Report to Congress

Compliance of Group Health Plans

(and Health Insurance Coverage Offered in Connection with Such Plans)

With the Requirements of the

Mental Health Parity and Addiction Equity Act of 2008

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U.S. Department of Labor

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I. INTRODUCTION

For over a decade the Departments of Labor, Health and Human Services, and Treasury (the Departments) have played an integral role in ensuring parity with respect to mental health and medical/surgical benefits provided through group health plan and health insurance coverage. The Departments' work began with their implementation of the Mental Health Parity Act of 1996. Expanding on those protections, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on October 3, 2008 as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of P.L. 110-343).[1] Since the passage of MHPAEA, the Departments have worked vigorously to ensure full implementation of the robust parity protections provided by the law. The Departments have worked closely with stakeholders and combined guidance issuance and outreach and training efforts to ensure parity is realized.

MHPAEA amended the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code) with parallel provisions governing mental health and substance use disorder benefits.[2] Accordingly, MHPAEA is subject to joint interpretive jurisdiction by the Departments. MHPAEA supplemented the Mental Health Parity Act of 1996 (MHPA 1996), which required parity in aggregate lifetime and annual dollar limits for mental health and medical/surgical benefits. In general, MHPAEA extended the dollar limit protections to include substance use disorder benefits and also requires parity in the application of any financial requirements and treatment limitations on mental health and substance use disorder benefits with medical/surgical benefits.

The statutory provisions of MHPAEA generally became applicable for plan years beginning on or after October 3, 2009. The Departments worked closely with stakeholders and issued interim final rules which generally became applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010 (which for calendar year plans, is January 1, 2011). The Departments carefully considered comments received and continued an

[1] A technical correction to the effective date for collectively bargained plans was made by P.L. 110-460, enacted on December 23, 2008. For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of MHPAEA do not apply to the plan (or health insurance coverage offered in connection with the plan) for plan years beginning before the later of either: (i) The date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008); or (ii) July 1, 2010.

[2] See, ERISA section 712, PHS Act section 2726, and Code section 9812.

ongoing dialogue with interested parties in order to develop final regulatory guidance. The final rules generally become applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2014. Each plan or issuer subject to the interim final rules must continue to comply with the applicable provisions of the interim final rules until the final regulations become applicable to that plan or issuer.

The Employee Benefits Security Administration (EBSA) within the Department of Labor (DOL) is charged with the administration of ERISA, including the development of regulations and interpretations to implement the provisions of ERISA, compliance assistance, consumer assistance, and enforcement.[3] DOL has a robust program in place to ensure compliance with the laws under ERISA, including MHPAEA. In accordance with these responsibilities, MHPAEA specifically required that the Secretary of Labor submit a report to the appropriate committees of Congress on compliance of group health plans (and health insurance coverage offered in connection with such plans) with its requirements by January 2012, and every two years thereafter.[4] On January 1, 2012, DOL submitted the first report to Congress, which summarized the steps the Departments have taken to implement MHPAEA. The initial report to Congress outlines the MHPAEA implementation framework that was developed by the Departments to achieve their ultimate goal of full MHPAEA implementation.

The Departments have continued their commitment to mental health parity, and made preliminary strides in implementation as they have worked through the framework set forth in the initial Report. This second report to Congress updates DOL's initial findings and outlines the next steps under consideration for continued implementation and enforcement of MHPAEA. Since the submission of the initial report, major developments in the MHPAEA infrastructure include the completion of the MHPAEA compliance study and the promulgation of the final rules. Both the complete MHPAEA compliance study and the final rules are attached to this report as appendices. The Departments have utilized the results of this study, along with feedback received from consumers and the regulated community, to further MHPAEA implementation by issuing final rules. This report provides an overview of these developments and highlights the ongoing efforts being taken in the context of the previously established MHPAEA implementation framework to ensure that parity is accomplished as intended by the law.

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[3] The Health Insurance Portability and Accountability Act of 1996 provided that very small plans, including certain retiree-only health plans, and excepted benefits, are generally exempt from Part 7 of ERISA, Title XXVII of the PHS Act, and Chapter 100 of the Code – including the provisions of MHPAEA. Such exemptions are pursuant to ERISA section 732, PHS Act 2723, and Code section 9831.

[4] See ERISA section 712(f).

II. MHPAEA OVERVIEW

A. Legislative Background

Prior to the passage of MHPAEA, MHPA 1996 was in effect and generally applied to plans sponsored by private and public sector employers with more than 50 employees.[5] MHPA 1996 provided for parity in the application of aggregate lifetime dollar limits, and annual dollar limits, between mental health benefits and medical/surgical benefits. The requirements under MHPA 1996 applied regardless of whether the mental health benefits were administered separately under the plan. Similar to MHPAEA, MHPA 1996 did not require a group health plan or health insurance coverage offered in connection with a group health plan to provide mental health benefits.

The Departments published interim final rules implementing the MHPA 1996 provisions on December 22, 1997. Among other things, the MHPA 1996 regulations clarified the application of the MHPA 1996 provisions to group health plans with varying types of dollar limitations (including inpatient/outpatient limits and in-network/out-of-network limits) and the procedures a plan would undertake to elect an increased cost exception permitted under the statute. In general, MHPA 1996 and the interim final rules promulgated thereunder applied to group health plans and issuers for plan years beginning on or after January 1, 1998.

On October 3, 2008, MHPAEA[6] was enacted and supplemented MHPA 1996. MHPAEA generally applies to group health plans (sponsored by private and public sector employers, whether self-insured or fully-insured), and health insurance coverage offered in connection with a group health plan.[7] The statutory provisions of MHPAEA generally became effective for plan years beginning on or after October 3, 2009.

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[5] Initially, MHPA 1996 amended only ERISA and the PHS Act. The Taxpayer Relief Act of 1997 (Pub. L. 105-34) was enacted on August 5, 1997, and added provisions substantively similar to those in MHPA 1996 in the Code.

[6] See, http://www.dol.gov/ebsa/newsroom/fsmhpaea.html for a fact sheet that summarizes MHPAEA.

[7] MHPAEA contains an exemption for a group health plan of a small employer (generally, an employer with not more than 50 employees). See section 712(c)(1) of ERISA, section2726 (c)(1) of the PHS Act, and section 9812(c)(1) of the Code. However, the HHS final regulation on essential health benefits (EHB) requires issuers of non-grandfathered plans in the individual and small group markets to ensure that such plans provide all EHB, including mental health and substance use disorder benefits, and those benefits must be provided in compliance with the requirements of the MHPAEA regulations, even where those requirements would not otherwise apply directly. See 78 FR 12834 (Feb. 25, 2013) and 45 CFR 156.115(a)(3).

The Patient Protection and Affordable Care Act (Affordable Care Act) extended MHPAEA to apply to the individual health insurance market and qualified health plans in the same manner and to the same extent as MHPAEA applies to health insurance issuers and group health plans.

MHPAEA amended ERISA, the PHS Act, and the Code with parallel provisions.[8] As such, the Departments develop and jointly issue regulations under the parallel provisions, so as to have the same effect at all times, consistent with the tri-agency Memorandum of Understanding (MOU)[9] that implements section 104 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

B. Regulatory Guidance

On April 28, 2009, the Departments published a request for information (RFI) soliciting comments on the requirements of MHPAEA. After consideration of the comments received in response to the RFI, the Departments published interim final regulations, with request for comment, on February 2, 2010. The interim final rules generally became applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010, which for calendar year plans, is January 1, 2011.

Under the interim final rules, a group health plan or group health insurance issuer generally cannot impose a financial requirement (such as copayments or coinsurance) or a quantitative treatment limitation (such as a limit on the number of outpatient visits or inpatient days covered) on mental health or substance use disorder benefits in any of six classifications that is more restrictive than the predominant requirements or limitations that apply to at least two-thirds of medical/surgical benefits in the same classification.[10] The interim final rules also prohibit a group health plan from applying cumulative financial requirements, such as deductibles, for mental health and substance use disorder benefits in a classification that accumulate separately from any such requirements or limitations established for medical/surgical benefits in the same classification.

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[8] In addition to the parity protections under MHPAEA, the Affordable Care Act included new participant rights to internal claims and appeals and external review processes, the requirements of which also apply to claim denials for behavioral health benefits. See 76 FR 37208 at 37216 (June 24, 2011).

[9] See 64 FR 70164 (December 15, 1999).

[10] The interim final rule sets forth six classifications for purposes of determining parity: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. See 75 FR 5440. Pursuant to sub-regulatory guidance issued on June 30, 2010, subsequent to the interim final rules, the outpatient classifications can be further divided into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under MHPAEA: (1) office visits, and (2) all other outpatient items and services. See http://www.dol.gov/ebsa/faqs/faq-mhpaea.html for a detailed discussion of these sub-classifications.

The interim final rules also include parity requirements with respect to nonquantitative treatment limitations (NQTLs).[11] The interim final rules provide that any processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits, except to the extent that recognized clinically appropriate standards of care may permit a difference.

MHPAEA also includes two new disclosure provisions for group health plans and group health insurance issuers. First, the criteria for medical necessity determinations made under a plan (or health insurance coverage) with respect to mental health or substance use disorder benefits must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request. The interim final rules repeat the statutory language with respect to the medical necessity determinations disclosure requirement without substantive change. Secondly, MHPAEA requires that the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary be made available, upon request or as otherwise required, by the plan administrator (or the health insurance issuer) to the participant or beneficiary. The interim final rules clarified that in order for plans subject to ERISA (and health insurance coverage offered in connection with such plans) to satisfy this requirement, disclosures must generally be made in a form and manner consistent with the ERISA claims procedure regulation at 29 CFR 2560.503-1.[12]

C. Sub-regulatory Guidance

After the interim final rules were issued, the Departments received numerous inquiries requesting clarification of and assistance with the implementation of the interim final rules. The Departments recognized the significance of providing guidance as promptly as possible in order to facilitate the continued implementation of the law. Therefore, several sets of sub-regulatory guidance have been issued regarding the issues most frequently raised by group

[11] The interim final rules included an illustrative list of NQTLs: Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether a treatment is experimental or investigative; Formulary design for prescription drugs; Standards for admission to plan provider networks, including reimbursement rates; Plan methods used to determine usual, customary, and reasonable fee charges; Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and Exclusions based on failure to complete a course of treatment. See 75 FR 5443.

[12] See, 26 CFR § 54.9812(d)(2), 29 CFR § 2590.712(d)(2), and 45 CFR § 146.136(d)(2).

health plans, issuers, and consumers. Specifically, the Departments published Frequently Asked Questions (FAQs) on June 30, 2010, December 22, 2010, November 17, 2011, May 9, 2012 and May 18, 2012. These FAQs were intended to provide clarity with respect to particular issues creating confusion in the marketplace and to help educate individuals regarding the protections available under MHPAEA relating to parity in mental health and substance use disorder benefits.

In order to address a frequently asked question regarding how to apply financial requirements and treatment limitations rules under MHPAEA to certain outpatient benefit plan designs, the Departments issued a clarification. Specifically, the first FAQ clarified that with respect to outpatient benefits, a plan or issuer is permitted to divide its benefits furnished on an outpatient basis into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under MHPAEA: (1) office visits, and (2) all other outpatient items and services.[13]

The second set of FAQs clarified what information and documentation must be disclosed under ERISA, particularly under MHPAEA, to participants, beneficiaries, providers, or authorized representatives and the timing of such disclosures, the applicability of MHPAEA and the interim final rules to certain entities, and the process for claiming the increased cost exemption under MHPAEA.[14]

The third set of FAQs answers questions from stakeholders regarding NQTLs and a common question the Departments received related to the application of a plan's specialist (as opposed to the generalist) copayment for services rendered by outpatient mental health and substance use disorder professionals.[15]

The Departments issued an additional set of FAQs specifically focused on bolstering understanding of MHPAEA implementation. The FAQs provide information regarding the application of the parity requirements to NQTLs as well as MHPAEA's interaction with State

[13] See FAQ on the Mental Health Parity and Addiction Equity Act (Sub-classifications), available at http://www.dol.gov/ebsa/faqs/faq-mhpaea.html.

[14] See FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation, available at http://www.dol.gov/ebsa/faqs/faq-aca5.html.

[15] See FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation, available at http://www.dol.gov/ebsa/faqs/faq-aca7.html.

mental health mandates. The FAQs also address a common question the Departments received related to managed behavioral health organizations and parity.[16]

The Departments also released a set of FAQs that explained the additional protections that MHPAEA affords employees. These FAQs summarize the basic concepts of the interim final rules and reiterate some of the previously issued FAQs.[17]

The Departments have met on numerous occasions with a broad range of stakeholders, such as consumers, providers, managed behavioral health organizations, industry associations, and other experts in the field of behavioral health to discuss other implementation and interpretation issues that may be present in the industry. Through those meetings the Departments have continued to gain knowledge about practical implementation issues arising in the private health insurance market, which has informed their interpretive guidance, compliance and participant assistance, and enforcement processes.

III. 2012 REPORT TO CONGRESS

In accordance with the statutory requirement, on January 1, 2012, the Secretary of Labor submitted DOL's initial report to Congress on the compliance of group health plans and health insurance coverage offered in connection with such plans with the requirements of MHPAEA.[18] The initial report detailed the MHPAEA infrastructure established by EBSA since the passage of MHPAEA. The report explained the four-pronged "Strategies of Implementation" that EBSA employed to achieve its ultimate goal of full MHPAEA implementation. The Strategies of Implementation included (1) issuing interpretative guidance; (2) engaging in external outreach and compliance assistance activities; (3) providing participant assistance; and (4) enforcing the law and regulations. In addition to these strategies, the initial report also outlined the approaches EBSA took in reinforcing these strategies of implementation. These approaches primarily consisted of extensive internal training of regional office staff who generally serve as EBSA's first point of contact for participants, beneficiaries and group health plans and issuers. The EBSA MHPAEA training comprised a combination of webinars and in-person presentations, as well as the rollout of several MHPAEA-specific compliance tools.

[16] See FAQs on Understanding Implementation of the Mental Health Parity and Addiction Equity Act of 2008, available at http://www.dol.gov/ebsa/faqs/faq-mhpaeaimplementation.html.

[17] See For Employees about the Mental Health Parity and Addiction Equity Act, available at http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html.

[18] See U.S. Department of Labor's 2012 Report to Congress: Compliance With the Mental Health Parity and Addiction Equity Act of 2008, available at http://www.dol.gov/ebsa/publications/mhpaeareporttocongress2012.html.

The initial report also explained that EBSA's strategies of implementation were reinforced by the commissioning of two studies that focused on specific issues related to MHPAEA. These studies include the NQTL and "Scope of Services" study (NQTL/SOS study) as well as a MHPAEA compliance study.

Under the interim final rules, plans and issuers are required to impose NQTLs, or restrictions that otherwise limit the scope or duration of treatment, in accordance with the MHPAEA parity requirements. The interim final rules set forth an illustrative, non-exhaustive list of common types of NQTLs, and established an approach by which plans and issuers may evaluate parity with respect to these types of limitations. The Departments also requested comments on whether and to what extent intermediate level services, including partial hospitalization, intensive outpatient, and residential treatment services should be addressed through future rulemaking.

Subsequent to the interim final rules, the Departments received several comments requesting additional guidance on how to administer NQTLs in accordance with MHPAEA. The regulated community, as well as consumers, also continued to seek guidance on the implications of MHPAEA on intermediate level services. In addition to the Departments issuing several rounds of FAQs, HHS commissioned a short-term research study to acquire additional real-life information on these two specific issues to help inform future guidance.[19] The Departments' aim was that feedback from both the comments and the study would help inform the process and identify areas where further clarifications were needed to fully implement MHPAEA's statutory requirements. The study focused on the use of NQTLs by group health plans and issuers and the implications on parity with respect to intermediate level services. The findings on NQTLs were based primarily on interviews with managed behavioral health industry experts and the deliberations of a technical expert panel comprising of well-known researchers and practitioners with clinical expertise regarding behavioral health and general medical treatment issues. The panel discussed a number of processes, strategies, and evidentiary standards that they considered reasonable and justifiable considerations for plans and insurers to use in establishing NQTLs for mental health and substance use disorder and medical/surgical benefits. The panel also discussed how the standards in the interim final rules require that these considerations be applied in a comparable way to mental health and substance use disorder benefits and medical/surgical benefits in determining how a plan or insurer would apply an NQTL. Furthermore, the panel discussed situations in which the outcome of applying these considerations in a comparable way may justifiably result in a different application of an NQTL to mental health and substance use disorder benefits compared to medical/surgical benefits.

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[19] See U.S. Department of Health and Human Services' Study: Short-Term Analysis to Support Mental Health and Substance Use Disorder Parity Implementation, available at http://aspe.hhs.gov/daltcp/reports/2012/mhsud.shtml.

The research into intermediate level services surveyed the degree to which group health plans and issuers cover intermediate mental health and substance use disorder services and the cost implications of health plan coverage for these types of services. The research demonstrated that group health plans were in fact covering such intermediate level services, and that the additional cost to cover such services was generally a small fraction of the total plan cost.

While this study encapsulates HHS' preliminary findings regarding these two specific issues, HHS continues to study the scope of services issues with an on-going examination of coverage levels for similar types of non-acute, intermediate medical/surgical services by group health plans and insurers. HHS also conducted in-depth analysis of public comments on the interim final rules regarding scope of services issues and has researched state laws that incorporate scope of services standards.

The initial report to Congress also discussed a second study that HHS commissioned related to MHPAEA compliance of group health plans and issuers. At the time the initial report to Congress was submitted, this study was still underway. The initial report outlined the primary focus of the study, which included evaluating the implementation of the interim final rules regarding financial requirements and quantitative treatment limitations by health plans and insurers in accordance with the standards detailed in the interim final rules for calculating the predominant level that applies to substantially all medical/surgical benefits. In addition, the initial report explains that the study will include an examination of the types of NQTLs that are commonly used by plans and insurers and whether and how these practices may have changed in response to MHPAEA.

Finally, the initial report outlined the progress the Departments are making in light of the Strategies of Implementation that were executed. The initial report also explained that, if appropriate, DOL will submit a supplemental report to the initial report to Congress including the preliminary findings of the compliance study.

IV. IMPLEMENTATION DEVELOPMENTS SINCE THE 2012 REPORT TO CONGRESS

Since the submission of the initial report to Congress, the Departments have been working diligently to achieve the ultimate goal of full MHPAEA implementation. The initial report to Congress primarily focused on depicting the initial framework established by EBSA and outlining the preliminary findings of MHPAEA compliance among group health plans and issuers as a result of the MHPAEA infrastructure instituted by EBSA. The Departments continue to advance a strategy to ensure parity in employment-based mental health and medical/surgical benefits through the ongoing progress of the Departments' implementation strategy, which includes (1) issuing interpretative guidance; (2) engaging in external outreach and compliance assistance

activities; (3) providing participant assistance; and (4) enforcing the law and regulations. Along with the ongoing progress of these initiatives, this subsequent report highlights two major developments with respect to MHPAEA implementation which include (1) the findings of the MHPAEA compliance study and (2) the issuance of final rules.

A. MHPAEA Compliance Study

Appendix A of this report is the *Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 Final Report* (MHPAEA compliance study). The Assistant Secretary for Planning and Evaluation (ASPE) of HHS contracted with National Opinion Research Center (NORC) at the University of Chicago to study how health plans and insurers have responded to MHPAEA in the first years after its effective date. NORC led a research team that included Milliman Inc., Aon Hewitt, Thomson Reuters/Truven Health Analytics, and George Washington University to perform an analysis of adherence to MHPAEA and the interim final rules among ERISA-governed employer-sponsored group health plans and health insurance coverage offered in connection with such group health plans. The study evaluated seven specific questions:

1. What types of financial requirements (e.g., copays, coinsurance) do group health plans use for mental health and substance use disorder benefits, and are such requirements consistent with the new MHPAEA standards for calculating the predominant level that applies to substantially all medical and surgical benefits?

2. What types of quantitative treatment limitations (e.g., day limits, visit limits) do group health plans use for mental health and substance use disorder benefits, and are such limitations consistent with the MHPAEA standards?

3. What types of NQTLs are commonly used by plans and issuers for mental health and/or substance abuse disorder benefits and how do these compare to NQTLs in place for medical/surgical benefits?

4. Are group health plans and insurers using separate deductibles for mental health and substance use disorder benefits?

5. Have financial requirements and treatment limits on medical/surgical benefits become more restrictive in order to achieve parity, instead of requirements and limits for mental health and substance use disorder benefits becoming less restrictive?

6. How many plans have eliminated mental health and substance use disorder treatment coverage altogether instead of complying with MHPAEA?

7. How have plans responded to MHPAEA's requirements regarding the disclosure of medical necessity criteria and reasons for claim denials?

Based on the findings of these specific questions, the MHPAEA compliance study concludes that employers and group health plans have made substantial changes to their plan designs in order to meet the parity standards set out by MHPAEA and the interim final rules. The study found that only a small proportion of employers, between one and two percent, claimed to have dropped or were planning to drop coverage for mental health or substance use disorders (MH/SUD) as a result of MHPAEA. The data demonstrate that most ERISA-governed group health plans and health insurance offered in connection with group health plans have eliminated most financial requirements that did not comport with the MHPAEA parity standards. The Study did not find any evidence that any plan increased medical/surgical financial requirements in order to achieve parity. The study also found that there has been a substantial decrease in the number of plans and issuers that impose disparate quantitative treatment limitations, such as inpatient day limits or outpatient visit limits.

The MHPAEA compliance study could not fully capture the extent to which the use of NQTLs changed in response to the law due to the limited source of information drawn primarily from large employers' health plans. The study employed document reviews and self-reporting from employers and group health plans to evaluate NQTL processes in place for MH/SUD and medical/surgical benefits. The study notes several areas of inconsistencies regarding NQTLs, namely network management processes (different standards and processes selection in-network providers) and lower mental health and substance use disorder provider reimbursement rates compared to medical/surgical standards.

B. MHPAEA Final Rules

Appendix B of this report is the *Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (final rules). The final rules were drafted largely in response to the comments received on the interim final rules as well as stakeholder feedback provided directly to the Departments regarding compliance concerns and issues that both the industry and consumers have raised since the promulgation of the interim final rules. Both the NQTL/SOS study and the MHPAEA compliance study also helped to inform the final rules. In addition, experience gained through the Departments' earlier implementation activities, specifically through enforcement efforts and through working with the regulated community to provide compliance assistance with respect to technical questions under MHPAEA, helped inform the process and identify areas where further guidance would be needed to ensure full

implementation of the law. Ongoing interfacing with the regulated community at MHPAEA-related outreach and training events held throughout the country, including events such as the Department of Labor's Health Benefits Education Campaign Seminars, also provided a forum for the Departments to gain meaningful feedback regarding questions or perceived obstacles to implementation of the law. The final rules sought to provide the additional guidance needed in order for plans and insurers to clearly understand how to comply with the requirements of the law and for participants and beneficiaries to understand the full breadth of the protections afforded them under the law. Promulgation of the final rules marked fulfillment of one of the Departments' key strategy elements to MHPAEA implementation, issuance of interpretive guidance. The final rules were published on November 13, 2013. The final rules become applicable to group health plans and health insurance coverage on the first day of the first plan year beginning on or after July 1, 2014. Each plan or issuer subject to the interim final rules must continue to comply with the applicable provisions of the interim final rules until the final rules become applicable to that plan or issuer.

The final rules encompass many of the concepts and requirements originally included in the interim final rules, but also contain several new clarifications and requirements. The final rules formally incorporate the clarifications previously issued by the Departments through FAQs since the issuance of the interim final rules. The Departments have continuously prioritized the importance of the implementation of the meaningful protections provided under MHPAEA. Therefore, FAQs were issued expeditiously to give stakeholders immediate knowledge of the Departments' interpretation with respect to certain issues under the interim rules that required clarification. The Departments were committed to ensuring that the FAQ, subregulatory guidance, was incorporated into final regulatory guidance and this strategic effort has been accomplished.

In response to many of the comments and questions raised to the Departments, the final rules also clarify the disclosure rights of plan participants with respect to both mental health and substance use disorder benefits and medical/surgical benefits. The final rules make clear that participants are entitled to request and receive the processes and evidentiary standards that plans rely on in imposing NQTLs on both mental health and substance use disorder benefits and medical/surgical benefits, as well as the reason for benefit denials and information regarding medical necessity determinations. The final rules also explain how this information is also required to be provided to participants and beneficiaries enrolled in employer-sponsored group health plans under ERISA, more generally. Even with these important disclosure requirements under existing law, the Departments remain focused on transparency, including ensuring that individuals have the necessary information to compare NQTLs of medical/surgical benefits and mental health and substance use disorder benefits to effectively ensure compliance with MHPAEA. Through both aggressive outreach and enforcement efforts, the Departments will

work to make certain that plans and insurers are providing and participants and beneficiaries are receiving the information that should be made available to ensure parity. Contemporaneous with the publication of the final rules, DOL and HHS published another set of MHPAEA FAQs,[20] which, among other things, solicit comments on whether and how to accomplish greater transparency and compliance.

While all of these clarifications help further the Departments' ultimate goal of full MHPAEA implementation by providing formal guidance in areas that presented challenges and uncertainty in compliance with MHPAEA, the final rules address two areas that have presented major implementation challenges: NQTLs and intermediate levels of care.

The interim final rules contained an exception to the general NQTL requirement permitting variation in NQTLs "to the extent that recognized clinically appropriate standards of care may permit a difference." It was brought to the Departments' attention that this exception could be subject to abuse and compounded the difficulty of applying the NQTL parity standard with respect to medical/surgical and mental health and substance use disorder benefits. Based on stakeholder and clinical experts' feedback, as well as in light of the data obtained through both the NQTL/SOS study and the MHPAEA compliance study, the final rules eliminate this exception to ensure full implementation of MHPAEA and compliance with its parity standards. Some plans and issuers had claimed broad parity exceptions based on this provision. The preamble to the final rules notes that plans and issuers continue to have the flexibility contained in the NQTL requirements to take into account clinically appropriate standards of care when determining whether and to what extent medical management techniques and other NQTLs apply to medical/surgical benefits and mental health and substance use disorder benefits, as long as the processes, strategies, evidentiary standards, and other factors used in applying an NQTL to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those with respect to medical/surgical benefits.

The final rules also provide that MHPAEA applies to intermediate levels of care for mental health conditions and substance use disorder benefits. The final rules clarify that plans and issuers must identify what is meant by an intermediate service with respect to both mental health conditions and substance use disorder benefits and medical/surgical benefits and treat such intermediate services comparably within the structure of plan benefits. That is, plans and issuers must assign covered intermediate mental health and substance use disorder benefits to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. The final rules also clarify that restrictions

[20] See FAQs about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation, available at http://www.dol.gov/ebsa/faqs/faq-aca17.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs17.html.

based on geographic location, facility type, provider specialty, and other criteria that might otherwise limit the scope of services as NQTLs are subject to the parity requirements of the final rules. By including these restrictions in the illustrative list of NQTLs, the Departments clarify that intermediate level services are also subject to the NQTL parity requirement of the final rules. The final rules also include additional examples illustrating the application of the NQTL rules to plan exclusions affecting the scope of services provided under the plan. Providing these clarifications with respect to NQTLs and intermediate services will address a high degree of uncertainty that had existed under the interim final rules. This guidance makes clear the Departments' interpretation with respect to application of the law in these areas and will advance greater compliance and implementation of the parity protections intended by the law.

With the issuance of the final regulatory guidance accomplished, the Departments can now focus their attention on their ongoing and robust training and outreach efforts related to MHPAEA implementation. While the interim final rules provided initial guidance necessary to develop an implementation infrastructure, the final rules include essential clarifications and additional guidance necessary to realizing full implementation of MHPAEA. As outlined in the previous report as part of the MHPAEA infrastructure, the Department of Labor is committed to providing compliance assistance by way of external outreach to the regulated community as well as through participant assistance, which is primarily achieved through the Department's benefit advisors. The Department is also working to ensure implementation through our vigorous enforcement efforts. As the final rules become effective, the Department is working diligently to ensure that all players have an understanding of these rules so that the goal of full MHPAEA implementation will be achieved.

With the issuance of any new guidance, the Departments ensure that national and regional staff receive comprehensive training on the requirements. DOL has benefits advisors throughout the country that serve as front-line responders to questions of varying complexities relating to participants' and beneficiaries' rights under MHPAEA. DOL works diligently to ensure that these individuals are properly versed in the requirements and protections under the law and can help individuals who contact the Department. Similarly, well-trained investigative staff are prepared to move ahead in their enforcement efforts, including review of plan materials and the provision of technical guidance to ensure plans comply with the law. Further, the Departments continually provide detailed, external trainings to stakeholders. These include webinars, conference calls and seminars provided for audiences including plan representatives, participants, beneficiaries, insurance representatives, third-party administrators, lawyers, consultants, and consumer organizations. These trainings, participant and compliance assistance, and enforcement efforts will continue to ensure that the

requirements of the law are understood throughout the regulated community and that individuals are receiving the benefits to which they are entitled under the law.

V. CONCLUSION

A. Departments' Progress Since 2012

Since the enactment of MHPAEA and the promulgation of the interim final rules, the Departments have made significant progress with respect to MHPAEA implementation. The Departments have established an infrastructure to achieve their ultimate goal of full MHPAEA implementation. EBSA has continuously trained its regional staff on the requirements of MHPAEA, and has worked to provide assistance to both the regulated community as well as consumers. Through data provided from both the NQTL/SOS and MHPAEA compliance studies, the Departments have gleaned a considerable amount of information regarding the implication of the MHPAEA infrastructure on the regulated community, as well as where the need for additional guidance is the most persistent. Both research initiatives also affirmed that the MHPAEA infrastructure has furthered the ultimate goal of reaching full MHPAEA implementation. All of these factors, along with the consistent communication with consumers and the regulated community, enabled the Departments to ascertain what next steps should be taken to continue to realize full MHPAEA implementation. It is DOL's hope that the final rules will provide much needed guidance that will enable group health plans and issuers to come into complete MHPAEA compliance.

The Departments will continue to work diligently to accomplish the ultimate goal of achieving full MHPAEA implementation. EBSA has developed relationships and established an informal process for meetings and communication with stakeholders to gain ongoing feedback regarding the successes and challenges that have arisen and will arise in the ongoing MHPAEA implementation process. The Departments are committed to working with consumers and the regulated community as the provisions of the final rules become applicable to group health plans and issuers. With the MHPAEA implementation infrastructure in place, the Departments are positioned to continue the work to ensure that full MHPAEA Implementation is achieved.

B. Future Reports to Congress

As previously discussed, the major developments since the submission of the initial report to Congress include the findings of the MHPAEA compliance study and the promulgation of the final rules. As the final rules become applicable and MHPAEA implementation continues, DOL will report any additional findings regarding compliance and enforcement in the subsequent report to Congress due on January 1, 2016.