



THE MENTAL HEALTH &
SUBSTANCE USE DISORDER
PARITY TASK FORCE

FINAL REPORT

October 2016



“TO REALIZE THE PROMISE OF COVERAGE EXPANSIONS AND PARITY PROTECTIONS IN HELPING INDIVIDUALS WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS, EXECUTIVE DEPARTMENTS AND AGENCIES NEED TO WORK TOGETHER TO ENSURE THAT AMERICANS ARE BENEFITING FROM THE FEDERAL PARITY PROTECTIONS THE LAW INTENDS.”

**- PRESIDENT BARACK OBAMA
PRESIDENTIAL MEMORANDUM ESTABLISHING THE
MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY TASK FORCE**

MARCH 29, 2016

Introduction

Parity: Improving the Lives of People with Mental Health and Substance Use Disorders

Over the past eight years, our nation has made significant progress in increasing coverage for mental health and substance use disorders (together sometimes called behavioral health disorders). In 2015 the number of Americans with health insurance coverage was at an all-time high with close to 290 million people with health insurance coverage compared to 260 million in 2011.¹ Because people with mental health and substance use disorders were among the most likely to be uninsured, a greater share of the increased access has been for these individuals. The Affordable Care Act (ACA) significantly expanded coverage of behavioral health care – mental health and substance use disorder coverage is part of the Essential Health Benefit (EHB) package, recommended preventive screenings, including for depression and alcohol misuse, are available to people with non-grandfathered coverage with no cost sharing; and, in the 31 states and the District of Columbia that have expanded Medicaid, important mental health and substance use disorder services are now available to roughly 15 million more people than before the ACA was enacted.²

Health insurance makes a big difference. It provides security and enables people to seek care they might not otherwise be able to receive. In addition to dramatically expanding health coverage through the ACA, the Obama Administration has taken important steps to ensure that insurance coverage for health care services for mental health and substance use disorder is comparable to—*or at parity with*—general medical care. Broadly, parity laws and regulations aim to eliminate restrictions health plans place on mental health and substance use coverage – like annual visit limits, higher copayments, separate deductibles for mental health and substance use disorder services, and rules on how care is managed (such as pre-authorizations or medical necessity reviews) – if comparable restrictions are not placed on medical and surgical benefits.

President John F. Kennedy started the conversation about mental health parity more than a half century ago, when he directed the Civil Service Commission to offer equal insurance coverage for mental health and “general medical care” in 1961. Subsequently, mental health parity legislation was introduced in but not enacted by eight Congresses. At the time, the concept of parity was limited to coverage for mental health care and did not address substance use disorder benefits. More than 30 years later, the Mental Health Parity Act of 1996 made important strides by requiring the use of comparable annual and lifetime dollar limits for mental health and medical/surgical care. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA or the 2008 parity law) finally became the law of the land in 2008, requiring full parity in financial and treatment limitations across most private group health plans and state and local government plans and extending parity protections to substance use disorders. The same overall standards are incorporated into separate statutory requirements for Medicaid managed care organizations. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) included a provision to eliminate higher copayments for mental health and substance use disorder services for Medicare beneficiaries. The ACA extended the protection of parity to individual insurance coverage and required mental health and substance use disorder benefit coverage by all non-grandfathered individual and small group health insurance. The combined reach of MHPAEA, the ACA and the application of parity in Medicaid plans has touched the health insurance coverage of approximately 174 million people.

¹ In this report “health insurance coverage” means insurance coverage or self-funded group health coverage of employers.

² Impacts of the Affordable Care Act’s Medicaid Expansion on Insurance Coverage and Access to Care. <<https://aspe.hhs.gov/pdf-report/impacts-affordable-care-acts-medicaid-expansion-insurance-coverage-aand-access-care>>

The Obama Administration has taken a number of meaningful steps toward parity implementation, including:

- The Administration issued Interim Final Regulations to implement the Mental Health Parity and Addictions Equity Act in 2010 and Final Regulations in 2013, providing parity protections to an estimated 103 million people.
- The Affordable Care Act and its implementing regulations expanded parity protections to non-grandfathered plans in the individual and small group markets, covering an additional 48 million people.³
- On March 30, 2016, the Department of Health and Human Services (HHS) published a final rule applying parity to Medicaid Managed Care, Children’s Health Insurance Program (CHIP) and Alternative Benefit Plans, expanding parity protections to about 23 million more people.⁴
- In July 2015, CMS issued guidance on a new policy under section 1115 demonstration authority to develop a full continuum of care for individuals with SUD, including coverage for short-term residential treatment services not otherwise covered by Medicaid. This new opportunity is geared to support states engaged in broad and deep SUD system transformation efforts, enabling them to provide a full continuum of care by introducing service, payment and delivery system reforms to improve the care for individuals with SUD. In addition, CMS issued the Medicaid managed care final rule in May of 2016 which recognizes that managed care plans have flexibility in ensuring access and availability of covered services including short-term inpatient psychiatric and SUD treatment.
- As directed by MIPPA, between 2010 and 2014, the Centers for Medicare & Medicaid Services (CMS) phased out higher copayments for Medicare Part B mental health and substance use disorder outpatient treatments that were unequal to the copayments for other Part B services, effectively eliminating the disparate “mental health treatment limit” (as directed in MIPPA) for Medicare Part B and making copayments for Part B mental health and substance use disorder services generally the same as for other Part B services.
- In September 2016, the Department of Defense finalized a rule to modernize the mental health and substance use disorder benefits and provide parity under TRICARE, the insurance program covering 9.4 million service members and their families.
- From October 2010 to September 2015, the Department of Labor’s Employee Benefits Security Administration (EBSA) conducted 1,515 investigations related to the Mental Health Parity and Addiction Equity Act and cited 171 violations for non-compliance with these rules.
- Since the final Mental Health Parity and Addiction Equity Act regulations were issued in 2013, HHS, DOL and the Department of the Treasury (Treasury) jointly released tri-departmental subregulatory guidance. Including Frequently Asked Questions (FAQs) issued today, HHS, DOL and Treasury have released 44 FAQs and a compliance checklist, on parity issues ranging from disclosure requirements to application of parity to opioid use disorder treatment.

³ Measuring Progress on Mental Health and Substance Use Disorder Parity. <<http://www.hhs.gov/blog/2016/06/07/progress-mental-health-and-substance-use-disorder-parity.html>>

⁴ Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans. <<https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>>

Federal regulators have supported enforcement activities at the state level by providing trainings and technical assistance and responding to inquiries. Collaboration with the National Association of Insurance Commissioners ensures that this support is targeted and effective.

Taken together, these steps provide important direct protections for the more than 40 million people – one in five American adults – who experienced some form of mental illness in the past year, and the over 20.2 million who had a substance use disorder. These protections are indirectly important for everyone, since over the course of their lifetimes, Americans face a 50 percent chance of needing behavioral health services.⁵

Mental health and substance use disorder benefits make a difference. These disorders affect society in ways that go beyond the direct cost of care. Without effective treatment, people with these health conditions may find it difficult to find or maintain a job, may be less able to pursue education and training opportunities, may require more social support services, and are more likely to have their housing stability threatened. Mental illness can be particularly disruptive for families, as family members often serve as caregivers for loved ones with serious mental illness. Substance use disorders frequently rob the happiness, potential and lives of the people who have them and significantly strain family and friends. Comprehensive insurance coverage that is consistent with parity requirements can provide access to treatment and services, which in turn can reduce the difficulties faced by people with mental health and substance use disorders, help their loved ones, and increase their independence.

But there is more work to be done. The ongoing prescription opioid and heroin epidemic, as well as the rise in suicide and substance use-related fatalities in America, reinforce the importance of identifying and addressing challenges in implementing and enforcing behavioral health parity.

“I, myself am a current mental health patient. I suffer from substance use disorder. I’m 46 years old, struggling with addiction for 30 years. I’ve never had more than a year clean. It’s just what I do, it’s all I know. Sad, but true. I pray every day on this. The struggle is real! I need mental health services. I’m relieved to know that there are now more options/health care services to assist me in my struggle with substance abuse and mental health issues. I’m an addict, but I’m only human. Thank you to all the health professionals and to our government for realizing we need more services.”

- Public Comment

⁵ Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. <<https://www.ncbi.nlm.nih.gov/pubmed/15939837>>

Establishing the Parity Task Force

On March 29, 2016, President Obama created the White House Mental Health and Substance Use Disorder Parity Task Force to build on his Administration’s momentum in improving access to high quality behavioral health care.

“The goal of the task force is to essentially develop a set of tools, guidelines, mechanisms so that it’s actually enforced, that the concept is not just a phrase—an empty phrase...[and] for business owners, for companies to recognize that they are much better off checking and pressing their insurer to see that, in fact, mental health and substance abuse parity does, in fact, exist, they will save money, their workers will be more productive, and they’ll be getting more bang for their insurance buck.”

- President Obama, March 29, 2016
Remarks during a panel discussion at the National Rx Drug Abuse & Heroin Summit

The President’s memorandum directs the White House Domestic Policy Council, the Departments of Treasury, Defense, Justice, Labor, Health and Human Services, and Veterans’ Affairs and the Offices of Personnel Management and National Drug Control Policy, to review parity implementation and:

“For too long Americans have paid for coverage that does not recognize that mental health and substance use disorders are every bit as important as physical health, and that going without adequate treatment can be debilitating and even life threatening...the President has made behavioral health a priority...”

- Cecilia Muñoz
Assistant to the President & Director of the Domestic Policy Council & Chair of the Task Force

1. Increase awareness of the protections that parity provides.
2. Improve understanding of the requirements of parity and of its protections among key stakeholders, including consumers, providers, employers, insurance issuers, and state regulators.
3. Increase the transparency of the compliance process and the support, resources, and tools available to ensure that coverage is in compliance with parity, and concurrently improve the monitoring and enforcement process.

The Task Force, led by the Domestic Policy Council, was charged with reviewing progress to date, identifying and taking immediate steps as warranted, outlining future recommendations and summarizing its work in this final report before October 31, 2016.

The Obama Administration has made parity a priority, and, by creating the Task Force, acknowledges that parity is only meaningful if health plans are implementing it fully, consumers and providers understand how it works, and there is appropriate oversight and enforcement.

Between March and October 2016, the Task Force gathered information from stakeholders on many issues, such as barriers to parity implementation and enforcement, defining parity compliance, documenting parity violations, identifying mental health and substance use health disorder workforce issues, documenting specific treatment limitations that may not comply with parity, clarifying the role of states and the federal government in bringing about parity, and numerous other topics.

The work of the Task Force would not have been possible without contributions in the form of presentations, oral and written comments, and ongoing discussions by and with individuals and groups who have a stake in the outcome. Consumers and their representatives, health care providers, issuers, employers, advocacy organizations and others came to the table multiple times and shared their insights, observations and thoughts about next steps. The stories received as part of the public comment process from people with mental health and substance use disorder personal experience and their families were essential to this endeavor. While views on how to move forward vary, the robust commitment and dedication of all of these stakeholders has been clear and unwavering.

Report Overview

The remaining sections of this report provide background on key developments in parity, explain what MHPAEA and the ACA require, discuss the impact of recent parity policy changes, and offer an overview of enforcement activities to date. Next, the report will discuss the work of the Task Force and describe the input received in listening sessions, meetings and via the more than 1,100 written comments submitted to the Task Force. Finally, the Task Force offers recommendations to advance parity in mental health and substance use disorder health benefits. Attached to the report is the President's memorandum establishing the Task Force.

[Timeline: Key Milestones in Mental Health and Substance Use Disorder Parity](#)

Key milestones in parity are depicted below. It is important to keep in mind a few important points while reading this history:

- Given the number of Americans affected by mental health and substance use disorders, parity affects many Americans either directly or through those they know and love. This policy area is personal and these illnesses ignore boundaries of age, geography, or political affiliation.
- Working together, diverse stakeholders and policy makers have made important progress in improving access to coverage for individuals with mental health and substance use disorders.
- Parity laws do not guarantee coverage or access, but making coverage comparable for behavioral health and physical health care can have a substantial impact.
- The Task Force has worked quickly over the past several months to identify and outline recommendations for moving forward on implementing parity, but the work will need to continue beyond the life of the Task Force.
- It remains for consumers, providers, issuers, employers, federal and state regulators and all stakeholders to collaborate and keep the progress moving apace.

“Although he was passionate on many issues, there was not another that surpassed [mental health parity] in terms of his passion.”

*- David Wellstone
Talking about his father, Senator Paul Wellstone*

YEAR	EVENT
1961	➤ President Kennedy directs the Civil Service Commission (now known as the Office of Personnel Management) to implement parity
1970s through present	➤ Parity laws enacted in many states – mostly for small group health plans; some for individual policies; many states establish minimum benefit level requirements for mental health and substance use disorders – employer-sponsored group health plans are generally exempt from state regulation
1992	➤ The first federal parity legislation is introduced in Congress
1996	➤ The Mental Health Parity Act enacted requiring comparable annual and lifetime dollar limits on mental health and medical coverage in large employer-sponsored group health plans
1999	➤ President Clinton directs the Office of Personnel Management to implement parity in the Federal Employees Health Benefits Program (FEHBP)
2003	➤ President Bush’s New Freedom Commission on Mental Health includes a recommendation regarding parity in the Commission’s Final Report
2008	<ul style="list-style-type: none"> ➤ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) is signed into law – applying to large employer-sponsored plans, effective for most plans starting in 2010, including substance use disorders for the first time ➤ Medicare Improvements for Patients and Providers Act enacted including a provision to phase out a statutory provision requiring a higher co-pay for outpatient mental health and substance use disorder services in Medicare Part B
2009	<ul style="list-style-type: none"> ➤ Children’s Health Insurance Program (CHIP) Reauthorization Act enacted requiring parity in CHIP plans ➤ CMS releases State Health Official letter to provide additional guidance regarding the Mental Health Parity and Addiction Equity Act’s application to CHIP
2010	➤ Interim final rules issued to implement the Mental Health Parity and Addiction Equity Act effective for plans in 2011
2010	➤ The Affordable Care Act (ACA) enacted and extends parity protections to individual health insurance policies including qualified health plans offered through Exchanges. In addition, the law requires coverage of mental health and substance use disorder treatment services as a category of Essential Health Benefits (EHBs), guaranteeing coverage for consumers enrolled in individual and small group market plans.
2013	<ul style="list-style-type: none"> ➤ Final rules are issued to implement the Mental Health Parity and Addiction Equity Act – effective for group health plans and health insurance issuers beginning in July 2014 ➤ Final rules on Essential Health Benefits are issued, implementing mental health and substance use disorder services as a category of EHB and extending MHPAEA requirements to non-grandfathered small group insurance plans starting in 2014 ➤ Final rules on Alternative Benefit Plans are issued providing further guidance regarding MHPAEA’s application to Essential Health Benefits in this Medicaid program ➤ Medicaid State Health Officials letter published providing guidance on the application of MHPAEA to Medicaid managed care organizations, Medicaid Alternative Benefit Plans, and the Children’s Health Insurance Program
2016	➤ TRICARE issues a proposed and a final rule that requires equivalent cost sharing between medical-surgical and behavioral health care and eliminates treatment limits for mental health and substance use disorder care
2016	➤ Final regulations issued on parity in Medicaid managed care organizations, Medicaid Alternative Benefit Plans, and the Children’s Health Insurance Program, with October 2, 2017 compliance deadline

[How do the Mental Health Parity & Addiction Equity Act and the Affordable Care Act Advance Parity?](#)

As the President said in his memorandum establishing the Task Force – and as echoed by many commenters during the process – parity provides the basic framework for ensuring comparability in coverage of mental health and substance use disorder services. This section provides an overview of the key elements of the two laws, based in large part on regulations, subregulatory guidance and other materials developed and disseminated by the Departments of Labor, Health and Human Services, and Treasury.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or the 2008 parity law) generally prohibits employment-based group health plans and health insurance issuers that provide group health coverage for mental health and substance use disorders from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. The 2008 parity law and its implementing regulations generally:

- Require that the financial requirements (such as copays and deductibles) and quantitative treatment limitations (such as visit limits) applied to mental health and substance use disorder benefits can generally be no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits within a specific classification (i.e., in-network outpatient, out-of-network outpatient, in-network inpatient, out-of-network inpatient, emergency care, and prescription drugs).
- Require parity in the application of non-quantitative treatment limitations (NQTLs) (such as medical management standards).
- Expand to substance use disorder benefits the parity requirements of the Mental Health Parity Act of 1996, which precluded plans and issuers from imposing a lifetime or annual dollar limit on mental health benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. The ACA prohibits group health coverage and non-grandfathered individual market insurance from imposing lifetime and annual dollar limits on Essential Health Benefits, including mental health and substance use disorder services, and prohibits grandfathered individual market policies from imposing lifetime dollar limits on the same.

Other important basic principles:

- While the Mental Health Parity and Addiction Equity Act does not require a plan to cover mental health or substance use disorder services or all diagnoses, if a plan does cover these services, it must provide coverage for mental health and substance use disorder services for all the classifications in which medical/surgical services are provided.
- Under the Mental Health Parity and Addiction Equity Act, mental health and substance use disorder benefits must be covered and managed in a way that is no more restrictive than general medical and surgical services under the plan even when a separate managed behavioral health organization or carve-out arrangement is used to provide or administer mental health and substance use disorder benefits.

“This shared commitment to address parity reflects a reality that anyone serious about mental health reform would be hard-pressed to ignore. No matter how many providers we train, grant programs we fund or community health centers we expand, if we don’t ensure basic insurance coverage for those services, then the vast majority of working and middle-class families won’t be able to afford them.”

– Patrick Kennedy
Former U.S. Representative

- The regulations set forth mathematical rules for analyzing financial requirements and treatment limitations that are expressed numerically. For NQTLs applied to mental health or substance use disorder benefits (e.g., pre-authorization requirements, concurrent review requirements, provider reimbursement structures), the processes, strategies, evidentiary standards or other factors used to apply the NQTLs must be comparable and cannot be applied more stringently than they are applied to medical/surgical benefits.
- The Mental Health Parity and Addiction Equity Act requires plans and issuers to disclose the criteria for medical necessity determinations and the reason for any denial with respect to mental health and substance use disorder benefits.
- The law is administered by the Departments of Labor, HHS and Treasury, in collaboration with the states.
- Final regulations applying the Mental Health Parity and Addiction Equity Act to the Medicaid and CHIP programs are administered by the Centers for Medicare & Medicaid Services, in collaboration with state Medicaid and CHIP agencies.

Building on the Mental Health Parity and Addiction Equity Act, the ACA increased access to mental health and substance use disorder coverage and extended the reach of parity in several ways. The ACA established Health Insurance Marketplaces in each state. Under the ACA, coverage that is offered through the Marketplace, as well as all non-grandfathered health plans in the individual and small group markets, must cover EHBs, which include mental health and substance use disorder benefits. The regulations implementing the EHB requirements require non-grandfathered individual and small group insurance plans to offer mental health and substance use disorder benefits in accordance with the requirements of the Mental Health Parity and Addiction Equity Act.

The ACA also extended the Mental Health Parity and Addiction Equity Act to apply to the individual health insurance market and to qualified health plans offered through the Health Insurance Marketplaces in the same manner in which MHPAEA applies to group health insurance issuers and group health plans. Additionally, the ACA provided an expansion of Medicaid to cover low-income Americans aged 19-64, and required that people newly eligible for Medicaid receive a benchmark benefit or benchmark-equivalent package that includes EHBs that are provided in compliance with parity.

[The Impact of Parity](#)

The landscape for access to mental health and substance use services has markedly improved in recent years. Although other factors may have also influenced these changes, health care consumers have benefited from parity changes in tangible ways. And, while there is more work to do, employers and health plans have made progress in complying with the Mental Health Parity and Addiction Equity Act, particularly in identifying and eliminating inequities in financial and quantitative treatment limitations (like different copays or visit limits).

The percentage of adults using mental health services had been flat at 13.8 percent in the United States since 2002. MHPAEA protections took effect for large group health plans in late 2009; by 2014, the percentage of adults using any mental health service climbed to nearly 15 percent.⁶ Overall, state-level substance use disorder parity laws have helped to increase the treatment rate by approximately 9 percent

⁶ Population Data/NSDUH. <<http://www.samhsa.gov/data/population-data-nsduh/reports>>

across substance use disorder specialty facilities and by about 15 percent in facilities that accept private insurance. This effect was found to be more pronounced in states with more comprehensive parity laws.⁷

Research indicates that inpatient admissions for non-elderly adults increased by 5.9 percent for mental health disorders and 19.5 percent for substance use disorders between 2010 and 2011.⁸ Additionally, the financial burden on households associated with obtaining treatment for mental health and substance use disorders declined in 2013 and again in 2014 according to the National Survey on Drug Use and Health, with reductions in the percentage of people reporting that they did not obtain treatment because of cost.⁹

In addition, treatment rates increased for children comparing the post-MHPAEA era (2010-2012) to a pre MHPAEA period (2003-2005). Rates of outpatient mental health care for children increased from 10.6 percent in 2003-2005 to 13.3 percent in 2010-2012. For those children with the most severe impairments, treatment rates rose from 35.5 percent to 44.6 percent, which is about a 26 percent change. The increases in care were spread across both pharmacotherapies and psycho-social treatments.¹⁰

One of the main findings from the Oregon Health Insurance Experiment, a randomized controlled study designed to evaluate the impact of Medicaid in the United States, is that the prevalence of depression was lower among the individuals who received Medicaid coverage. This finding suggests that gaining insurance coverage that includes behavioral health treatments might have a positive impact on mental health outcomes.¹¹

It is highly likely that these trends will continue. A number of studies have shown evidence of positive impacts of parity protections, based on evaluations of state and federal parity legislation. Research examining the impact of parity on benefit design indicates that differences in financial requirements and quantitative treatment limitations between behavioral health and medical/surgical treatment were largely eliminated after parity implementation; restrictions on coverage such as visit limits, copays and coinsurance, and out of pocket spending limits are now generally comparable for mental health and substance use disorder treatment and medical/surgical treatments in the vast majority of large-group employer-sponsored health plans.¹² In addition, parity protections have been found to decrease out of pocket costs for mental health and substance use disorder services.¹³ This decrease in out of pocket consumer spending is not associated with an increase in health plan spending on behavioral health treatments.¹⁴

⁷ State parity laws and access to treatment for substance use disorder in the United States: implications for federal parity legislation. <<https://www.ncbi.nlm.nih.gov/pubmed/24154931>>

⁸ Issue Brief: The Impact of the Mental Health Parity and Addiction Equity Act on Inpatient Admissions. <<http://www.healthcostinstitute.org/news-and-events/issue-brief-impact-mental-health-parity-and-addiction-equity-act-inpatient-admission>>

⁹ Population Data/DSDUH. <<http://www.samhsa.gov/data/population-data-nsduh/reports>>

¹⁰ Trends in Mental Health Care among Children and Adolescents. <<http://www.nejm.org/doi/full/10.1056/NEJMsa1413512>>

¹¹ The Oregon Experiment — Effects of Medicaid on Clinical Outcomes. <<http://www.nejm.org/doi/full/10.1056/NEJMsa1212321>>

¹² 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. <<https://aspe.hhs.gov/report/consistency-large-employer-and-group-health-plan-benefits-requirements-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act-2008>>

¹³ Behavioral Health Insurance Parity for Federal Employees. <<http://www.nejm.org/doi/full/10.1056/NEJMsa053737#t=abstract>>

¹⁴ The Costs of Mental Health Parity: Still an Impediment? <<http://content.healthaffairs.org/content/25/3/623.full>>

Ensuring Compliance with Parity: Enforcing the Law

“We are keenly aware that parity is only meaningful if health plans properly implement its requirements. It’s only meaningful if consumers and providers understand how it works. And it’s only meaningful if there is appropriate oversight by both federal and state agencies.”

- Phyllis C. Borzi
Assistant Secretary of Labor of
EBSA

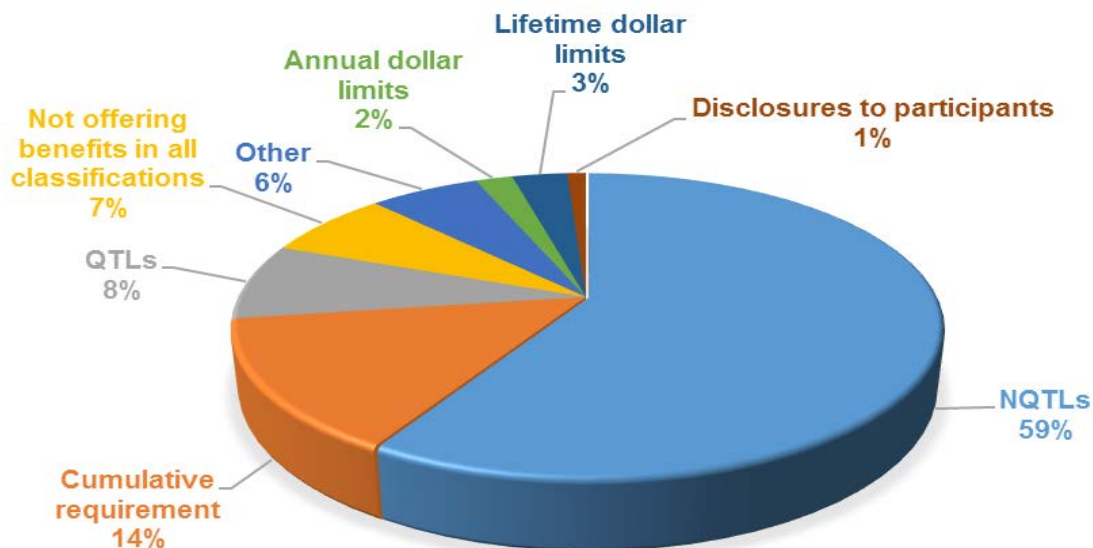
Employers and group health plans made observable changes after the Mental Health Parity and Addiction Equity Act was enacted. In 2012, an HHS MHPAEA compliance study found that most group health plans had eliminated most financial requirements that did not comport with the law.¹⁵ The study also found a substantial decrease in the number of plans and issuers imposing disparate quantitative limitations (such as inpatient day limits or outpatient visit limits) between behavioral health and medical/surgical benefits. In addition, despite fears that parity requirements would reduce behavioral health coverage, only one to two percent of employers dropped or were planning to drop behavioral health coverage. There was no evidence that any plan imposed more restrictive medical/surgical financial requirements in order to achieve parity.

Advancing compliance with parity – through monitoring and enforcement – was a critical component of the charge to the Task

Force and remains an ongoing focus of the Administration. The Administration has worked since the implementation of the Mental Health Parity and Addiction Equity Act to educate consumers, providers and plans and to investigate parity violations and enforce the law.

In accordance with the statutory requirement and to promote awareness and understanding of parity protections, the Department of Labor produces biannual Reports to Congress. The 2016 DOL Report to Congress outlines the federal investigations of employment-based plans, regulations and guidance, and outreach actions the government has taken to enforce the Mental Health Parity and Addiction Equity Act.

Figure 1. Types of Violations Found in DOL Enforcement Actions, FY 2010–2015



A text only version of Figure 1 is found at the end of this report

¹⁵ 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. <<https://aspe.hhs.gov/report/consistency-large-employer-and-group-health-plan-benefits-requirements-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act-2008>>

DOL has enforcement authority over private employer-sponsored group health plans that are subject to MHPAEA. From 2010 to 2015, DOL's Employee Benefits Security Administration (EBSA) closed over 3,000 civil investigations of health plans. Of those, 1,515 were subject to the 2008 parity law and therefore were reviewed for compliance, which resulted in citing 171 violations. Figure 1 summarizes the types of violations found by these enforcement actions.

While DOL's investigations uncovered a variety of violations involving quantitative limitations, such as impermissible visit limits on behavioral health benefits, the majority of violations identified in the investigations involved impermissible non-quantitative treatment limitations. Some of the violations DOL found included broad preauthorization requirements on all mental health and substance use disorder treatments, written treatment plan requirements that only applied to behavioral health services, and making mental health or substance use disorder treatment conditional upon its likelihood of the patient succeeding without applying a similar requirement to medical/surgical treatment. DOL brought these plans into compliance with the law and, as a result, more participants accessed the benefits to which they are entitled. DOL has also worked with several large insurance companies to remove impermissible barriers to mental health and substance use disorder benefits, ensuring that hundreds of thousands of plans are no longer imposing these requirements.

DOL also employs approximately 110 Benefits Advisors across the country to answer inquiries from and provide technical assistance to participants and beneficiaries regarding their health benefits, including the consumer protections of the Mental Health Parity and Addiction Equity Act. These Benefits Advisors are available through a toll-free hotline, through EBSA's regional office-specific phone numbers and mailboxes and through an online portal. Benefits Advisors are required to respond to any call within one business day, to online inquiries within two business days, and to mail inquiries within 30 calendar days.

In fiscal years 2010 through 2015, EBSA received 1,079 customer service inquiries related to the Mental Health Parity and Addiction Equity Act (out of approximately 1.5 million total inquiries involving Employee Retirement Income Security Act (ERISA) covered employee benefit plans). While the majority of these contacts involved questions about the routine operation of the law, others raised potentially actionable allegations of MHPAEA violations by plans that may require further investigation. Often the inquiries involved numerous contacts, plan material reviews, and conversations with health plan representatives to ensure benefits are being provided as required by the law. Benefits Advisors first seek voluntary, plan-wide correction from plans that may be in violation of the law. Issues initially fielded by EBSA Benefits Advisors may also be referred to an EBSA investigator as a lead for a potential audit of a plan. EBSA also makes efforts to work with issuers, employers and third-party administrators to correct parity violations that are identified. As DOL learns lessons from these consumer assistance and enforcement actions, they are used to inform and shape additional DOL, HHS, and Treasury subregulatory guidance.

In addition, EBSA has made parity presentations to consumers and health plan representatives in numerous states, as well as through online webcasts and stakeholder calls, to gather feedback on implementation of the Mental Health Parity and Addiction Equity Act and refine DOL's enforcement actions. Finally, EBSA has developed consumer publications, online tools, and compliance assistance materials to help enhance consumers' understanding of parity.¹⁶

HHS has direct enforcement authority with respect to the Mental Health Parity and Addiction Equity Act over group health plans for employees of state and local governments (public sector group health plans also referred to as non-federal governmental plans). HHS has investigated numerous complaints regarding the Mental Health Parity and Addiction Equity Act with respect to these plans, many of which deal with NQTLs. In the complaints where investigations led to a finding of a violation of the 2008 parity law,

¹⁶ Department of Labor: Mental Health and Substance Use Disorder Parity. <<https://www.dol.gov/ebsa/mentalhealthparity/>>

corrective action was taken by the plans to come into compliance including, where necessary, retroactive correction such as re-adjudication of claims.

With respect to health insurance issuers selling products in the individual and fully insured group markets, HHS has primary enforcement authority with respect to the Mental Health Parity and Addiction Equity Act only when a state elects not to enforce or fails to substantially enforce MHPAEA. Currently, HHS is enforcing the Mental Health Parity and Addiction Equity Act in four states: Missouri, Oklahoma, Texas and Wyoming. In those states, HHS reviews all policy forms of issuers in the individual and group markets for compliance with the 2008 parity law and other federal laws before they can be offered for sale in the states. Through this process, numerous parity issues were identified by HHS reviewers and corrected by the issuers before individuals were enrolled in the products. HHS also investigates complaints regarding issuers in those four states.

In the past year, HHS has created a market conduct examination process where health insurance issuers in states where HHS is directly enforcing and non-federal governmental plans are audited for compliance with applicable federal law. To date, five initial market conduct examinations have been initiated against entities in states where HHS is directly enforcing and against a public sector group health plan, all of which involve MHPAEA issues. HHS is working to expand its capacity for conducting market conduct examinations and will be initiating more in the future.

Parity Perspectives: Hearing from Stakeholders

President Obama gave the Task Force seven months to do its work with a final report due in October. From March to September 2016, the Task Force held multiple listening sessions, solicited written comments and feedback on the state of parity, reviewed the research on parity implementation, and synthesized findings to make its recommendations.

In total the Task Force received 1,161 comments from a variety of stakeholders including patients, families, consumer advocates, health care providers, issuers, state regulators, and others, on their experience with mental health and substance use disorder parity requirements. The listening sessions focused on such topics as the existing barriers to parity; gaps in guidance on parity; and the role of different stakeholders in improving compliance and implementing parity.

A diverse community of stakeholders from across the country generously provided input to the Task Force. Over half of the comments—596 in total—were provided by consumers (269 comments), friends and relatives of consumers who use or are in need of mental health and substance use disorder services (229 comments), and consumer advocates (98 comments). Providers and provider organizations submitted 40 percent of the comments (498 comments). The remaining 134 comments were submitted by a variety of other stakeholders, including Members of Congress, health insurance officials, benefits managers, and researchers.

The major themes that were raised in the listening sessions were echoed in the written comments, including: parity as a critical health care issue, parity awareness and education, quantitative treatment limitations (QTLs), non-quantitative treatment limitations (NQTLs), appeals and disclosure, and enforcement. The majority of the comments were focused on parity issues for both group health plans and health insurance issuers. Similar themes have been raised related to Medicaid, but they may not have been a primary focus in comments to the Task Force because the compliance deadline for Medicaid programs is still nearly a year away.

Several commenters mentioned challenges related to obtaining and paying for mental health and substance use care services. These issues are not directly about parity implementation but they are important to understanding the context within which parity plays out.

Commenters took great care in providing detailed comments within each of these seven categories. Some highlights are featured below:

Parity as a Critical Health Care Issue

- Stakeholders re-affirmed many times that parity is a critical issue, and successful implementation is vital for consumers, providers, issuers, and regulators.
- Stakeholders felt that it is a historic time for the transformation of health care thanks to the ACA and this Administration's efforts and ongoing focus on mental health and substance use disorder parity should continue to be a priority.

Awareness and Education

- Commenters value the progress that has been made on parity issues, but there is still a need to improve parity awareness. The issue of awareness of parity requirements was raised most often in reference to

QTLs and NQTLs, the appeals process for claims denials, and disclosure requirements for plans and insurers.

- Commenters expressed that people having trouble accessing mental health and substance use disorder care do not know how to determine if their parity rights are being violated and they don't know where to turn for help figuring this out. Stakeholders recommended that the federal government help clarify what is covered under health insurance plans and require plans to be more transparent.

“So much more needs to be done to educate the public about what parity is and how to know if their health plan is compliant with the parity rules.”

– Public comment

- There is a general lack of awareness of the need for mental health and substance use disorder services, and in particular the need for services related to certain conditions such as eating disorders, autism spectrum disorder, and substance use disorders. At one of the Task Force listening sessions, insurance regulators from three states with large rural populations noted that in their states, the belief that mental health and substance use disorder issues are true medical issues was still evolving. They believed that this culture leads to automatic denial for many mental health and substance use disorder insurance claims. Representatives noted that this culture is especially problematic given the high suicide and opioid overdose rates observed in these states.

Financial Requirements and Quantitative Treatment Limitations (QTLs)

- Stakeholders noted the significant progress in parity for financial requirements and quantitative treatment limitations; the disparities between mental health and substance use disorder coverage and medical/surgical coverage co-pays and other quantitative limitations have significantly diminished.
- The two main stakeholder groups that discussed QTLs the most were insurance issuers and states. Insurance issuers commented that there is evidence that large group plans on the whole met parity requirements and that many did so before the passage of the Mental Health Parity and Addiction Equity Act. Consumer groups, such as those representing people with autism, noted that there still may be some outstanding concerns with QTLs. State insurance representatives agreed with issuers and noted that, since parity legislation had passed, they have observed issuers harmonizing the cost-sharing percentages for behavioral health with medical treatment.
- While progress has been made on achieving parity in QTLs, there is still room for improvement, particularly with regard to EHB base benchmark plans and what constitutes a mental health condition or substance use disorder.

Non-Quantitative Treatment Limitations (NQTLs)

- Building on the progress toward parity in quantitative treatment limitations, stakeholders noted the need for further attention to non-quantitative treatment limitations. NQTLs were a common issue raised in all of the listening sessions and also in submitted comments; many of these commenters were concerned that plans and issuers were not complying with NQTL requirements.
- Stakeholders from the regulated community stressed that plans and issuers need more guidance on what they are required to do to determine compliance with parity requirements for NQTLs. Parity in NQTLs can be difficult to assess because NQTLs are often not listed in plan documents and because

comparisons of coverage restrictions and care management strategies between mental health/substance use disorder and medical/surgical benefits are complex.

- Commenters focused on four common forms of NQTLs: prior authorization, utilization review, “fail first” or step therapy, and reimbursement rates:
 - *Prior authorization* means the consumer must get approval from the plan or issuer before a service or medication is covered. Some commenters provided examples of how prior authorization is applied differently to mental health and substance use disorder services compared to general medical services. Others said prior authorization forms are long and burdensome, especially for small practices.
 - *Utilization review* requires that the plan or insurer or an external panel of providers assess a course of treatment or services to determine if it is medically necessary and merits coverage, typically after or during the episode of care. Many commenters believed this review process is imposed more frequently or stringently on mental health and substance use disorder treatment.
 - “*Fail first*” or *step therapy* applies when there are several alternative services or medications to treat a given condition. The plan or issuer establishes an order in which services or medications must be used in order to have the services covered. The consumer is required to seek treatment initially with one service or medication and then move to the next service or medication in the sequence if the outcome of the initial service or medication is unsatisfactory. Commenters expressed concern about fail first policies for benefits --such as residential treatment and medications -- being applied differently for mental health and substance use disorder benefits than medical/surgical benefits.
 - *Provider reimbursement rates* are among the factors for inclusion in provider networks that are considered NQTLs. Commenters raised concerns at several listening sessions and in many written comments about the way reimbursement rates for mental health and substance use disorder providers are determined, resulting in reimbursement rates for mental health and substance use disorder services that may be lower than for medical/surgical services.

Appeals and Disclosure

- One key theme from stakeholders related to plans’ appeals and disclosure practices when consumer claims for mental health and substance use disorder treatment are denied. Stakeholders asserted that more guidance is needed on what plans and issuers are required to disclose to consumers, providers, and regulators. Some stakeholders noted that, compared to claims for medical/surgical care, they believed that a disproportionate number of claims for mental health and substance use disorder care seem to be denied by issuers and group health plans.
- An additional theme was ensuring the right to full disclosure of information to consumers while ensuring that consumers receive information in understandable and usable ways, without overly burdening plans and issuers.
- During the listening sessions and in written comments, several people commented that enforcement hinges on plan disclosure. Commenters also noted that the response from plans and issuers to parity disclosure requests varies.

- Some commenters thought further guidance on disclosure requirements might focus on ensuring that clear and straightforward information is provided to consumers. Stakeholders noted that in some cases, consumers and their families do not know what to do when a claim is denied or they suspect a parity violation. Commenters suggested that the federal government already has effective tools available for receiving other types of complaints that could be adapted for parity: one example was the web-based complaint reporting tool used by agencies to report workplace safety-related concerns to the Occupational Health and Safety Administration.

Enforcement

- Commenters noted that it is important to identify areas of noncompliance with parity and fully enforce MHPAEA regulations. States are on the front line of implementing parity efforts with respect to health insurance issuers. State regulators face the challenge of training and educating staff in all relevant state agencies on the implications of parity. The parity laws and regulations are complex, and these training efforts can be time-consuming and costly. State regulators said that further guidance from the federal government on education and training state staff would be appreciated.
- Multiple stakeholders across several listening sessions said that more resources are needed for enforcement at the state level. One stakeholder noted that this would be especially useful as states work to integrate the federal parity requirements with their existing state regulations.
- Plans and issuers said that they need more guidance on what they are required to do to determine compliance with parity requirements for NQTLs. For example, they need guidance on non-quantitative treatment limitations and other medical management practices on the medical/surgical side to enable comparisons to be made to what is applied on the behavioral health side.
- State insurance regulators also mentioned that additional compliance checklists or tools on how to review insurance plans before and after approval for sale would be helpful. They also asked that current tools be improved with input from states.
- Several stakeholders suggested that random audits might be an effective enforcement method, although some recognized that with limited resources, enforcement activities currently prioritize following up on complaints.

“The need for an educated and seasoned workforce stems not only from demand, but high turnover rates, a shortage of professionals, aging workers and low compensation. And with the advent of the Mental Health Parity and Addiction Equity Act and the Affordable Care Act services for [behavioral health care] must be covered just as other medical care is.”

- “Building the Behavioral Workforce,” SAMHSA.

Relevant Mental Health & Substance Use Disorder Issues Not Directly Related to Parity Implementation

- There is more to ensuring access to quality mental health and substance use disorder care than parity in health coverage. Some commenters raised issues about behavioral health services more generally – the landscape behind parity implementation.

- Although it is not directly a parity issue, a larger issue that many stakeholders raised is that coverage and parity do not automatically lead to access. Issuers, providers, and state representatives agreed that there are significant shortages of providers in the behavioral health field. These shortages may be particularly acute for psychiatrists and clinical social workers as well as for addiction care providers. Over 300 written comments from consumers referenced their personal difficulties in finding mental health and substance use disorder providers in their area.
- The workforce shortage is exacerbated, according to some commenters, by mental health and substance use providers opting not to join a health plan network due to lower reimbursement rates than they could receive from cash payment. One issuer representative noted that, despite having one of the largest behavioral health provider networks in the country, one of the primary complaints received is the lack of access to care. It is important to note that while workforce shortages are not a parity issue, a plan's processes and standards for provider inclusion in the network and provider rate setting are parity issues.
- To address the workforce shortage, many stakeholders recommended finding ways to incentivize a new generation of behavioral health professionals, to help improve access to care.
- Another issue mentioned by many commenters was the need for more awareness of the importance of using evidence based treatments, especially for substance use disorders.

“Because parity is an abstract concept, most people have little understanding of it. We need public interest messaging and brochures that explain parity in layman’s terms...”

- Public comment

Actions Taken with Task Force Input

President Obama charged the Task Force with developing recommendations to advance understanding and enforcement of parity, but he also directed the Task Force to lead the way by implementing actions during its tenure to advance parity in mental health and substance use disorder coverage. It quickly became apparent to Task Force members and stakeholders that there were a number of immediate actions that could be taken. The listening sessions, meetings and comments provided essential grounding to the members of the Task Force and the input is reflected in the following examples of significant *indicators of progress*, listed below under each of the President's three charges.

Education and Awareness

The Mental Health Parity and Addiction Equity Act can be difficult to understand; yet consumers must know what their rights are and how to raise questions and concerns. In June 2016, HHS and DOL jointly released a pamphlet for consumers entitled *Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits*¹⁷, outlining the basic protections guaranteed by the Mental Health Parity and Addiction Equity Act and the basic consumer rights to transparency and appeals.

Clarifying Parity Requirements

Achieving consistency in the implementation of parity requirements across all markets and expanding the parity protections to cover the greatest number of individuals is an important goal. In March 2016, the Centers for Medicare & Medicaid Services (CMS) within HHS released a final rule to align the mental health and substance use disorder coverage benefits offered by managed care organizations and ABPs in Medicaid and the Children's Health Insurance Program (CHIP) with the parity protections required of the commercial market, improving access to mental health and substance use disorder services for an estimated 23 million beneficiaries.¹⁸ In conjunction with the release of the final rule, CMS also released Frequently Asked Questions (FAQ)¹⁹ and hosted a webinar to detail the parity protections in the final rule.

Improving Compliance, Monitoring, and Enforcement

States play an important role in implementing and enforcing parity with respect to the individual and small group markets. Some states have developed promising practices that would provide a useful model for other states to follow. In August 2016, SAMHSA released an issue brief highlighting best practices from state insurance commissioners with regard to implementing MHPAEA and monitoring and enforcement efforts to ensure compliance.²⁰ The report outlines promising practices from the following states: California, Connecticut, Maryland, Massachusetts, New York, Oregon, and Rhode Island.

¹⁷ Department of Labor: Mental Health and Substance Use Disorder Parity. <https://www.dol.gov/ebsa/mentalhealthparity/>

¹⁸ CMS finalizes mental health and substance use disorder parity rule for Medicaid and CHIP. <<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-03-29.html>>

¹⁹ Medicaid: Behavioral Health Services. <<http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.html>>

²⁰ Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA). <<http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>>

As the departments learn more about NQTL compliance through investigations, in the spirit of transparency and to help plans and issuers comply, the departments worked to release information regarding the provisions that tend to operate as red flags for NQTL compliance. As understanding of parity increases, there is an immediate need to get the facts out on non-quantitative treatment limitations. As a supplement to the DOL compliance checksheet that DOL releases to assist plans and issuers in achieving parity compliance, in June 2016, DOL and HHS published Warning Signs—Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance,²¹ a brief guide for consumers, issuers, state regulators and other stakeholders outlining example provisions from health insurance plans that could be “red flags” which require careful analysis in order to ensure MHPAEA NQTL compliance.

²¹ Department of Labor: Mental Health and Substance Use Disorder Parity. <<https://www.dol.gov/ebsa/mentalhealthparity/>>

Actions & Recommendations

Based on input and feedback received from diverse stakeholders throughout the Task Force's tenure, the Task Force presents the following recommendations as a roadmap for future efforts to improve understanding of parity protections, clarify parity requirements, and improve monitoring and enforcement efforts. Given the President's charge to take actions in a timely way, the Task Force is not only making recommendations, but taking initial steps to implement as many of these recommendations as possible, as described below. These recommendations, particularly those related to suggested statutory changes, are subject to future budget and policy deliberations.

Supporting Consumers

- **Create a one-stop consumer web portal to help consumers navigate parity:** Throughout the Task Force's listening sessions with consumer groups and advocates, as well as in the public comments submitted to the Task Force, many stakeholders pointed to the challenge consumers face in understanding their parity rights and in knowing how to exercise these rights. In particular, stakeholders noted how complicated it can be to find the right entry point for assistance, especially when it is often less than clear to consumers whether their insurance is regulated at the state or federal level, or which regulatory body is responsible for their particular coverage. Commenters pointed to the need for a one-stop parity Web site that will help consumers get to the correct resource to help them solve their coverage issue, file a complaint, or submit an appeal, as necessary. The Task Force recommends the creation of such a consumer portal.
 - **Today's step:** The Task Force recognizes that fully implementing this recommendation will require time and resources; however, as an initial step; today, it is releasing a beta version of a **Consumer Web Portal** that will help drive consumers to the appropriate agency and resources for parity complaints, appeals and other actions. HHS is optimizing search terms to help consumers find and use this resource to connect to the appropriate federal or state regulatory body to assist with their mental health or substance use disorder benefit concerns. This resource creates a starting point for future efforts to build out additional functionality such as complaint tracking.

- **Provide simplified disclosure tools to provide consistent information for consumers, plans and issuers.** One of the first actions of the Task Force was the issuance of guidance, in the form of frequently asked questions, defining the documents and plan information that must be made available upon request to consumers and their providers. Task Force listening sessions made clear that the documentation associated with the processes, strategies, evidentiary standards, and other factors used to inform health plans determinations about mental health and substance use disorder benefits can be considerable. Employer-sponsored ERISA group health plans have a legal obligation to disclose fully responsive information when requested. The Task Force also is aware that consumers may not know what information to request or which specific information would best respond to their particular questions or circumstances. Commenters suggested that templates could be developed in coordination with the National Association of Insurance Commissioners (NAIC) to provide user friendly tools for consumers or their providers to best identify the information they are seeking. To facilitate disclosure, the Task Force recommends that, in coordination with NAIC, templates and other sample standardized tools be developed to improve consumer access to plan information.
 - **Today's step:** To begin to implement this recommendation, the Departments of Health and Human Services (HHS), Labor and Treasury are requesting comments in FAQs about ACA

Implementation and MHPAEA, Part 34, **soliciting feedback on how the disclosure request process can be improved and streamlined**, while continuing to ensure consumers' rights to access all appropriate information and documentation. In particular, **the FAQ asks about the development of model forms for disclosure requests**. Comments are being sought by January 3, 2017.

- **Expand consumer education about parity protections:** During the tenure of the Task Force, a consumer-friendly brochure was released by SAMHSA and DOL, as described above. The brochure, entitled *Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits*,²² aims to increase awareness among consumers of their parity rights under the Mental Health Parity and Addiction Equity Act. The federal government will continue to work in partnership with states and other stakeholders to increase consumer awareness and understanding of parity protections and seek out opportunities to distribute the brochure through additional dissemination avenues. On May 26, 2016, EBSA conducted a webcast that provided important information about MHPAEA to help consumers understand the law. This included information to consider when submitting a mental health or substance use disorder claim, including consumers' rights to disclosure and to appeal and how EBSA's enforcement efforts have helped consumers get the benefits they deserve. The Task Force recommends continuing and expanding the work to educate consumers about parity and partnering with consumer groups in this work.
 - **Today's step:** The Task Force recognizes the need for consumer friendly materials to improve consumer awareness of parity protections. Today, in conjunction with the Task Force report, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Labor are releasing a **Consumer Guide to Disclosure Rights**. Consumer groups have long observed that people do not always know what type of information to ask for when attempting to understand if their plan is in compliance with parity. The guide provides a user-friendly tool to explain the various federal disclosure laws affecting private sector employer-sponsored group health plans and issuers.

Improving Parity Implementation

- **Update guidance to address the applicability of parity to opioid use disorder services.** Despite significant national efforts to combat the prescription opioid and heroin epidemic, commenters noted that health plans may not be consistently applying parity to coverage of the treatment of opioid use disorders, including coverage of FDA-approved medications to treat these disorders. The Task Force recommends the issuance of guidance clarifying the application of parity to opioid use disorder treatment benefits and to address specific scenarios associated with these benefits raised by consumers. Further, the Task Force recommends regularly updating this guidance as warranted.
 - **Today's step:** In conjunction with Task Force report, the HHS, Labor and Treasury are issuing sub-regulatory guidance in the form of **Frequently Asked Questions on Parity and Opioid Use Disorder Treatment** and addressing specific questions related to issues such as opioid treatment access, coverage of court-ordered treatment and how to seek help with your mental health and substance use disorder benefits from the federal government.
- **Implement the Medicaid and Children's Health Insurance Program parity final rule in a timely manner.** Technical assistance will be provided to state Medicaid and CHIP agencies as they implement parity in their programs. Written materials will include a parity analysis toolkit to help states assess

²² Department of Labor: Mental Health and Substance Use Disorder Parity. <<https://www.dol.gov/ebsa/mentalhealthparity/>>

compliance with the final rules on parity for Medicaid and CHIP programs, including key considerations for defining and classifying mental health/substance use disorder benefits (including intermediate and long term supports and services), conducting claims-based analyses for QTLs, identifying and analyzing NQTLs, assessing availability of information requirements, and special considerations for Alternative Benefit Plans and CHIP. The toolkit will be accompanied by a parity implementation roadmap intended to provide state Medicaid and CHIP policymakers with an overview of how to approach parity implementation and compliance from a planning and operations perspective. Direct assistance for specific questions on parity implementation will also be available in 2017, and additional factsheets may be developed as needed.

- **Conduct a thorough review of how parity principles apply in Medicare.** Medicare has taken steps to improve equity in cost sharing for outpatient mental health visits, but work remains. Recent reviews of Medicare Advantage plan benefits have shown that cost sharing for mental health services is on par with cost sharing for other health services. We will undertake a review of mental health and substance use disorder benefits in Medicare Advantage plans and identify any necessary improvements to advance parity protections.

“The final MHPAEA regulations have created a strong legal framework, but more detailed federal guidance to issuers and state regulators, including insurance departments and Medicaid agencies, is needed.”

– Public comment

- **Strengthen parity in Medicare Part A benefits:** As indicated above, Congress took action in 2008 to eliminate the disparity in the Part B coinsurance in mental health and substance use disorder benefits so that by 2014, the coinsurance in Part B for mental health and substance use disorder coverage was the same as for medical coverage. In Part A, however, there still remains a 190 day lifetime limit on inpatient treatment in psychiatric hospitals while there is no such limit on inpatient medical/surgical hospital treatment. The Task Force recommends that the Administration continue to request that Congress eliminate the lifetime day limit on treatment in psychiatric hospitals, as it did in the 2017 budget.
- **Expand access to mental health and substance use disorder services in TRICARE.** While the requirements of the Mental Health Parity Act of 1996 and MHPAEA and ACA do not apply to the TRICARE program, which is governed by separate set of statutes, the Department of Defense (DOD) fully supports the principle of parity. DOD published a final rule on September 2, 2016, modifying regulations regarding the TRICARE mental health and substance use disorder treatment benefit to be consistent with the principles of parity, eliminating unnecessary quantitative and non-quantitative treatment limitations on substance use disorder and mental health benefit coverage and aligning beneficiary cost-sharing for mental health and substance use disorder benefits with those applicable to medical/surgical benefits. A TRICARE contract modification change order has been issued to ensure that removal of quantitative limits on mental health and substance use disorder care and removal of differential cost-shares and co-pays were effective on October 3, 2016. In the year ahead, DOD will publish additional TRICARE contract modifications to advance implementation of this rule and monitor access to mental health and substance use disorder care to ensure parity with medical/surgical care.

Enhancing Parity Compliance and Enforcement

- **Provide federal support for state efforts to enforce parity through trainings, resources and new implementation tools.** Federal and state agencies must work together to ensure that the promise of parity is fully realized for consumers. As described above, one of the products that the Task Force released during its tenure is a white paper called **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**. To identify key strategies for advancing parity oversight and compliance, SAMHSA developed the paper based on interviews with state insurance commissioners and their staff. A Task Force listening session with state insurance regulators highlighted the need for additional support in training state staff to review plans for parity compliance and enforcement as well as the importance of ongoing federal-state collaboration in implementing parity. The Task Force recommends continued federal efforts to provide training and other resources to states to support compliance efforts including partnerships between state mental health/substance use, Medicaid and state insurance departments. Further, the Task Force recommends that federal regulators work with the National Association of Insurance Commissioners (NAIC) and the states to develop a standardized template that states might use to help assess parity compliance. Some states, such as California, have developed such templates, and stakeholders suggested that such a tool would be a useful model for other states. In addition, the Task Force encourages federal regulators, NAIC, and other stakeholders to consider a joint effort to develop a model prior authorization form and other model forms.

Today's steps:

- To help support states' role in parity implementation, the Centers for Medicare & Medicaid Services (CMS) is announcing it will be making grants totaling **\$9.3 million to States to support parity implementation**. CMS funding is intended to help state insurance regulators work to ensure issuer compliance with key Affordable Care Act consumer protections, including parity in mental health and substance use disorder benefits.
 - SAMHSA is announcing that it will host two **State Policy Academies on Parity Implementation for State Officials** in Fiscal Year 2017. These policy academies are a unique opportunity to bring together national experts to conduct technical assistance for teams of state officials on strategies to advance parity compliance and lessons learned from other states' implementation efforts. One of the academies will focus on advancing parity compliance in the commercial market, and the other will focus on parity in Medicaid and the Children's Health Insurance Program.
 - To provide a single resource of parity guidance, today, DOL, HHS and Treasury are issuing a **Compliance Assistance Materials Index**. The Departments have issued a total of 44 Frequently Asked Questions (FAQs) over the past six years related to parity, generally as part of larger guidance documents, as well as other materials. Several commenters suggested that putting all the parity-related FAQs and guidance together in one place would be make the information easier to find and use.
- **Develop additional examples of parity compliance best practices and of potential warning signs of non-compliance.** As described above, the Departments of Labor and HHS released a "**Warning Signs**" document in May 2016 identifying non-quantitative treatment limitations (NQTLs) that require additional analysis to determine if they are in compliance with parity, e.g., blanket preauthorization requirements that apply to all mental health and substance use disorder services. The document noted that the "warning signs" were meant to identify plan provisions that likely require additional review to ensure that these types of limitations are similarly applied to medical and surgical benefits in the plan.

The Task Force heard from stakeholders about the value of this document and also about the potential usefulness of illustrations or case studies of appropriate implementation of non-quantitative treatment limitations, such as key strategies that demonstrate effective compliance. The Task Force recommends the development of a “Warning Signs 2.0” document to address additional potentially problematic non-quantitative treatment limitations and well as the development of a similar document illustrating appropriate application of comparable non-quantitative treatment limitations and other actions that would reflect best practices in compliance with parity. The Task Force recommends the Departments consider the inclusion of network adequacy issues in the development of these documents, given the considerable feedback it received on this topic throughout its work. Further, the Task Force emphasizes the importance of balancing best practices for compliance with identifying and remediating violations.

- **Increase federal agencies’ capacity to audit health plans for parity compliance.** Given current resources, federal parity enforcement efforts to date have generally focused on investigating consumer, provider and other parity complaints rather than doing random audits. Agencies’ capacity to expand enforcement activities, including conducting random audits, is limited by their staffing resources. The Task Force recommends that agencies’ future budgets include funding to expand audit capacity.
- **Allow the Department of Labor to assess civil monetary penalties for parity violations.** Under current law, the penalties for parity violations under ERISA limit the relief that can be obtained by the Department in its investigations. Civil monetary penalty authority would lead to more meaningful penalties for non-compliance, which would be expected to incentivize compliance. The Task Force recommends that Congress provide the Department of Labor with this authority.
- **Clarify that health plan disclosure requirements include medical and surgical benefits:** As noted above, DOL, HHS and Treasury issued sub-regulatory guidance (FAQ #31, Question 9) clarifying the information a provider acting as an authorized representative for a participant may request from an ERISA group health plan to assist in evaluating the plan’s compliance with the Mental Health Parity and Addiction Equity Act. Commenters from both consumer groups and behavioral health plans noted that it can be challenging to ensure parity compliance when the processes, strategies, evidentiary standards, and other factors used to apply limitations on medical and surgical benefits are not readily available to allow for comparison to mental health and substance use disorder benefits. Disclosure of the processes, strategies, evidentiary standards, and other factors used to apply limitations to medical and surgical services is currently required for ERISA plans. The Task Force recommends that Congress extend this requirement to non-ERISA plans.
- **Eliminate the HIPAA opt-out process for self-funded non-federal governmental plans:** Currently, self-funded non-federal governmental plans have the ability to elect to not comply with certain federal provisions including the Mental Health Parity and Addiction Equity Act, which deprives thousands of employees of state and local governments of the mental health and substance use disorder parity protections. The Task Force recommends that Congress eliminate the ability of these plans to opt out of these critical consumer protections.
- **Release data annually on closed federal parity investigations, results and violations.** Since October 2010, the Employee Benefits Security Administration has conducted 1,515 investigations related to the Mental Health Parity and Addiction Equity Act and cited 171 violations. In one example, EBSA helped a person whose plan imposed different copayment amounts and coverage levels on mental health benefits than on medical/surgical benefits. EBSA staff determined the plan was not in compliance with the law. As a result, the plan was amended, claims were reprocessed, and \$59,000 in previously denied benefits were paid. From 2010-2015, the Department of Labor reports that parity violations for

non-quantitative treatment limitations were far more common than violations of the quantitative treatment limitation requirements. The Task Force recommends and the Department of Labor has committed to annually releasing information on investigations and public reporting of the findings as well as violations cited to ensure compliance and inform future policymaking efforts. The Task Force also recommends that the Department of Health and Human Services provide annual information on investigations and public reporting of the findings as well as violations cited to ensure compliance and inform future policymaking efforts.

- **Ensure parity compliance in state essential health benefit benchmark plans:** Commenters noted that the EHB benchmark plans in some States did not comply with the Mental Health Parity and Addiction Equity Act. Because EHB benchmark plan benefits are based on plans that were sold in 2012 (for plans in 2014-2016) or 2014 (for plans in 2017), some of the benchmark plan designs may not comply with current federal requirements, including the Mental Health Parity and Addiction Equity Act. However, as described in HHS regulations at 45 CFR 156.115(a)(3), plans subject to the EHB requirements must comply with the standards implemented under the Mental Health Parity and Addiction Equity Act, including standards that are effective in the 2017 plan year. CMS has added Mental Health Parity and Addiction Equity Act compliance to its review of plans subject to the EHB requirement and expects state regulators to do so as well.
- **Review substance use disorder benefits in FEHBP.** Federal Employees Health Benefits Program insurance carriers have made significant strides toward ensuring parity in mental health and substance use disorder benefits. Commenters noted that non-quantitative treatment limits may still need examination and modification to ensure full compliance, and consistent definitions of terms relating to residential treatment would provide greater transparency for consumers. In the coming year, the US Office of Personnel Management will undertake a detailed review of NQTLs applicable to substance use disorder benefits, and take corrective action as indicated by the findings.

Moving Forward

President Obama's call to action in establishing the Mental Health and Substance Use Disorder Parity Task Force demonstrates the Administration's ongoing commitment to ensuring that people with mental health and substance use disorders receive the care they need. Over seven months, the Task Force benefited from the views and experiences of a vast and diverse community of consumers, providers, plans, employers, state officials, and others. While the Administration had made substantial progress in creating the framework for parity through the issuance of regulations and guidance, the direction from President Obama increased the pace of progress and enabled several important concrete steps to be taken and new actions to be identified. Equally important, the work of the Task Force provides a road map for moving forward and serves as the basis for setting additional goals for future progress.

"...Thank you for your continuing work to ensure equal coverage of and meaningful access to mental health and substance use disorder care...The federal MH/SUD parity law and the ACA present the greatest opportunities our nation has ever had to dramatically improve access to care for these diseases..."

- Public Comment

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

March 29, 2016

March 29, 2016

MEMORANDUM FOR THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

SUBJECT: Mental Health and Substance Use Disorder
Parity Task Force

My Administration has made behavioral health a priority and taken a number of steps to improve the prevention, early intervention, and treatment of mental health and substance use disorders. These actions are especially important in light of the prescription drug abuse and heroin epidemic as well as the suicide and substance use-related fatalities that have reversed increases in longevity in certain populations. One important response has been the expansion and implementation of mental health and substance use disorder parity protections to ensure that coverage for these benefits is comparable to coverage for medical and surgical care. The Affordable Care Act builds on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act to expand mental health and substance use disorder benefits and Federal parity protections for more than 60 million Americans. To realize the promise of coverage expansion and parity protections in helping individuals with mental health and substance use disorders, executive departments and agencies need to work together to ensure that Americans are benefiting from the Federal parity protections the law intends. To that end, I hereby direct the following:

Section 1. Mental Health and Substance Use Disorder Parity Task Force. There is established an interagency Mental Health and Substance Use Disorder Parity Task Force (Task Force), which will identify and promote best practices for executive departments and agencies (agencies), as well as State agencies, to better ensure compliance with and implementation of requirements related to mental health and substance use disorder parity, and determine areas that would benefit from further guidance. The Director of the Domestic Policy Council shall serve as Chair of the Task Force.

(a) Membership of the Task Force. In addition to the Director of the Domestic Policy Council, the Task Force shall consist of the heads of the following agencies and offices, or their designees:

- (i) the Department of the Treasury;
- (ii) the Department of Defense;
- (iii) the Department of Justice;
- (iv) the Department of Labor;

- (v) the Department of Health and Human Services;
- (vi) the Department of Veterans Affairs;
- (vii) the Office of Personnel Management;
- (viii) the Office of National Drug Control Policy;
and
- (ix) such other agencies or offices as the President may designate.

At the request of the Chair, the Task Force may establish subgroups consisting exclusively of Task Force members or their designees under this section, as appropriate.

(b) Administration of the Task Force. The Department of Health and Human Services shall provide funding and administrative support for the Task Force to the extent permitted by law and within existing appropriations.

Sec. 2. Mission and Functions of the Task Force. The Task Force shall coordinate across agencies to:

- (a) identify and promote best practices for compliance and implementation;
- (b) identify and address gaps in guidance, particularly with regard to substance use disorder parity; and
- (c) implement actions during its tenure and at its conclusion to advance parity in mental health and substance use disorder treatment.

Sec. 3. Outreach. Consistent with the objectives set out in section 2 of this memorandum, the Task Force, in accordance with applicable law, shall conduct outreach to patients, consumer advocates, health care providers, specialists in mental health care and substance use disorder treatment, employers, insurers, State regulators, and other stakeholders as the Task Force deems appropriate.

Sec. 4. Transparency and Reports. The Task Force shall present to the President a report before October 31, 2016, on its findings and recommendations, which shall be made public.

Sec. 5. General Provisions. (a) The heads of agencies shall assist and provide information to the Task Force, consistent with applicable law, as may be necessary to carry out the functions of the Task Force.

- (b) Nothing in this memorandum shall be construed to impair or otherwise affect:
 - (i) the authority granted by law to an executive department, agency, or the head thereof; or
 - (ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(c) This memorandum shall be implemented consistent with applicable law and subject to the availability of appropriations.

(d) This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(e) The Secretary of Health and Human Services is authorized and directed to publish this memorandum in the *Federal Register*.

BARACK OBAMA

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Text Only Version of Figure 1

Pie chart depicting the types of violations found in DOL enforcement actions, FY 2010-2015. The chart is divided into the following slices:

- NQTLs - 59%
- Cumulative requirement - 14%
- QTLs - 8%
- Not offering benefits in all classifications - 7%
- Other - 6%
- Lifetime dollar limits - 3%
- Annual dollar limits - 2%
- Disclosures to participants - 1%

