the following documentation to EBSA within 90 days after the end of the quarter (with the final quarterly submission due 90 days after the end of the Monitoring Period):

   a. Data specified in Attachment A, Tables 1-6, in Excel format;

   b. Explanation of methodologies used to identify inputs into Attachment A, Tables 1-6;

   c. Summary of any analysis of the data;

   d. Identification of any Network Gaps and explanation of how they were identified;

   e. Any action plans prepared in response to the Network Gaps identified, and the basis for concluding that the action plans will close the Network Gaps within the Monitoring Period; and

   f. If requested by EBSA, underlying data and supporting documentation used to derive the data specified in Attachment A, Tables 1-6.

5. After completion of the Monitoring Period, the Fund will continue to monitor the

adequacy of its Network Administrator's Network at least annually thereafter. Until such time as specific statutory or regulatory requirements for measuring provider networks supersede the requirements set forth herein, the Fund will continue to use the measurements specified in II.A.3 above, but will not be required to automatically report to EBSA on a quarterly basis as required during the Monitoring Period.

6. For any Network Gap identified during the Monitoring Period and in any of its own subsequent annual reviews of the adequacy of its Network:
    a. The Fund will take affirmative steps that are reasonably designed to close the Network Gaps within the Monitoring Period.
    b. The Fund will define and document all steps taken to close identified Network Gaps, including Network Gaps identified by the Fund or identified by the Network Administrator.
    c. The Fund will measure progress toward closing Network Gaps using the same data-based measures it used to identify the Network Gaps.
    d. The Fund or its Network Administrator will review MH/SUD OON claims to identify providers for recruitment to join the Network.
    e. The Fund or its Network Administrator will engage efforts to recruit new MH/SUD providers to the Network.
    f. The Fund or its Network Administrator will document these recruitment efforts and their outcome. This documentation will include sufficient detail to identify whether and when either of the following considerations resulted in the failure of new providers to join the Network:
        i. Insufficient reimbursement rates; or
        ii. Administrative burdens.

g. The Fund will request information from the Network Administrator regarding its efforts to contract with new MH/SUD providers. The Fund will request from the Network Administrator copies of the corresponding executed contracts with new MH/SUD providers that resulted from efforts to expand the Network based on identified gaps. If the Fund's Network Administrator fails to timely provide the requested information to the Fund, the Fund will immediately notify EBSA of the Network Administrator's failure, and nothing in this Agreement shall prevent EBSA from taking appropriate action to protect the Plan's participants and beneficiaries. If the Fund determines it is reasonable and appropriate to pursue direct contracting, the Fund will provide copies of its efforts and agreements to EBSA during the Monitoring Period.

7. The Fund will provide to EBSA, within 90 days after the end of each quarter during the Monitoring Period, documentation of the following in connection with its efforts to close any identified Network Gap:
    a. Documentation noted in 6.b. above;
    b. Documentation noted in 6.f. above;
    c. Any new or amended contracts between the Fund and the Network Administrator as it relates to efforts to close Network Gaps;
    d. Any policies or procedures the Fund implements related to its Network Administrator's Network adequacy or the measurement thereof;

B. **Request for Information**

1. At least once during the Monitoring Period, the Fund will send an RFI to other Network Administrators to evaluate the adequacy of its Network as compared to Networks

offered by competing Network Administrators. The RFI will include data requests sufficient to evaluate parity with respect to MH/SUD and M/S providers.

2. For any RFI comparing the adequacy of the Network Administrator's Network that occurs during the Monitoring Period, the Fund will provide EBSA documentation of the RFI analysis within 90 days after completion of the analysis, but in no event later than 90 days after the end of the Monitoring Period.

C. **Supplemental Network for the Fund**

1. The Fund or Network Administrator will review and identify additional facilities that are candidates for the Network Administrator to contract with as Preferred Facilities for participation in the Substance Abuse Treatment Program.
2. The Fund will review and consider implementation of a Preferred Facilities program for the treatment of acute mental illnesses.
3. The Fund will ensure that any Substance Abuse Treatment Program hotlines offered to the Fund's participants and beneficiaries are directing individuals with mental health conditions to available resources.
4. Within 90 days after the end of each quarter during the Monitoring Period, the Fund will provide EBSA with documentation of its review, identification, and recommendations performed pursuant to Section II.C. of this Agreement. This will include meeting minutes and any other documentation used in the decision-making process.

D. **Collaborative Care Model Providers**

1. The Fund will provide directions on its website for participants and beneficiaries to locate CoCM providers through the Network Administrator. The directions shall be written and presented in a culturally and linguistically appropriate manner calculated

to be understood by the average participant, beneficiary, or enrollee.

2. The Fund will confirm with the Network Administrator that there is only one provider directory available for the Fund's participants and beneficiaries. If a secondary provider directory exists, the Fund will request all directories be modified to identify CoCM providers, as needed.
3. The Fund will modify the Summary Plan Description ("SPD") to define CoCM providers[1], identify the types of practitioners that may participate in a collaborative care program, and explain how to locate CoCM providers. The SPD shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.
4. The Fund will request that the Network Administrator update its customer service scripts to describe the available CoCM benefits for the Plan participants and beneficiaries. The Fund will inform the Network Administrator that scripts shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.
5. Within 90 days of the Effective Date, the Fund will send a letter to all Plan participants and beneficiaries with 2021, 2022, and 2023 claims associated with a CoCM provider or facility and provide them with information regarding CoCM. The letter shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.

[1] Effective January 1, 2024, the SPD was amended to include the following definition of Collaborative Care: Collaborative care is a team-based, comprehensive model of patient treatment. It brings together numerous physicians and caregivers to consider a patient as a whole person, rather than just as a body or disease. This model aims to improve patient outcomes through inter-professional cooperation. It combines general and behavioral medical practices and involves various health practitioners, including primary care physicians, mental health practitioners, and other specialists. Collaborative care provides holistic care by delivering both medical and mental health care in primary care settings. When you visit a Provider who participates in the Collaborative Care Program, the Provider can refer you to a primary care physician, mental health practitioner, or other specialist to collaboratively address your health care needs.

6. Within 90 days of the Effective Date, the Fund will provide EBSA with the following documentation:
    a. A screenshot of the current Fund website confirming that it includes directions to locate CoCM providers through the Network Administrator.
    b. Written confirmation that there is only one provider directory available to the Fund's participants and beneficiaries or, alternatively, that the Fund has requested that all relevant directories be modified to identify CoCM providers.
    c. Documentation of the Fund's request that the Network Administrator update its customer service scripts as required in Section II.D. of this Agreement.
    d. An example of the letter sent to participants and beneficiaries as required in Section II.D. of this Agreement and an attestation under penalty of perjury that to the best of the Fund's knowledge, based upon the Fund's data, the letter was mailed to all Plan participants and beneficiaries with 2021, 2022, and 2023 claims associated with a CoCM provider or facility.
7. Within 90 days of the Effective Date, the Fund will provide EBSA with an amendment to the SPD as required in Section II.D. of this Agreement.

E. **Expansion of Summary Plan Description Section Titled "When Out-of-Network Services are Payable at the In-Network Level"[2]**

1. If a Network Gap is identified, the Fund will amend the SPD Section titled "When Out-of-Network Services are Payable at the In-Network Level" to cover MH/SUD services as if they were in-network, in geographic areas where the Fund's MH/SUD Network does not meet the Fund's Network adequacy standards. Upon identification of such

[2] In 2018, this was Section 4.4. In the 2023 SPD, this is Section 3.4.

geographic areas, the Fund will change the SPD to allow for, and set clear parameters regarding when OON services will be treated as in-network services (for purposes of coverage and cost-sharing). The SPD shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.

2. The Fund acknowledges that it is aware of and will continue to comply with the Consolidated Appropriations Act's provisions regarding continuity of care plans.
3. The Fund will add phone numbers for participants and beneficiaries to call and obtain additional information regarding when OON services are payable at the in-network level to the Fund's website. Additionally, the Fund has requested and will review any customer service scripts from its Network Administrator regarding this section of the SPD. The Fund will inform the Network Administrator that the scripts shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.
4. If an amendment is required, as set forth in Section II.E.1 above, the Fund will provide a copy of the amendment to EBSA.
5. Within 90 days of the Effective Date, the Fund will provide documentation that the Fund's website has been updated with the phone number for beneficiaries to call as required in Section II.E. of this Agreement.

F. **Expansion of Telehealth**

1. The Fund will review and identify additional MH/SUD telehealth providers to ensure access to MH/SUD telehealth providers is comparable to and no more restrictive than access to M/S telehealth providers, and the Fund will amend the SPD to reflect the changes to the MH/SUD telehealth coverage as needed. The SPD shall be written and

presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.

2. The Fund will contact Cigna to determine whether the Network Administrator's provider or facility contracts require patient contact after an inpatient stay.
3. The Fund will ensure that a participant's or beneficiary's search for a telehealth provider only produces results for providers licensed in the state where the patient is located unless the participant or beneficiary specifically seeks providers located in another state. The Fund will also ensure that if a participant seeks to search for providers located in another state, that the search capabilities are able to produce those results.
4. The Fund will, within the annual telehealth mailer, define or explain Plan telehealth benefits available relating to eligible provider types, face-to-face visits, and audio-only visits as appropriate, and the reimbursement of the same. The annual telehealth mailer shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.
5. Within 90 days of the Effective Date, the Fund will provide EBSA with the following:
    a. Documentation of review, recommendations, and decisions made regarding the addition of MH/SUD telehealth providers to its Network.
    b. Documentation confirming that searches for telehealth providers only produce results for providers licensed in the state where the patient is located, and that participants and beneficiaries also have the ability to search for providers in other states.
6. During the Monitoring Period, within 90 days of the end of the quarter in which the Fund sends its annual telehealth mailer, the Fund will provide EBSA with a copy of the

mailer and an attestation under penalty of perjury that the mailer was sent to all Fund participants and beneficiaries.

G. **Additional Assistance for Participants and Beneficiaries Seeking Mental Health or Substance Use Disorder Treatment**

1. The Fund will send a mailing to all Plan participants and beneficiaries identified during the OON utilization review, as outlined in item A.3.a, with inpatient and outpatient OON MH/SUD claims to remind them about the benefits of using in-network providers, give them the Network Administrator's telephone number to use for participant assistance in finding a provider, and further explain the benefits of the CoCM. The mailing shall be written and presented in a culturally and linguistically appropriate manner calculated to be understood by the average participant, beneficiary, or enrollee.
2. Within 90 days of the Effective Date, the Fund will provide EBSA with a copy of the mailing sent to participants and beneficiaries as required under Section II.G. of this Agreement and an attestation under penalty of perjury that to the best of the Fund's knowledge, based upon the Fund's data, the mailer was sent to all Plan participants and beneficiaries.

III. **Release**

A. By EBSA. Except as necessary to enforce the rights and obligations in this Agreement, EBSA and its agents, attorneys, representatives, assigns, predecessors and successors-in-interest, acting in their official capacities, do hereby release, waive, and forever discharge any and all claims, demands, actions, causes of action, liabilities, penalties, and fines that they have against the Fund relating to the alleged IDL Violations, between August 4, 2021 and the Effective Date (the "Released Claims"). EBSA shall not institute or maintain

any investigation relating to the Released Claims, nor shall it refer any issue relating to the Released Claims for litigation. Nothing herein shall preclude any action to enforce the terms of this Agreement.

B. By the Fund. Except as necessary to enforce the rights and obligations in this Agreement, the Fund hereby releases, waives, and forever discharges any and all claims, demands, causes of action, liabilities, penalties, and fines, including those claims arising under the Equal Access to Justice Act or any other statute, rule, or regulation, that the Fund may have against EBSA and its agents, attorneys, representatives, assigns, predecessors and successors-in-interest ("EBSA Releasees") that related in any manner to the investigation of the NQTL by EBSA or the settlement that is the subject of this Agreement between August 4, 2021 and the Effective Date. The Fund agrees not to institute, maintain, or prosecute any action or legal proceeding against the EBSA Releasees relating to the investigation of the NQTL, or the settlement that is the subject of this Agreement. Nothing herein shall preclude any action to enforce the terms of this Agreement.

IV. Other Provisions

A. Headings. The headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

B. Scope. This Agreement is limited to the NQTL defined in this Agreement and addressed by the Negotiated Corrections, described herein. This Agreement does not affect, in any manner, or for any purpose, EBSA's claims with respect to any other issues, nor shall it affect the relief EBSA may obtain in relation to those issues and is not binding on any governmental agency other than EBSA.

C. Entire Agreement. This Agreement constitutes the entire agreement between the Parties

and supersedes any prior agreement or understanding, whether oral or in writing, regarding the subject of the Agreement. This Agreement may not be amended or modified except by a writing signed by all Parties.

D. Waiver. No relaxation, forbearance, delay, or indulgence by a Party in enforcing its rights hereunder or the granting of time by such Party will prejudice or affect its rights hereunder. A provision of this Agreement may be waived only by an instrument in writing executed by the waiving Party and specifically waiving such provision. The waiver of any provision of this Agreement by any Party shall not be deemed to be construed as a continuing waiver or a waiver of any other provision of this Agreement.

E. Authority. The undersigned representatives each expressly acknowledge and represent that they are authorized and empowered to execute this Agreement on behalf of the Parties represented.

F. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. An executed copy of this Agreement delivered by facsimile and/or email shall be deemed to be as effective as an original signed copy.

G. Notices. Any notice required or permitted to be given pursuant to this Agreement shall be sent to the following person/address:

If to EBSA:

Kansas City Regional Office
Mark F. Underwood, Regional Director
c/o [redacted], Investigator
2300 Main Street, Suite 11093
Kansas City, MO 64108-2415
Phone: [redacted]
Email: [redacted]@dol.gov

If to the Fund:

Boilermakers National Health & Welfare Fund
c/o [redacted] Chief Legal Officer and Managing Director
12200 N. Ambassador Drive, Suite 326
Kansas City, MO 64163
Phone: [redacted]
Email: [redacted]

FOR THE SECRETARY OF LABOR:

Dated: February 8, 2024

Mark Underwood

Mark F. Underwood
Regional Director
Kansas City Regional Office
Employee Benefits Security Administration

FOR THE BOILERMAKERS NATIONAL HEALTH & WELFARE FUND:

Dated: February 8, 2024

[redacted]

By: [redacted]

Title: Chief Legal Officer & Managing Director

Attachment A

Table 1: OON Utilization

OON categories to track separately:

1. Inpatient vs. outpatient
2. MH vs. SUD vs. med/surg
3. Professional vs. facility, and specific provider types within those-
   a. MH and SUD professional: psychiatrist (not including child/adolescent psychiatrists), child/adolescent psychiatrist, psychologist (not including child/adolescent psychologists), child/adolescent psychologists, physician board- certified in addiction medicine, behavioral health non-MD prescriber, master's level providers, non-master's level professional providers
   b. Med/surg professional: PCP/family practice, pediatrician, OB/GYN, all other specialty
   c. MH and SUD outpatient facility: IOP, child/adolescent, all other
   d. MH and SUD inpatient facility: acute, PHP, residential, child/adolescent
   e. Med/surg facility: child/adolescent, all other
4. Total billed amount
5. Total allowed amount
6. Total paid amount
7. Total claim lines

Table 1 (sample chart format)

		INN Claims (Service by Participating Providers)				OON Providers (Services by Non-Participating Providers)			
		Total Billed Amt	Total Allowed Amt	Total Paid Amt	Total# Claim Lines	Total Billed Amt	Total Allowed Amt	Total Paid Amt	Total# Claim Lines
Outpatient Services	Med/Surg professional • PCP/family practice • Pediatrician •OB/GYN • All Other								
	MH professional • Psychiatrist • Psychiatrist - child/adolescent • Psychologist • BHNPw/Rx Capability • All other								
	SUD professional • Psychiatrist • Psychiatrist - child/adolescent • Psychologist • BH NPw/Rx capability								

	• All other								
	Med/surg facility • Child/adolescent • All other								
	MH Facility • IOP • Child/adolescent • All other								
	SUD Facility • IOP • Child/adolescent • All other								
Inpatient Services	Med/Surg professional • PCP/family practice • Pediatrician • OB/GYN • All Other								
	MH professional • Psychiatrist • Psychiatrist - child/adolescent • Psychologist • BH NPw/Rx Capability • All other								
	SUD professional • Psychiatrist • Psychiatrist - child/adolescent • Psychologist • BH NPw/Rx Capability • All other								
	Med/surg facility • Child/adolescent • All other								
	MH Facility • IOP • Child/adolescent • All other								
	SUD Facility • IOP • Child/adolescent • All other								

Table 2: Network Providers Actively Submitting Claims

Data to report for Network providers actively submitting claims and accepting new patients. For each of the requests below, break out in-person providers vs. telehealth providers.

1. Total number of Network providers (do not include single case agreement providers)
2. Total number (and%) of Network providers noted as accepting new patients in

directory

3. Total number (and%) of Network providers who have submitted 0 network claims in the last 6 months
4. Total number (and%) of Network providers who have submitted Network claims for 1-4 unique P/Bs in the last 6 months
5. Total number (and%) of Network providers who have submitted Network claims for 5 or more unique P/Bs in the last 6 months
6. Categories to use in breaking out above numbers should include the following providers, in addition to all provider types the plan or Network has identified as "high volume" or "high impact":
    a. MH/SUD
        i. Psychiatrists (not including child/adolescent psychiatrists);
        ii. Psychologists (not including child/adolescent psychologists);
        iii. Child/adolescent psychiatrists;
        iv. Child/adolescent psychologists;
        v. Master's level MH providers (counselors, marriage and family therapists, independent clinical social workers, advanced social workers);
        vi. Non-master's level MH providers;
        vii. Board certified SUD addiction medicine physicians; and
        viii. Other non-physician SUD professionals.
    b. Med/surg
        i. PCP/family practice (not including pediatricians)
        ii. Pediatrician
        iii. OB/GYN
        iv. Cardiologists
        v. Neurologists
        vi. All other specialty physicians (not otherwise listed);
        vii. Non-physician primary care providers; and
        viii. Non-physician specialty providers

Table 3: Wait Times for New and Existing Patients

Data to report (based on participant/patient surveys) for wait times:

1. Median wait time for new patient appointment
2. Mean wait time for new patient appointment
3. Median wait time for returning patient appointment
4. Mean wait time for returning patient appointment
5. Categories to use should include the following providers, in addition to all provider types the plan has identified as "high volume" or "high impact":
    a. MH/SUD
        i. Psychiatrists (not including child/adolescent psychiatrists);
        ii. Psychologists (not including child/adolescent psychologists);
        iii. Child/adolescent psychiatrists;
        iv. Child/adolescent psychologists;
        v. Master's level MH providers (counselors, marriage and family therapists, independent clinical social workers, advanced social workers);
        vi. Non-master's level MH providers;
        vii. Board certified SUD addiction medicine physicians;
        viii. Other non-physician SUD professionals;
        ix. MH acute facility;
        x. MH subacute facility (such as PHP, residential);
        xi. MH child/adolescent facility (of any level of care);
        xii. SUD acute facility;
        xiii. SUD subacute facility
    b. Med/surg
        i. PCP/family practice (not including pediatricians)
        ii. Pediatrician\

iii. OB/GYN

iv. Cardiologists

v. Neurologists

vi. All other specialty physicians (not otherwise listed);

vii. Non-physician primary care providers;

viii. Non-physician specialty providers;

ix. Acute facility;

x. Subacute facility;

xi. Child/adolescent facility (any level of care).

Wait times survey methodology: If BNF uses a sampling methodology, that methodology must be reasonably designed to survey a sufficient number of each provider type as to constitute an unbiased representative sample of each provider type. The survey must include only providers and facilities who actively submitted one or more claims in the last 6 months.

Table 4: Time & Distance Measurements - (Use the same categories as Table 3 above.)

Methodology:

1. Explain methodology for counting providers for purposes of time/distance metrics. How are the following counted: multi-provider practice groups, single providers with multiple locations, facilities with different patient or bed capacities?

2. They must identify the time/distance metric used and basis of determination.

Data to report on time/distance metrics:

1. Time/distance metrics for each provider category by county type: large metro, metro, micro, Rural, and CEAC.

2. Number and % of these types of counties that meet time/distance standards. When assessing the number and % of these types of counties that meet time/distance standards, BNF must count only providers and facilities who actively submitted one or more claims in the last 6 months.

Table 5: Provider-To-Member Ratios - (Use the same categories as Table 3 above.)

Methodology:

1. Explain methodology for counting providers for purposes of ratios. How are the following counted: multi-provider practice groups, single providers with multiple locations, facilities with different patient, bed capacities or in-person vs. telehealth?

2. They must identify the time/distance metric used and basis of determination.

Data to report on provider-member ratios:

1. Target ratios by category;

2. Actual ratios by category - when calculating actual ratios by category, BNF must count only providers and facilities who actively submitted one or more claims in the last 6 months.

Table 6: Network Retention/Loss Analysis - (Use the same categories as Table 3 above.) Network retention/loss data to report:

1. Number of providers who were part of the Network but left the Network in the last two years;

2. Number of prospective providers who engaged in application process and/or negotiation to join Network, but ultimately did not join Network;

3. Reason for leaving or not joining Network;

4. Explain methodology for counting providers.