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MENTAL HEALTH PARITY FAQS ADDRESS NONQUANTITATIVE LIMITS, DISCLOSURES

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In This Article

Recent guidance to help health plans comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) includes a set of FAQs and a model disclosure request form. Issued Sept. 5 by the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury, the final FAQs and optional form have few changes from the proposed FAQs and revised draft form released last year. Employers should use the FAQ guidance in their own parity analyses and prepare for responding to parity disclosure requests. Although the latest DOL enforcement fact sheet shows an overall decrease in MHPAEA investigations and violations from 2017 to 2018, failure to comply with nonquantitative treatment limitations (NQTLs) account for a growing share of violations and increasing litigation.

PARITY BASICS

Under the MHPAEA, self-funded and fully insured group health plans that cover mental health conditions and substance use disorders (MH/SUD) must provide those benefits at the same level as medical and surgical (M/S) benefits. The Affordable Care Act (ACA) expanded on MHPAEA by including MH/SUD benefits as one of the 10 essential health benefits (EHBs) that all individual and small-group health insurance plans must cover and requiring parity compliance.

Retiree-only plans, plans offering just excepted benefits, and self-insured plans sponsored by small employers (50 or fewer employees) are exempt from the law. Self-insured state or local government plans can opt out of compliance by taking certain administrative steps, such as sending notice to enrollees. In addition, any plan may request a temporary exemption if initial compliance costs exceed certain levels. Similar but separate MHPAEA regulations apply to Medicaid and the Children's Health Insurance Program, but those rules are not discussed in this GRIST.

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Types of Parity Required

To meet the parity standards, a health plan's financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket limits) and quantitative treatment limitations (such as annual, episode or lifetime limits on treatment days or visits) for MH/SUD benefits must be no more restrictive than the predominant requirements that apply to substantially all M/S benefits in a classification. In addition, a plan cannot impose an NQTL (such as medical-management standards, formulary or network tiers, or provider reimbursement criteria) for MH/SUD benefits in a classification, unless under the plan's written terms and actual operations, any processes, strategies, evidentiary standards or other factors used to apply the NQTL are comparable to and applied no more stringently than the ones used for M/S benefits in the same classification.

Application of Parity Protections

This parity requirement applies separately within each of six classifications:

- Inpatient, in-network benefits
- Inpatient, out-of-network benefits
- Outpatient, in-network benefits
- Outpatient, out-of-network benefits
- Prescription drug benefits
- Emergency benefits

Health plans can exclude all treatments and services related to a particular MH/SUD condition or all MH/SUD conditions. But if a plan covers a MH/SUD condition in any of the above classifications, it must provide coverage in all of the classifications in which M/S benefits are available.

Plans can treat office visits as a separate subclass of outpatient services, and plans with multiple tiers of in-network providers can treat the tiers as subclasses for financial (but not NQTL) parity requirements if certain requirements are met. Multi-tiered prescription drug benefits are permissible if based on reasonable factors and without regard to whether a drug is generally prescribed for M/S or MH/SUD conditions. Reasonable factors include cost, efficacy, generic vs. brand name, and mail-order vs. pharmacy pick-up.

Required Disclosures

Under the MHPAEA, health plans must disclose the criteria used for medical-necessity determinations about MH/SUD benefits to any current or potential participant, beneficiary or contracting provider requesting this information. Plans must also provide the reason for any denied MH/SUD reimbursement or payment for services to participants and beneficiaries.

In addition, ERISA's requirement to furnish the instruments under which the plan is established or operated within 30 days of a plan participant's request can support a parity inquiry. Participants are entitled to any

plan documents describing procedures, formulas, methodologies or schedules applied to determine or calculate a benefit. On request, plans must supply documents reflecting the processes, strategies, evidentiary standards and other factors used to apply an NQTL. Under ERISA's claim and appeal rules, claimants (or their authorized representatives) appealing an adverse benefit determination (or a final internal adverse benefit determination) can request reasonable access to — and free copies of — all documents, records and other information relevant to the denied claim. Most of these ERISA claims rules also apply to all insurance issuers under the ACA's internal claims review requirements.

Under both MHPAEA and ERISA, required disclosures include the plan's medical-necessity criteria for M/S and MH/SUD benefits, as well as the processes, strategies, evidentiary standards and other factors used to apply an NQTL.

SCOPE OF NEW GUIDANCE

The latest FAQs, model disclosure request form and enforcement summary respond to an ongoing mandate under the 21st Century Cures Act of 2016. The Cures Act requires the agencies to improve federal and state coordination of MHPAEA enforcement and to provide clear and practical examples to help health plans comply — particularly with the NQTL and disclosure requirements. The Cures Act also extends parity standards to any eating disorder benefits, including residential treatment, covered by a group health plan.

Consistent with the Cures Act, eight of the 11 FAQs finalized Sept. 5 focus on NQTL issues, while the other three address disclosure requirements. The guidance comes from the three agencies overseeing MHPAEA compliance:

- ***DOL's Employee Benefits Security Administration (EBSA)*** enforces MHPAEA requirements for large employers sponsoring group health plans, although individual beneficiaries can sue under ERISA to enforce the parity requirements without filing a DOL complaint. While ERISA generally prevents EBSA from bringing MHPAEA actions against the insurance carrier for an insured plan, in the FY 2018 Enforcement Fact Sheet, EBSA recently said that it can enforce MHPAEA provisions for insurance companies that provide only administrative services to self-funded ERISA-covered plans.

- ***HHS*** supports states' enforcement of MHPAEA requirements for insurance carriers and directly enforces the law's provisions for state and local government plans.

- ***IRS*** can fine a group health plan up to $100 per day for each individual affected by a parity violation.

According to the agencies, the latest FAQs "do not contain any new interpretations … but instead provide additional examples of how the MHPAEA final regulations apply to different fact patterns to promote compliance." In fact, the FAQs largely restate the draft version issued in 2018, with clarifying edits and additional compliance suggestions. Those suggestions generally focus on using comparable processes to establish NQTLs for MH/SUD and M/S benefits, along with documenting the development and application of those NQTLs.

NQTL FAQS

Both DOL and HHS's Centers for Medicare & Medicaid Services (CMS) have MHPAEA webpages with links to regulations, more than a dozen FAQs and fact sheets, a self-compliance tool for employers, and publications for plan participants and beneficiaries. Despite these resources, health plans still find the parity requirements challenging — particularly when complying with the NQTL standards. As a result, most of the latest FAQs aim to provide clarity on how the NQTL requirements apply to specific scenarios.

Benefit denials are important, but not the sole factor for parity analysis. The introduction to the NQTL FAQs cautions that benefit denial rates "are NOT determinative of compliance," although higher denial rates for MH/SUD than M/S benefits "may be … a warning sign, or indicator of potential operational parity noncompliance." The agencies stress that plans need parity in the processes used to develop and administer NQTLs. For example, an NQTL applied in a reasonable rather than arbitrary or discriminatory manner should not end up limiting all MH/SUD benefits but only some M/S benefits in the same class.

Investigative or Experimental Treatment Exclusions (FAQ 1)

In this FAQ's example, a plan excluded MH/SUD and M/S benefits for any experimental and investigative treatment when no professionally recognized treatment guidelines define clinically appropriate care, and fewer than two randomized controlled trials support that treatment. In practice, however, the plan denied applied behavioral analysis (ABA) therapy as an experimental treatment for children with autism spectrum disorders, even though professional guidelines and at least two randomized trials support ABA therapy for autism.

Applying this NQTL more stringently for MH/SUD treatments than for M/S benefits violates MHPAEA. However, no violation would occur if after applying the same standard imposed for investigative or experimental M/S treatments, the plan determines other factors justify excluding the requested MH/SUD treatment and documents the factors used for that decision.

Exceptions to Excluded Experimental or Investigative Treatments (FAQ 2)

If a plan document generally excludes experimental or investigative treatments but allows exceptions when medically appropriate, providing an exception process for only experimental or investigative M/S — but not MH/SUD — treatments is a parity violation. Plan operations must provide the same exception process for MH/SUD and M/S benefits to comply with MHPAEA. Plans should document the availability of and the requirements for seeking exceptions and factors used to determine exceptions to MH/SUD and M/S benefit exclusions, and provide this documentation on request.

Medical-Management Standards (FAQ 3)

Medical-management standards that limit or exclude benefits based on medical appropriateness, medical necessity or other factors are NQTLs. In this FAQ's example, the plan applied more restrictive dosage limits than professional treatment guidelines recommend for a prescription medication (buprenorphine) used to treat opioid use disorders. However, the plan followed professional guidelines when setting dosage limits for M/S prescriptions. If medical-management standards differ for M/S vs. MH/SUD benefits, the plan must have used a comparable development process that justifies those differences.

A decision by a plan's pharmacy and therapeutics (P&T) committee to follow or deviate from professional guidelines for prescription dosage limits does not automatically violate the parity rules. However, the committee members must have comparable expertise on MH/SUD and M/S conditions, and they must have engaged in comparable evaluations of the treatment guidelines for both types of conditions.

Blanket Exclusion of Specific MH/SUD Conditions (FAQ 4)

Excluding all items and services — including prescription medication — to treat a specific MH/SUD condition is not a "treatment limitation" or a parity violation. However, the MHPAEA regulations require a plan that provides benefits for a particular MH/SUD condition to do so in every classification for which M/S benefits are provided. Fully insured plans must also comply with state-mandated coverage of certain MH/SUD conditions and match the benefits in the applicable EHB benchmark plan for individual and small group plans.

Step-Therapy Protocols (FAQ 5)

Step-therapy guidelines that are more restrictive for inpatient MH/SUD than for M/S benefits are a red flag. In this example, a plan allowed inpatient M/S treatment after only one unsuccessful attempt at outpatient treatment, but required two unsuccessful outpatient treatments before approving inpatient MH/SUD treatment. The differing step-therapy NQTLs for MH/SUD and M/S benefits might be permissible if the plan relied on comparable evidentiary standards or other factors to develop and apply the protocols. If this is the case, the plan should document the factors used to support the different protocols and make this documentation available on request.

Nonphysician Reimbursement Rates (FAQ 6)

Applying a standard reduction in the reimbursement rate for every CPT code whenever healthcare practitioners other than physicians deliver MH/SUD services, but doing the same for nonphysician M/S service providers only when certain factors support the reduction is a parity violation. The MHPAEA doesn't require the same reimbursement rate for M/S and MH/SUD service providers, but a plan's methodology for setting and applying those rates is an NQTL. So plans must use a comparable rate-setting methodology and apply it no more stringently to MH/SUD benefits than to M/S benefits. In this FAQ's example, the plan didn't use a comparable process to determine reimbursement rates for nonphysicians who deliver MH/SUD services and thus violated the parity rules.

Network Adequacy (FAQ 7)

Standards for provider admission to a plan's network are NQTLs. The MHPAEA does not require plans to have the same number of in-network MH/SUD and M/S providers, but "greatly disparate results" is a red flag that warrants close inspection. In this FAQ, the plan considered network adequacy in setting provider admission standards, but it assessed a patient's ability to secure a nonurgent appointment within 15 days only for M/S providers — and not for MH/SUD providers. Because the MH/SUD vs. M/S network admission processes failed to use comparable standards, the plan did not comply with the MHPAEA.

Coverage Restrictions on Facility Types (FAQ 8)

Plan or coverage restrictions based on facility types are NQTLs. Blanket coverage restriction of certain MH/SUD treatment facilities while covering the same facility type for M/S treatment only under certain

conditions is problematic. In this FAQ, the plan had a blanket exclusion for all inpatient, out-of-network treatment for eating disorders, including nonhospital residential treatment. But the plan covered inpatient, out-of-network treatment if medically appropriate and preauthorized for M/S conditions, as long as the facility met licensing and certification requirements.

Excluding nonhospital residential treatment for MH/SUD conditions may be permissible in certain circumstances, but an unequivocal exclusion is unlikely to comply with the MHPAEA. A plan must use comparable factors to develop this NQTL and apply it no more stringently to MH/SUD benefits than M/S benefits. The plan also should document the factors — including statistical, clinical, incidence of fraud and others — used in developing the NQTL.

DISCLOSURE FAQS AND REVISED MODEL REQUEST FORM

The last three FAQs provide examples of how the MHPAEA and ERISA require disclosures relevant to MH/SUD benefits:

- ***For general information regarding limitations to MH/SUD benefits,*** FAQ 9 encourages participants to request and review the group health plan's summary plan description (SPD) and summary of benefits and coverage (SBC), both of which are required by ERISA. Enrollees can also use the model document request form to request the relevant portions of the SPD or plan document.

- ***For information on network providers (FAQ 10),*** ERISA requires SPDs to have a general description of the provider network, and plans must furnish — free of charge — a current list of providers. This list can be provided separately from the SPD but must be reasonably up-to-date, accurate and complete.

- ***For electronic disclosures (FAQ 11),*** ERISA regulations allow plans to supply the network provider list via a hyperlink in the SPD or similar means, as long as electronic-disclosure rules are satisfied. Separate rules require the SBC to include an internet address or similar contact information for obtaining a list of network providers.

Optional Disclosure Request Form

The model disclosure request form aims to facilitate beneficiaries' requests for information about a plan's restrictions on MH/SUD benefits or the reasons for an adverse MH/SUD benefit determination. A plan participant or beneficiary does not have to initiate a formal claim for benefits or an appeal before requesting certain plan documents. Participants and beneficiaries can use the optional form when requesting any document that ERISA requires a plan to make available.

For requests related to a claim or a denied benefit, the form provides a number of options so a participant can indicate the specific NQTL(s) on which information is sought. For example, a participant can check boxes indicating the request relates to medical-necessity criteria, medical-management guidelines or network-adequacy standards, among other NQTLs.

The form then provides an opportunity for participants to indicate what information they want to receive about the particular NQTL. For example, participants may want to obtain plan language related to the NQTL. Or they may be seeking information on the factors used to develop the NQTL; the processes, strategies, evidentiary standards and other resources used to evaluate those factors; or the methods and analysis used to develop the NQTL.

A plan has 30 days from receipt of a request to make the requested information available at no charge.

DOL ENFORCEMENT ACTIVITIES

Responsibility for MHPAEA compliance rests with the group health plan and/or the health insurance carrier. At least one federal appeals court has found that a third-party administrator (TPA) of a self-insured health plan can be liable for MHPAEA violations when the TPA exercises control over benefit claims. In that 2015 decision, the 2nd US Circuit Court of Appeals held that MHPAEA requirements can apply indirectly to a TPA through ERISA when the TPA is acting as a plan's fiduciary (*New York State Psychiatric Ass'n v. UnitedHealth Group*, 798 F.3d 125 (2015)).

For employer-sponsored large group health plans, DOL's EBSA conducts MHPAEA compliance reviews, often in response to participant complaints suggesting a systemic problem. When a violation is found, EBSA generally requires the plan to correct noncompliant plan provisions, which could include paying any improperly denied benefits. EBSA has 10 regional offices conducting health plan investigations.

The latest fact sheet on MHPAEA enforcement indicates that when EBSA finds parity violations in one health plan, the agency has pursued "global corrections" from TPAs and managed behavioral health organizations. According to EBSA, this strategy results in fewer investigations but has greater impact, since multiple plans make corrections. However, neither HHS nor EBSA have actually analyzed whether this strategy increases or decreases the odds of MH/SUD parity violations, according to a report from the Government Accountability Office (GAO).

In 2018, EBSA closed 115 parity investigations (down from 187 in 2017) and found 21 violations (a significant drop from to 92 in 2017). Of the parity violations found, the share involving NQTLs increased from nearly 50% in 2017 to 55% in 2018. Two examples include:

- A self-funded plan required preauthorization for all outpatient MH/SUD benefits after 24 visits but imposed no such requirement for outpatient M/S benefits. To correct this violation, the plan had to remove the preauthorization requirements and visit limits for outpatient MH/SUD benefits and notify plan participants of the change. The plan also had to reprocess 174 claims and pay $20,075 in claims to affected participants and providers.

- A self-funded plan required measurable goals, continued progress toward functional behavior and termination of treatment for payment of MH/SUD benefits. Without evidence of positive response to treatment, the plan would deny continued MH/SUD benefits. No similar requirement existed for M/S benefits. To remedy the parity violation, the plan had to remove this NQTL for MH/SUD benefits.

Plans should note that the DOL enforcement statistics do not reflect any IRS excise tax/civil penalties for MHPAEA noncompliance or ERISA penalties for fiduciary violations related to parity claims. Individuals can also bring ERISA lawsuits for MHPAEA violations, regardless of any federal or state enforcement action.

FOCUS FOR EMPLOYERS

While health plan sponsors don't need to make any immediate changes to parity compliance activities, the latest FAQs and model disclosure request form signal the agencies' continuing focus on parity and efforts to provide more guidance on NQTLs. The development and application of NQTLs are perhaps the most challenging aspect of the mental health parity requirements. Employers — especially those sponsoring self-insured plans — may want to review their current compliance strategies against this latest round of NQTL examples. The suggested steps below may facilitate this review.

Evaluate Parity Compliance To Reduce Legal Risks

Self-insured employers should not assume that plan administrators are in compliance with parity requirements. Although the latest enforcement data indicate EBSA is focusing on TPAs, self-insured employers are at risk for agency enforcement and litigation brought by plan participants, beneficiaries and providers. Large employers in particular have become targets of high-profile parity litigation in the last few years. In addition, some of the recent litigation against health insurers acting as TPAs for self-insured plans raises questions about how the insurers are reviewing certain mental health benefit claims of employees. This should concern employers.

Use DOL's self-compliance tool. DOL's self-compliance tool gives background on the MHPAEA and helps employers evaluate their plans' compliance. The tool includes the same audit checklist that DOL investigators use when reviewing employer plans. The checklist incorporates earlier FAQs that address NQTLs and disclosure requirements.

Work with benefit compliance professionals. Employers can work with benefit compliance professionals to review a group health plan's MHPAEA compliance in benefit provisions; processes and procedures for conducting medical-necessity reviews and responding to document requests; and new and emerging benefit offerings — particularly in the total health management space. Public-sector plans may consider opting out of MHPAEA compliance and evaluate the requirements for doing so.

Confirm Coverage of MH/SUD Treatment in Every Classification, If Required

A plan can entirely exclude a MH/SUD condition or all MH/SUD and M/S benefits in a certain classification (such as out-of-network inpatient treatment centers). According to the latest FAQs, however, a plan cannot exclude MH/SUD benefits from a certain classification if M/S benefits are offered in that classification.

For example, a plan can exclude all benefits related to autism (assuming it's considered a MH/SUD condition under the plan). But if autism is covered, a plan cannot necessarily exclude all out-of-network treatments (such as speech therapy) for autism while covering out-of-network therapy for M/S conditions. At a minimum, a plan must evaluate an NQTL excluding out-of-network benefits for autism to determine whether the processes and strategies used to apply this exclusion are comparable to those used for out-of-network M/S benefits. Plans should evaluate the NQTL rules — especially the requirement to offer

MH/SUD benefits in the same classifications that M/S benefits are provided — before excluding out-of-network MH/SUD benefits.

Whether a plan that covers autism as a MH condition can exclude a certain treatment — like out-of-network speech therapy — when a similar exclusion applies to M/S conditions is an open question. As an NQTL that affects the "continuum of care" or "scope of services" for autism, the exclusion would have to be justified through a parity analysis. On the other hand, the preamble to the final MHPAEA rules says the agencies do not intend this parity requirement to impose a benefit mandate that could require greater benefits for MH/SUD conditions than for M/S conditions.

Check Network Adequacy for MH/SUD Benefits

The latest FAQs remind plans that admission standards for provider networks are NQTLs that must be comparable and applied no more stringently to MH/SUD providers than to M/S providers. If the network criteria for M/S vs. MH/SUD providers diverge, plans need to justify those differences through a parity analysis.

In practice, having an adequate network of MH/SUD providers can prove challenging, due to the scarcity of MH/SUD providers in some regions and the relatively high number who decline to join networks and accept only cash payment. A recent study confirmed disparities in access to behavioral health care and the need to rely on out-of-network providers. If a plan's standards for provider admission include factors related to network adequacy, the plan may have to implement alternative strategies — like raising reimbursement rates for MH/SUD providers -- to boost network participation. Use of behavioral health telemedicine or a behavioral health center of excellence might also boost in network options for employees. A plan with insufficient in-network options should also be careful about excluding all out-of-network MH/SUD services in a certain classification.

Review Medical-Management Techniques for MH/SUD Benefits

Medical-management techniques are NQTLs, so comparable factors must go into developing these standards for MH/SUD and M/S benefits, and plans must apply these NQTLs no more stringently to MH/SUD benefits than to M/S benefits. Plans often refer to professionally recognized standards of care when developing and applying medical-management techniques to benefit decisions. However, this can present parity challenges: While many areas of medicine have widely recognized standards of care, this is not always the case for MH/SUD treatments.

As a result, plan sponsors should rely on comparable clinical expertise in developing medical-management NQTLs for MH/SUD vs. M/S benefits, and document the factors used to support a parity analysis and potential disclosure request. For example, a plan that covers services when medically necessary under generally accepted medical standards should not have more restrictive coverage guidelines for MH/SUD conditions. Recent litigation has increasingly focused on the guidelines that plans use to make medical-necessity decisions on MH claims (see, for example, Ariana v. Humana Health Plan of Texas, No. 18-20700, 884 F.3d 246 and 854 F.3d 753 (5th Cir. Nov. 8, 2019, March 1, 2018, and April 21, 2017); *Doe v. Oxford Health Plan Insurance Inc.*, No. 17-1485 (D. Conn. Nov. 5, 2019); and *Wit v. United Behavioral Health*, No. 14-2346 (N.D. Cal. Feb. 28, 2019). Nonetheless, other factors considered in developing an

NQTL — like documented incidence of fraud — may dictate different outcomes for certain MH/SUD treatments than M/S treatments.

Prepare for Disclosure Requests

Plan administrators don't have to supply the optional disclosure request form to plan participants. Some have argued that the form encourages overly broad requests, but others might find the form can help focus otherwise vague or seemingly broad disclosure requests. Regardless of how a disclosure request is made, large self-insured employers are generally responsible for ensuring a timely response, although the plan's TPA may supply the disclosure or help prepare the response. Employers relying on TPAs to administer claims may want to review the adequacy of their TPA's current responses to various disclosure requests. Carriers are responsible for handling disclosure requests for fully insured plans.

Plan administrators must disclose information within 30 days of receiving a request, so they should have a process and procedure for timely handling these disclosures. Because the optional request form is designed to target particular types of information, use of this form could help expedite responses. However, self-insured employers (with assistance from their TPAs) should carefully review the categories of NQTLs, ensure the process for developing those NQTLs is well-documented, and confirm the plan can demonstrate that the NQTL is applied no more stringently to MH/SUD benefits than to M/S benefits.

Monitor Parity Developments To Combat Opioid Crisis

Employers should expect further MHPAEA guidance, as enforcement agencies say they intend to continue issuing MHPAEA implementation information "on a rolling basis." A recent White House policy roundtable, Turning the Tide — Improving Access to Addiction Care and Overcoming Obstacles to Parity, also highlights the continued focus on mental health parity as part of the response to the opioid crisis. Roundtable participants, which included Mercer, noted that parity laws achieve meaningful goals only if health plans are properly implementing the laws, consumers and providers understand how parity works, and the government provides clear guidance.

RELATED RESOURCES

Non-Mercer Resources

- Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies (GAO, Dec. 13, 2019)
- *Ariana v. Humana Health Plan of Texas*, No. 18-20700, 884 F.3d 246 and 854 F.3d 753 (5th Cir. Nov. 8, 2019, March 1, 2018, and April 21, 2017)
- *Doe v. Oxford Health Plan Insurance Inc.*, No. 17-1485 (D. Conn. Nov. 5, 2019)
- Affordable Care Act (ACA) Implementation FAQs, Part 39, MH/SUD Parity Implementation and the 21st Century Cures Act (DOL/HHS/IRS, Sept. 5, 2019)
- FY 2018 MHPAEA Enforcement Fact Sheet (DOL, Sept. 5, 2019)

- MHPAEA Violation Guidance Compendium (DOL, Sept. 5, 2019)
- *Wit v. United Behavioral Health*, No. 14-2346 (N.D. Cal. Feb. 28, 2019)
- Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (DOL, April 25, 2018)
- FY 2017 MHPAEA Enforcement Fact Sheet (DOL, April 24, 2018)
- Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement (Milliman, Nov. 20, 2019)
- ACA Implementation FAQs, Part 38, MH/SUD Parity Implementation and the 21st Century Cures Act (DOL/HHS/IRS, June 16, 2017)
- *Ariana v. Humana Health Plan of Texas*, 884 F.3d 246 (2017)
- Parity Compliance Toolkit: Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs (CMS, Jan. 17, 2017)
- 21st Century Cures Act (PL 114-255) (GPO, Nov. 30, 2016)
- ACA Implementation FAQs, Part 34, Mental Health and Substance Use Disorder Parity Implementation (DOL/HHS/IRS, Oct. 27, 2016)
- Warning Signs — Plan or Policy NQTLs That Require Additional Analysis for Mental health Parity Compliance (DOL, June 1, 2016)
- ACA Implementation FAQs, Part 31, Mental Health Parity Implementation (DOL/HHS/IRS, April 20, 2016)
- Final MHPAEA Regulations (Federal Register, Nov 13, 2013)
- MHPAEA Resources (CMS)
- MH/SUD Resources (EBSA)

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- Top 10 Compliance Issues for 2020 Health and Fringe Benefit Planning (June 25, 2019)

Other Mercer Resources

- Mercer Participates in White House Roundtable on Mental Health, Addiction Treatment (Sept. 19, 2019)
- If You Don't Cover MAT for Opioid Use Disorder, Here's Why You Should (Sept. 26, 2018)

- Mental Health and Opioids in Health Policy Spotlight (April 26, 2018)
- Proof That Focus Is Needed on Mental Health Benefits (Oct. 12, 2017)
- How Does Your Benefits Plan Stack Up Against Mental Health Parity Regulations? (Sept. 22, 2017)

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