

Report to Congress

**Compliance of Group Health Plans
(and Health Insurance Coverage Offered in Connection with
Such Plans)
With the Requirements of the
Mental Health Parity and Addiction Equity Act of 2008**

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Report to Congress Compliance With the Requirements of the Mental Health Parity and Addiction Equity Act of 2008

I. EXECUTIVE SUMMARY

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires the Secretary of Labor to provide Congress with a biennial report¹, beginning on January 1, 2012, on compliance of group health plans and group health insurance issuers with the requirements of MHPAEA (Report).

The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) promulgated interim final rules on February 2, 2010 to implement the provisions of MHPAEA. Subsequently, the Departments issued three separate sets of sub-regulatory guidance to clarify certain requirements in the interim final rules to assist the marketplace with the implementation of and facilitate the understanding of and compliance with MHPAEA.

The statutory provisions of MHPAEA generally became applicable for plan years beginning on or after October 3, 2009 and the interim final rules became applicable for plan years beginning on or after July 1, 2010, which is January 1, 2011 for calendar year plans. Accordingly, this Report focuses on summarizing DOL's initial implementation efforts. The Report provides an overview of MHPAEA, the Departments' joint interim final rules and sub-regulatory guidance, as well as a discussion of DOL's Employee Benefits Security Administration's efforts in developing an infrastructure for MHPAEA implementation. To achieve its ultimate goal of successfully implementing MHPAEA, EBSA has created a robust MHPAEA program that includes four "Strategies of Implementation" (Strategies): 1) issuing interpretive guidance; 2) conducting external outreach and compliance assistance activities; 3) providing participant assistance; and 4) enforcing the law and regulations. EBSA is also conducting internal training and quality control as well as commissioning research studies to reinforce each Strategy and ensure EBSA accomplishes its mission of helping the marketplace understand MHPAEA and benefit from it, as intended.

¹ See, section 712(f) of the Employee Retirement Income Security Act (ERISA), as added by MHPAEA.

II. INTRODUCTION

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on October 3, 2008 as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of P.L. 110-343).² MHPAEA amended the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code) with parallel provisions governing mental health and substance use disorder benefits.³ Accordingly, MHPAEA is subject to joint interpretive jurisdiction by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments). MHPAEA supplemented the Mental Health Parity Act of 1996 (MHPA 1996), which required parity in aggregate lifetime and annual dollar limits for mental health and medical/surgical benefits. In general, MHPAEA extended the dollar limit protections to include substance use disorder benefits and also requires parity in the application of any financial requirements and treatment limitations on mental health and substance use disorder benefits with medical/surgical benefits.

The DOL's Employee Benefits Security Administration (EBSA) is charged with the administration of ERISA, including the development of regulations and interpretations to implement the provisions of ERISA, compliance assistance, consumer assistance, and enforcement.⁴ EBSA has taken a series of timely and significant steps to implement MHPAEA.

² A technical correction to the effective date for collectively bargained plans was made by P.L. 110-460, enacted on December 23, 2008. For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of MHPAEA do not apply to the plan (or health insurance coverage offered in connection with the plan) for plan years beginning before the later of either: (i) The date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008); or (ii) July 1, 2010.

³ See, ERISA section 712, PHS Act section 2726, and Code section 9812.

⁴ The Health Insurance Portability and Accountability Act of 1996 provided that very small plans, including certain retiree-only health plans, and excepted benefits, are generally exempt from Part 7 of ERISA, Title XXVII of the PHS Act, and Chapter 100 of the Code – including the provisions of MHPAEA. Such exemptions are pursuant to ERISA section 732, PHS Act 2722, and the Code section 9831.

The statutory provisions of MHPAEA generally became applicable for plan years beginning on or after October 3, 2009. The interim final rules generally became applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010, which for calendar year plans, is January 1, 2011. Therefore, many group health plans and health insurance issuers first began compliance with the Departments' regulations in 2011. In order to facilitate the implementation process for MHPAEA and the interim final rules EBSA has created a robust MHPAEA program that includes four "Strategies of Implementation" (Strategies): 1) issuing interpretive guidance; 2) conducting external outreach and compliance assistance activities; 3) providing participant assistance; and 4) enforcing the law and regulations. In order to bolster each of those Strategies, EBSA is also conducting internal training and quality control as well as commissioning research studies.

This approach to implementation for this first year of applicability has been to work together with plans, issuers, consumers, providers, States, and other stakeholders to help members of the regulated community come into compliance with the law and help families and individuals understand it law and benefit from it, as Congress intended. Accordingly, this Report summarizes EBSA accomplishments to date and outlines next steps under development for the future.⁵

III. LEGISLATIVE BACKGROUND

A. The Mental Health Parity Act of 1996

Prior to the passage of MHPAEA, MHPA 1996 was in effect and generally applied to plans sponsored by private and public sector employers with more than 50 employees.⁶ MHPA 1996 provided for parity in the application of aggregate lifetime dollar limits, and annual dollar limits, between mental health benefits and

⁵ The ongoing work by the Departments with respect to the implementation of MHPAEA will expand upon the initial findings reported by the Government Accountability Office (GAO) in its report titled "Employers' Insurance Coverage Maintained or Enhanced Since Parity Act, but Effect of Coverage on Enrollees Varied" published on November 30, 2011, which can be accessed at <http://www.gao.gov/new.items/d1263.pdf>.

⁶ Initially, MHPA 1996 amended only ERISA and the PHS Act. The Taxpayer Relief Act of 1997 (Pub. L. 105-34) was enacted on August 5, 1997, and added provisions substantively similar to those in MHPA 1996 in the Code.

medical/surgical benefits. The requirements under MHPA 1996 applied regardless of whether the mental health benefits were administered separately under the plan. Similar to MHPAEA, MHPA 1996 did not require a group health plan or health insurance coverage offered in connection with a group health plan to provide mental health benefits.

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

B. The Mental Health Parity and Addiction Equity Act of 2008

On October 3, 2008, MHPAEA⁷ was enacted and supplemented MHPA 1996. MHPAEA generally applies to plans sponsored by private and public sector employers with more than 50 employees⁸, including self-insured as well as fully-insured arrangements. MHPAEA also applies to health insurance issuers who offer or provide coverage to employers with more than 50 employees. The statutory provisions of MHPAEA generally became effective for plan years beginning on or after October 3, 2009.

MHPAEA also amended ERISA, the PHS Act, and the Code with parallel provisions.⁹ As such, regulations under the parallel provisions are developed and issued jointly, so as to

⁷ See, <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html> for a fact sheet that summarizes MHPAEA.

⁸ Starting in 2014, for certain purposes, the PHS Act (as amended) will define a small employer as one that has 100 or fewer employees; however, ERISA and the Code will continue to define a small employer as one that has 50 or fewer employees. See the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) Implementation FAQs Part V, question 8, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html>.

⁹ In addition to the parity protections under MHPAEA, the Affordable Care Act included new participant rights to internal claims and appeals and external review processes, the requirements of which also apply to claim denials for behavioral health benefits. See 76 FR 37208 at 37216 (June 24, 2011).

have the same effect at all times, and consistent with the tri-agency Memorandum of Understanding (MOU)¹⁰ that implements section 104 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted on August 21, 1996.

Similar to MHPA 1996, MHPAEA includes parity protections with respect to annual and lifetime limits for mental health benefits, however, MHPAEA also extends parity protections to annual and lifetime dollar limits for substance use disorder benefits.¹¹ In addition to maintaining parity in dollar limits, MHPAEA also contained new requirements for group health plans and group health insurance coverage.¹²

First, MHPAEA requires that a group health plan or health insurance coverage offered in connection with a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits ensure that:

- (i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
- (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.¹³

¹⁰ See 64 FR 70164 (December 15, 1999).

¹¹ See, ERISA Sections 712(a)(1) and (2), PHS Act Sections 2726(a)(1) and (2), and Code sections 9812(a)(1) and (2).

¹² MHPAEA does not require plans to cover mental health and substance use disorder benefits. It applies only if a plan chooses to provide those benefits.

¹³ ERISA Section 712(a)(3), PHS Act Section 2726(a)(3), and Code section 9812(a)(3).

In addition, MHPAEA adds two new disclosure provisions for group health plans and group health insurance issuers. First, the criteria for medical necessity determinations made under a plan (or health insurance coverage) with respect to mental health or substance use disorder benefits must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request. The interim final rules repeat the statutory language with respect to the medical necessity determinations disclosure requirement without substantive change. Secondly, MHPAEA requires that the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary be made available, upon request or as otherwise required, by the plan administrator (or the health insurance issuer) to the participant or beneficiary. The interim final rules clarified that in order for plans subject to ERISA (and health insurance coverage offered in connection with such plans) to satisfy this requirement, disclosures must generally be made in a form and manner consistent with the ERISA claims procedure regulations at 29 CFR 2560.503-1.¹⁴

Finally, MHPAEA, similar to MHPA 1996, includes an increased cost exemption under which, if certain requirements are met, plans that incur increased costs above a certain threshold as a result of the application of the parity requirements of both these laws can be exempt from the statutory parity requirements. MHPAEA changed the MHPA 1996 increased cost exemption in several ways, including: (1) raising the threshold for qualification from one percent to two percent for the first year for which the plan is subject to MHPAEA; (2) requiring certification by qualified and licensed actuaries who are members in good standing of the American Academy of Actuaries; and (3) revising the notice requirements. Under MHPAEA, plans that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan year, and the exemption lasts for one year. Thus, the statutory increased cost exemption may only be claimed for alternating plan years. Because of these changes, the interim final rules, published on February 2, 2010, withdraw the MHPA 1996 regulatory guidance on the increased cost exemption. The interim final rules did not, however, provide guidance on how to claim the increased cost exemption but instead invited comments on how to implement this new statutory requirement. In the meantime, the Departments provided in sub-regulatory guidance an interim enforcement safe harbor, until future regulatory guidance is effective, for claiming the increased cost exemption under MHPAEA.¹⁵

¹⁴ See, 26 CFR § 54.9812(d)(2), 29 CFR § 2590.712(d)(2), and 45 CFR § 146.136(d)(2).

¹⁵ See, <http://www.dol.gov/ebsa/faqs/faq-aca5.html>.

IV. DEVELOPMENT OF A DEPARTMENTAL MHPAEA INFRASTRUCTURE

To achieve its ultimate goal of full MHPAEA implementation, EBSA has created a robust MHPAEA infrastructure that includes four “Strategies of Implementation” (Strategies): 1) issuing interpretive guidance; 2) engaging in external outreach and compliance assistance activities; 3) providing participant assistance; and 4) enforcing the law and regulations. EBSA has also implemented internal training and quality control measures as well as working with HHS to conduct research studies to reinforce each Strategy and ensure EBSA accomplishes its mission of helping the marketplace understand MHPAEA and families and individuals benefit from it, as intended. These ongoing efforts will form the basis for MHPAEA’s successful implementation.

A. INTERPRETIVE GUIDANCE

The first Strategy for accomplishing DOL’s goal of successful MHPAEA implementation is to issue interim final rules to implement MHPAEA’s statutory requirements and sub-regulatory guidance to clarify the requirements in the interim final rules. As discussed in more detail below, the Departments issued inter-agency regulations and sub-regulatory guidance to begin the MHPAEA implementation process.

1. Interim Final Rules

On April 28, 2009, the Departments published a request for information (RFI) soliciting comments on the requirements of MHPAEA.¹⁶ After consideration of the comments received in response to the RFI, the Departments published interim final regulations¹⁷, with request for comment, on February 2, 2010. The interim final rules generally became applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010, which for calendar year plans, is January 1, 2011.

¹⁶ 74 FR 19155 (April 28, 2009).

¹⁷ 75 FR 5410 (February 2, 2010).

Under the interim final rules, a group health plan or group health insurance issuer generally cannot impose a financial requirement (such as copayments or coinsurance) or a quantitative treatment limitation (such as a limit on the number of outpatient visits or inpatient days covered) on mental health or substance user disorder benefits in any of six classifications that is more restrictive than the predominant requirements or limitations that apply to at least two-thirds of medical/surgical benefits in the same classification. The six classifications of benefits defined in the interim final rules are:

- (1) inpatient, in-network;
- (2) inpatient, out-of-network;
- (3) outpatient, in-network;
- (4) outpatient out-of-network;
- (5) emergency care; and
- (6) prescription drugs.¹⁸

a. Measuring Plan Benefits

In order to apply the substantive requirements under MHPAEA, there must be a standard to measure plan benefits, which the MHPAEA interim final rules establish. For instance, the portion of plan payments subject to a financial requirement or quantitative treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year.¹⁹

Any reasonable method may be used to determine the dollar amount expected to be paid under the plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation. Some cumulative financial requirements, such as deductibles and out-of-pocket maximums, involve a threshold amount that causes the

¹⁸ Pursuant to sub-regulatory guidance issued on June 30, 2010, subsequent to the interim final rules, the outpatient classifications can be further divided into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under MHPAEA: (1) office visits, and (2) all other outpatient items and services. See <http://www.dol.gov/ebsa/faqs/faq-mhpaea.html> for a detailed discussion of these sub-classifications.

¹⁹ See, 26 CFR § 54.9812(c)(3)(i)(C), 29 CFR § 2590.712(c)(3)(i)(C), and 45 CFR § 146.136(c)(3)(i)(C).

amount of a plan payment to change. For purposes of deductibles, the dollar amount of plan payments includes all payments with respect to claims that would be subject to the deductible if it had not been satisfied. For purposes of out-of-pocket maximums, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that were taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Other threshold requirements are treated similarly.

b. Determining the Substantially All Threshold

After measuring plan benefits, the first step in applying the general parity requirement under MHPAEA is to determine whether a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification. Regulations issued under MHPA 1996 interpreted the term “substantially all” to mean at least two-thirds. Under the MHPAEA interim final rules, a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in that classification.²⁰

If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of the medical surgical benefits in a classification, that type of requirement or limitation cannot be applied to mental health or substance use disorder benefits in that classification. If a single level of a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of medical/surgical benefits in a classification, then it is also the predominant level and that is the end of the analysis. However, if the financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification but has multiple levels and no single level applies to at least two-thirds of all medical/surgical benefits in the classification, then additional analysis is required. In such a case, the next step is to determine which level of the financial requirement or quantitative treatment limitation is considered predominant.

c. Determining the Predominant Financial Requirements or Treatment Limitations

MHPAEA provides that a financial requirement or treatment limitation is predominant if it is the most common or frequent of a type of limit or requirement.²¹ Under the

²⁰ See, 26 CFR § 54.9812(c)(3)(i)(A), 29 CFR § 2590.712(c)(3)(i)(A), and 45 CFR § 146.136(c)(3)(i)(A).

²¹ See, ERISA Section 712(a)(3)(B)(ii), PHS Act Section 2726(a)(3)(B)(ii), and Code section 9812(a)(3)(B)(ii).

MHPAEA interim final rules, the predominant level of a type of financial requirement or quantitative treatment limitation is the level that applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in that classification.²²

If a single level of a type of financial requirement or quantitative treatment limitation applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in a classification (based on plan costs, as discussed earlier), the plan may not apply that particular financial requirement or quantitative treatment limitation to mental health or substance use disorder benefits at a level that is more restrictive than the level that has been determined to be predominant. If no single level applies to more than one-half of medical/surgical benefits subject to a financial requirement or quantitative treatment limitation in a classification, plan payments for multiple levels of the same type of financial requirement or quantitative treatment limitation can be combined by the plan (or health insurance issuer) until the portion of plan payments subject to the financial requirement or quantitative treatment limitation exceeds one-half.²³ Thus, an example that illustrates the substantially all and predominant test is – if a plan generally applies a \$25 copayment to at least two-thirds of in-network, out-patient medical/surgical benefits, a higher copayment could not be imposed on in-network, out-patient mental health or substance use disorder benefits.

For any combination of levels that exceeds one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in a classification, the plan may not apply that particular financial requirement or quantitative treatment limitation to mental health and substance use disorder benefits at a level that is more restrictive than the least restrictive level within the combination. The plan may combine plan payments for the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.

d. Nonquantitative Treatment Limitations

In addition to financial requirements and quantitative treatment limitations, plans and issuers often impose nonquantitative treatment limitations (NQTLs), such as:

²² See, 26 CFR § 54.9812(c)(3)(i)(B), 29 CFR § 2590.712(c)(3)(i)(B), and 45 CFR § 146.136(c)(3)(i)(B).

²³ See, 26 CFR § 54.9812(c)(3)(iv), 29 CFR § 2590.712(c)(3)(iv), and 45 CFR § 146.136(c)(3)(iv), for examples that illustrate the application of this rule.

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

The parity standard for NQTLs does not require applying a simple arithmetic test to compare the treatment of mental health or substance use disorder benefits to the treatment of medical/surgical benefits. The interim final rules provide that any processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits, except to the extent that recognized clinically appropriate standards of care may permit a difference.²⁴

Examples in the interim final rules illustrate how to apply the MHPAEA rules for NQTLs. The following summarizes those examples:

- A group health plan limits benefits to treatment that is medically necessary, requires concurrent review for inpatient, in-network mental health and substance use disorder benefits but does not require concurrent review for any inpatient, in-network medical/surgical benefits, and instead conducts

²⁴ The Departments' interim final rules did not address "scope of services" or "continuum of care" issues, such as whether (or to what extent) a plan or issuer may be required to cover non-hospital residential inpatient mental health and substance use disorder conditions if there are non-hospital residential inpatient benefits for one or more medical/surgical conditions. See, 75 FR 5410 at 5416. The Departments received a number of comments on the interim final regulation and scope-of-services issues may be addressed in future regulations.

retrospective review for inpatient, in-network medical/surgical benefits. The plan violates MHPAEA's rules for NQTLs. 26 CFR § 54.9812(c)(4)(iii), at Example 1, 29 CFR § 2590.712(c)(4)(iii), at Example 1, and 45 CFR § 146.136(c)(4)(iii), at Example 1.

- A plan requires prior approval that a course of treatment is medically necessary for outpatient, in-network medical/surgical, mental health, and substance use disorder benefits, however, the plan denies payment for mental health and substance use disorder treatments that do not have prior approval, and only reduces by 25 percent payment for medical/surgical treatments that do not have prior approval. The plan violates MHPAEA's rules for NQTLs. 26 CFR § 54.9812(c)(4)(iii), at Example 2, 29 CFR § 2590.712(c)(4)(iii), at Example 2, and 45 CFR § 146.136(c)(4)(iii), at Example 2.
- A plan generally covers medically appropriate treatments, and for all benefits, the evidentiary standards the plan uses in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved and are applied in a manner that may differ based on clinically appropriate standards of care for a condition. The plan complies with MHPAEA's rules for NQTLs. 26 CFR § 54.9812(c)(4)(iii), at Example 3, 29 CFR § 2590.712(c)(4)(iii), at Example 3, and 45 CFR § 146.136(c)(4)(iii), at Example 3.
- A plan generally covers medically appropriate treatments and in determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration, but for other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care. The plan violates MHPAEA's rules for NQTLs. 26 CFR § 54.9812(c)(4)(iii), at Example 4, 29 CFR § 2590.712(c)(4)(iii), at Example 4, and 45 CFR § 146.136(c)(4)(iii), at Example 4.
- An employer maintains both a major medical program and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical program only after exhausting the counseling sessions provided by the EAP, but no similar exhaustion requirement applies

with respect to medical/surgical benefits provided under the major medical program. The plan violates MHPAEA's rules for NQTLs. 26 CFR § 54.9812(c)(4)(iii), at Example 5, 29 CFR § 2590.712(c)(4)(iii), at Example 5, and 45 CFR § 146.136(c)(4)(iii), at Example 5.

e. Cumulative Financial Requirements and Quantitative Treatment Limitations

MHPAEA also prohibits a group health plan from applying cumulative financial requirements, such as deductibles, for mental health and substance use disorder benefits in a classification that accumulate separately from any such requirements or limitations established for medical/surgical benefits in the same classification. 26 CFR § 54.9812(c)(3)(v), 29 CFR § 2590.712(c)(3)(v), and 45 CFR § 146.136(c)(3)(v).

In response to a Request for Information issued on April 28, 2009, the Departments received a number of comments regarding how to apply the parity requirements to cumulative financial requirements, in particular to deductibles (although some also referred to out-of-pocket maximums). The comments reflected two opposing views. One view is that a plan can have deductibles that accumulate separately for medical/surgical benefits on the one hand, and mental health or substance use disorder benefits on the other, as long as the level of the two deductibles is the same (separately accumulating deductibles). The opposing view is that expenses for both mental health or substance use disorder benefits and medical/surgical benefits must accumulate to satisfy a single combined deductible before the plan provides either medical/surgical benefits or mental health or substance use disorder benefits (combined deductible).

The provisions of the statute imposing parity on financial requirements and treatment limitations do not specifically address this issue; the language of the statute can be interpreted to support either position. The comments that supported allowing separately accumulating deductibles maintained that it is commonplace for plans to have such deductibles, and that the projected cost of converting systems to permit unified deductibles would be extremely high for the many plans that use a separate managed behavioral health organization.

By contrast, comments that supported requiring combined deductibles argued that allowing separately accumulating deductibles undermines a central goal of parity legislation, to affirm that mental health and substance use disorder benefits are integral components of comprehensive health care and generally should not be distinguished from medical/surgical benefits. Distinguishing between the two requires individuals who need both kinds of care to satisfy a deductible that is greater than that required for individuals needing only medical/surgical care. Other comments that supported requiring combined deductibles noted that mental health and substance use disorder benefits typically comprise only 2 to 5 percent of a plan's costs, so that even using

identical levels for separately accumulating deductibles imposes a greater barrier to mental health and substance use disorder benefits.

The Departments carefully considered the positions advanced by both groups of comments regarding separately accumulating and combined deductibles. Given that the statutory language does not preclude either interpretation, the Departments' view is that prohibiting separately accumulating financial restrictions and quantitative treatment limitations is more consistent with the policy goals that led to the enactment of MHPAEA. Consequently, the interim regulations provide that a plan may not apply cumulative financial requirements or cumulative quantitative treatment limitations to mental health or substance use disorder benefits in a classification that accumulate separately from any such cumulative financial requirements or cumulative quantitative treatment limitations established for medical/surgical benefits in the same classification.

2. Sub-Regulatory Guidance

Since the interim final rules were issued, the Departments have received numerous inquiries requesting clarification of and assistance with the implementation of the new MHPAEA rules. The Departments recognized the significance of providing guidance as promptly as possible in order to facilitate the continued implementation of the law. Therefore, three sets of sub-regulatory guidance have been issued regarding some of the issues most frequently raised by group health plans, issuers, and consumers. Specifically, the Departments published Frequently Asked Questions (FAQs) on June 30, 2010, December 22, 2010, and November 17, 2011. These FAQs were intended to provide clarity with respect to particular issues creating confusion in the marketplace and to help educate individuals regarding the protections available under MHPAEA relating to parity in mental health and substance use disorder benefits.

In order to address a frequently asked question regarding how to apply financial requirements and treatment limitations rules under MHPAEA to certain outpatient benefit plan designs, the Departments issued a clarification. Specifically, the first FAQ clarified that with respect to outpatient benefits, a plan or issuer is permitted to divide its benefits furnished on an outpatient basis into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under MHPAEA: (1) office visits, and (2) all other outpatient items and services.²⁵

²⁵ See, <http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>.

The second set of FAQs clarified what information and documentation must be disclosed under ERISA, particularly under MHPAEA, to participants, beneficiaries, providers, or authorized representatives and the timing of such disclosures, the applicability of MHPAEA and the interim final rules to certain entities, and the process for claiming the increased cost exemption under MHPAEA.²⁶

The third set of FAQs answers questions from stakeholders regarding NQTLs and a common question the Departments received related to the application of a plan's specialist (as opposed to the generalist) copayment for services rendered by outpatient mental health and substance use disorder professionals.²⁷

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

B. EXTERNAL OUTREACH AND COMPLIANCE ASSISTANCE ACTIVITIES

As part of the second Strategy to achieve full implementation of MHPAEA, EBSA has conducted various external outreach presentations and compliance assistance activities for the regulated community impacted by the new requirements.

1. External Outreach Activities

On several occasions throughout the year, EBSA participates in various outreach activities to help the marketplace with the implementation of MHPAEA and the interim final rules. These outreach activities identify various implementation issues and help inform EBSA in its efforts to issue additional interpretive guidance and other materials. The following are examples of those activities and materials:

²⁶ See, <http://www.dol.gov/ebsa/faqs/faq-aca5.html>.

²⁷ See, <http://www.dol.gov/ebsa/faqs/faq-aca7.html>.

- Health Benefits Education Campaign²⁸ (see Figure 1) — This Campaign, was launched in 1998 with over 70 partners representing a wide range of interests from employees to employers to health care providers. Through the Campaign, EBSA develops and distributes educational materials and tools and conducts outreach on Federal health care benefits laws for employees, employers, plan administrators, issuers, TPAs, and State insurance department staff. The Campaign sponsors compliance assistance seminars in coordination with the State Insurance Commissioners across the country to help increase awareness and understanding of the Federal health care benefits laws and to answer questions from the regulated community. Attendees also receive an extensive kit of materials including guidance, publications, and model notices. EBSA works with the states and other Federal agencies to provide employers and health benefit plan service providers with a comprehensive two-day seminar addressing the health benefits laws that impact their health plan. To date, EBSA has conducted 80 seminars nationwide. The seminars are constantly updated to address new guidance and new laws. Since MHPAEA was enacted, 20 seminars have been held with a comprehensive discussion of MHPAEA and the interim final rules. These seminars, in addition to the quality control measures developed for EBSA staff, are dedicated to assisting the public in its compliance with and understanding of MHPAEA, as well as the other ERISA provisions and related regulations. EBSA has received very positive feedback on these seminars and believes they will continue to be beneficial to the regulated community and consumers in determining compliance with the Federal health care benefit law requirements, including MHPAEA and the interim final rules that apply to private sector group health plans.

²⁸ See, <http://www.dol.gov/ebsa/HBEC.html>.



Previous Seminar Locations		
Albany NY	Dover DE	Overland Park KS
Albuquerque NM	Durham NC	Pierre SD
Anchorage AK	Fargo ND	Plantation FL
Annapolis MD	Harrisburg PA	Portland ME
Arlington VA	Hartford CT	Raleigh NC
Atlanta GA	Helena MT	Richmond VA
Austin TX	Indianapolis IN	Rutland City VT
Baton Rouge LA	Jackson MS	Salem OR
Birmingham AL	Lansing MI	Salt Lake City UT
Boise ID	Las Vegas NV	San Antonio TX
Camp Hill PA	Little Rock AR	San Diego CA
Carlisle PA	Los Angeles CA	Savannah GA
Casper WY	Louisville KY	Seattle WA
Chandler AZ	Manchester NH	Shreveport LA
Charleston WV	Minneapolis MN	St. Louis MO
Chicago IL	Nashville TN	Tallahassee FL
Cincinnati OH	New Orleans LA	Troy NY
Columbia SC	New York NY	Tulsa OK
Columbus OH	Newark NJ	Warwick RI
Concord NH	Oklahoma City OK	Washington DC
Denver CO	Omaha NE	
Des Moines IA	Orlando FL	

Figure 1. Previous Locations of EBSA’s Health Benefits Education Campaign.

- Panel discussions providing technical assistance to employers, health plans, issuers, TPAs, lawyers, and other stakeholders in the regulated community. For instance, EBSA has participated in the following meetings/discussions, specifically related to MHPAEA guidance:
 - o American Law Institute-American Bar Association (ALI-ABA) Webcast
 - o American Benefits Council teleconference
 - o Office of Personnel Management/America’s Health Insurance Plans Conference
 - o National Association of Insurance Commissioners quarterly meetings
 - o Multiple All-States conference calls
 - o Northeast Regional meeting with States, consumer groups, provider groups, and insurance industry representatives.

- o Approximately 6 stakeholder meetings with organizations such as the Association for Behavioral Health and Wellness and the Parity Implementation Coalition
- Throughout the year, representatives from EBSA's national office and regional offices participate in seminars and presentations to educate and familiarize employees, employers, plan administrators, issuers, third-party administrators (TPAs), and State insurance department staff with Part 7 of ERISA, including MHPAEA.
- Sub-regulatory guidance in the form of FAQs drawn from common MHPAEA questions asked by the regulated community and consumers.

EBSA's participation in this wide array of outreach events is a key component in the ongoing process of MHPAEA implementation. At these events, not only do EBSA representatives provide training, but EBSA representatives hear feedback and questions related to the MHPAEA guidance that has been issued. These events provide a vehicle for the sharing of information and help inform the process as to what the specific issues are and which issues are most prevalent as the Departments continue to focus on issuing interpretive guidance. This sharing of information will be valuable in the development of future interpretive guidance and EBSA's compliance/participant assistance and enforcement programs.

2. Compliance Assistance Activities

In addition to the targeted outreach activities to help the regulated community understand and comply with the intricacies of MHPAEA, EBSA often receives inquiries directly from consumers, providers, and health care and benefits attorneys and consultants regarding potential violations by employer-sponsored group health plans. Furthermore, on several occasions EBSA has been asked by industry associations and other groups to participate in individual meetings to discuss the implementation of MHPAEA and the interim final rules, specifically. Since the interim final rules were issued, EBSA has met with an industry group or consumer advocacy group, on average, once a month to discuss issues specific to the MHPAEA implementation process.

Moreover, as discussed later in this Report, EBSA staff has been effectively trained to field inquiries regarding MHPAEA issues and is equipped to provide individuals with accurate technical guidance and assistance related to the law and regulations. EBSA staff is also able to provide such guidance and additional materials to individuals in an

expedited manner by quickly assisting individuals in navigating and locating valuable information available on the EBSA website. The EBSA website contains a comprehensive compilation of the most up-to-date guidance, tools, and resources for information including compliance assistance materials, technical guidance, FAQs, and fact sheets to help the general public understand MHPAEA and the interim final rules.

Many of the inquiries that EBSA receives are through its website (<http://askebsa.dol.gov/>) and/or toll-free hotline (1-866-444-EBSA), both of which are available for general information and submitting questions about the laws and regulations administered by EBSA. EBSA's website directs visitors to the consumer assistance web page which provide self-help tools and enables individuals to submit a question, and file a complaint to report a problem through an electronic intake form. When EBSA receives a MHPAEA inquiry, trained staff is able to effectively use fact-finding techniques to determine the nature of the inquiry and the resources that may be helpful in responding to such inquiry.

C. PARTICIPANT ASSISTANCE

In addition to its many outreach and compliance assistance activities, EBSA also provides participant assistance to consumers related to MHPAEA and its rules. Since the publication of the interim final rules, EBSA and its benefits advisors have responded to hundreds of emails and calls (through its website and toll-free hotline) from participants inquiring about whether their health plans are in compliance with the rules. Inquiries raised to EBSA often highlight where confusion regarding compliance exists.

For instance, EBSA has received many inquiries related to a health plan charging the "specialist" copayment for outpatient mental health/substance use disorder services and the "generalist" copayment (typically lower than the "specialist" copayment) for outpatient medical/surgical services. In these cases, EBSA requested documentation or an analysis from the health plan to explain the disparity in copayments. In some cases, the health plan agreed that the "generalist," rather than the "specialist," copayment should apply and immediately amended its plan design. Awareness of this issue gained by EBSA through the participant assistance process resulted in the inter-Departmental development of a new FAQ that highlights and underscores how the rule applies in these scenarios.

In other cases, EBSA was able to help a participant's health plan (or issuer offering such plan) determine the application of MHPAEA's "substantially all" and "predominant" tests, ensuring that the health plan was accurately determining the allowable copayment to charge. This process of inquiry, coordination, and where appropriate, the issuance of additional informal guidance is facilitating an efficient and responsive

implementation process. EBSA also offers participants with comprehensive information and materials related to understanding their health and welfare benefits. Such information and materials can be found on EBSA's website at www.dol.gov/ebsa under the Consumer Information section.

D. ENFORCEMENT

The final Strategy that needs to be executed to ensure successful MHPAEA implementation is DOL's enforcement efforts. As mentioned earlier, the statutory provisions of MHPAEA generally became applicable for plan years beginning on or after October 3, 2009. The interim final rules generally became applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010, which for calendar year plans, is January 1, 2011. Therefore, many group health plans and health insurance issuers first began compliance with the Departments' regulations in 2011.

Before it could deploy its enforcement efforts to determine the extent of compliance with MHPAEA and the interim final rules, DOL needed to initially develop a MHPAEA infrastructure focusing on the first three Strategies of Implementation: 1) issuing interpretive guidance; 2) conducting external outreach and compliance assistance activities; and 3) providing participant assistance. As these first three Strategies are successfully launched into FY 2012, DOL has and will continue to evaluate compliance with the law and regulations.

As stated earlier in this Report, the Departments operate under a MOU²⁹ that implements section 104 of HIPAA, enacted on August 21, 1996, and subsequent amendments, and provides that requirements over which two or more Secretaries have responsibility (Shared Provisions) must be administered so as to have the same effect at all times. HIPAA section 104 also requires the coordination of policies relating to enforcing the Shared Provisions in order to avoid duplication of enforcement efforts and to assign priorities in enforcement.

DOL and the IRS generally have enforcement authority over private sector employment-based plans that are subject to ERISA. HHS has direct enforcement authority with respect to self-funded non-Federal governmental plans. While State insurance commissioners have primary authority over issuers in the large group market, HHS has secondary enforcement authority. Therefore, if there is a complaint regarding MHPAEA, the Departments generally collaborate with one another, as appropriate, on any investigations and broad-based compliance assistance efforts.

²⁹ See 64 FR 70164 (December 15, 1999).

V. REINFORCEMENT OF STRATEGIES

In order to effectively launch the Strategies of Implementation, particularly outreach/compliance assistance, participant assistance, and enforcement, EBSA has been conducting intensive internal training sessions to ensure EBSA staff is well-equipped to respond to inquiries and issues raised under MHPAEA. In addition, research studies that are being conducted will help to reinforce all four Strategies and will provide valuable information related to how MHPAEA and the interim final rules have affected group health plan and issuer behavior in the marketplace.

A. INTERNAL TRAINING/QUALITY CONTROL

After the RFI, interim final rules, and sub-regulatory guidance were published, EBSA national office staff conducted separate MHPAEA-specific internal training for its regional office staff (benefits advisors and investigators) to ensure that EBSA staff provides the regulated community and consumers with accurate and up-to-date information related to MHPAEA and the interim final rules. Such internal training generally consists of an interactive webinar or in-person presentation that provides a general overview of the law and rules, a discussion of newly-published technical guidance, and a question and answer session specifically targeted towards real-life scenarios and situations.

As benefits advisors are often the first point of contact for participants, beneficiaries, group health plans and issuers, and are fielding inquiries related to individuals' mental health parity-related rights and benefits and plan compliance with the requirements of rules, proper benefits advisor training is paramount in effective implementation of MHPAEA and the interim final rules. For investigators, investigative aids were developed and used in connection with internal investigator training. Specifically, EBSA updated the investigator checklist to include the requirements of MHPAEA and the interim final rules to help with the investigative process. These tools are used by investigators to effectively review group health plan documents for compliance with the requirements of MHPAEA and the interim final rules. These trainings and tools play an important role in ensuring that investigators are knowledgeable and prepared to work with plans in identifying and correcting MHPAEA compliance problems. These practices are collectively a key aspect of the MHPAEA implementation process. Each of EBSA's regional and district offices provide the regulated community and consumers with a

point contact for assistance with understanding and complying with MHPAEA and the interim final rules.

Simultaneous with updating its investigative checklist to incorporate the new requirements under MHPAEA, EBSA revised its Self-Compliance Tool within its HIPAA Compliance Assistance Guide³⁰ (HIPAA Guide) to include a discussion of MHPAEA. The HIPAA Guide provides transparency and a public version of the checklist, which is comparable to the investigative aid used by EBSA regional office staff to analyze a group health plan's compliance with each ERISA Part 7 requirement. In addition to referring individuals to the Self-Compliance Tool, EBSA's benefits advisors, who receive public inquiries and participate in compliance assistance outreach regarding the provisions of Part 7 of ERISA, often use it as well. As MHPAEA implementation progresses, DOL is likely to continue to refine these tools based on any feedback regarding what would make the tools easier to use and to incorporate additional tips (such as issues recently addressed in the publicly available FAQs) into the tools to make them a comprehensive compliance and participant assistance aid.

Such rigorous internal training and program updates help to maximize the level of quality control over the information and interpretive guidance provided to the public and reinforce EBSA's efforts to successfully implement MHPAEA. Given the complexity of MHPAEA and the interim final rules, these updates will ensure that EBSA staff is providing individuals with the most accurate and up-to-date information. In addition, EBSA has a Senior Technical Advisor who serves as a liaison between the regional and national office EBSA staff to coordinate consideration of highly technical inquiries. These processes enable EBSA to stay abreast of the issues arising with respect to MHPAEA implementation and provide a constant stream of feedback from the regulated community and consumers to EBSA. EBSA uses this information to assess the needs and appropriately develop and provide additional guidance, training, and tools, as appropriate, to maintain a high level of quality control over the dissemination of MHPAEA-related information.

B. MHPAEA STUDIES AND EXPERT PANEL

1. NQTL and "Scope Of Services" Study

HHS commissioned short-term research studies in FY 2011 on two issues specific to MHPAEA and the interim final rules. The Departments believed that further research on these issues would be particularly useful in implementing the rules and providing

³⁰ See, <http://www.dol.gov/ebsa/publications/CAG.html> to access the updated Self-Compliance Tool (Appendix A).

further guidance. These studies focused on the use of NQTLs by group health plans and group health insurance issuers and implications on parity for the scope of services covered by such plans and issuers. The findings on NQTLs were based primarily on interviews with managed behavioral health industry experts and the deliberations of a technical expert panel comprised of well-known researchers and practitioners with clinical expertise regarding behavioral health and general medical treatment issues.

The deliberations of the technical expert panel were focused on how NQTLs are used by plans and issuers to manage mental health and substance use disorder benefits and any clinical justifications for variations as to how NQTLs apply to mental health and substance use disorder benefits compared to medical benefits. Three main categories of NQTLs were discussed: medical necessity definitions and criteria, utilization management practices, and provider network management. The panel discussed a number of processes, strategies, and evidentiary standards that they considered justifiable considerations for plans and issuers to use in establishing NQTLs for mental health and substance use disorder and medical surgical benefits. The justifiable considerations identified by the panel included evidence of clinical efficacy, diagnostic uncertainties, unexplained rising costs, availability of alternative treatments with different costs, variation in provider qualifications and credentialing standards, high utilization relative to benchmarks, high practice variation, inconsistent adherence to practice guidelines, whether care is experimental or investigational, and geographic variation in availability of providers. The panel also discussed how the standard in the MHPAEA interim final rules requires that these considerations be applied in a comparable way to mental health and substance use disorder benefits and medical/surgical benefits in determining how a plan or issuer will apply an NQTL. Furthermore, the panel discussed situations in which the outcome of applying these considerations in a comparable way may justifiably result in a different application of an NQTL to mental health and substance use disorder benefits compared to medical/surgical benefits. The findings from this study as well as input from various stakeholders and public comments on the interim final rules informed the Departments' development of guidance regarding NQTLs in the most recently issued set of FAQs regarding MHPAEA.

Regarding scope of services, HHS commissioned a study on the degree to which group health plans and group health insurance issuers cover intermediate mental health and substance use disorder services including partial hospitalization, intensive outpatient, and residential treatment services and the cost implications of health plan coverage for these types of services. HHS continues to study scope of services issues with an ongoing examination of coverage levels for similar types of non-acute, intermediate medical/surgical services by group health plans and insurers. HHS also conducted in-depth analysis of public comments on the interim final rules regarding scope of services issues and has researched state laws that incorporate scope of services standards.

2. Compliance Study

HHS has also commissioned a study to examine compliance with MHPAEA by employer-sponsored group health plans and health insurance coverage offered in connection with such group health plans. This on-going study will focus primarily on implementation of the rules regarding financial requirements and quantitative treatment limitations by health plans and insurers in accordance with the standards detailed in the interim final rules for calculating the predominant level that applies to substantially all medical and surgical benefits. In addition, this study will include an examination of the types of NQTLs that are commonly used by plans and insurers and whether and how these practices may have changed in response to MHPAEA. The study will also include an overview of the types of plans and programs subject to MHPAEA and those that are exempt from MHPAEA as well as the interplay between state parity mandates, MHPAEA, and provisions in the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). This analysis will also provide estimates of the number of people served by these different types of plans and programs, both those subject to MHPAEA and those exempt, as well as the types of unequal limits and requirements that remain in effect in exempt plans and programs.

VI. CONCLUSION

A. THE DEPARTMENTS ARE MAKING PROGRESS

Congress enacted MHPAEA in an effort to address the disparities present in the marketplace with respect to the provision of mental health and substance use disorder benefits and medical/surgical benefits. The Departments were then tasked with developing regulations to implement the intricate statutory requirements under MHPAEA.

Upon issuing the MHPAEA interim final rules, the Departments realized that the complexity of the law and regulations gives rise to many highly technical issues and questions. Considerable confusion regarding the practical details of implementation of the interim final rules has been brought to the attention of the Departments by a wide-range of representatives from Congress, the Parity Implementation Coalition, Mental Health America, and American Psychiatric Association, among others. Recognizing this, the Departments have remained extensively involved in on-going discussions with stakeholders. In addition, the Departments have worked diligently to coordinate internally and inter-Departmentally to identify and address issues as they have been brought to the Departments' attention. To attempt to provide as much publicly available guidance in the most time-effective manner, the Departments issued sub-regulatory guidance to address the initial waves of comments and inquiries. This demonstrates the Departments' efforts to remain involved and facilitate the ongoing process of MHPAEA implementation. The Departments intend to continue this ongoing process and to issue additional sub-regulatory guidance in the future to address other common issues related to the implementation of MHPAEA and the interim final rules.

The Departments were faced with MHPAEA implementation efforts taking form, just as the challenges of implementing and navigating the new world of health care reform under the Affordable Care Act were just beginning. Significantly, the Affordable Care Act advances the notion of providing equal and quality benefits to all Americans. The Departments remain committed to and have worked diligently to ensure meaningful impact of the protections intended to reach the affected behavioral health community as well as interested stakeholders. This is demonstrated in part through the Departments interpreting and implementing complex provisions of health care law, particularly with respect to behavioral health benefits.

To achieve its ultimate goal of successfully implementing MHPAEA, EBSA has created a robust MHPAEA infrastructure that includes four Strategies: 1) issuing interpretive guidance; 2) conducting external outreach and compliance assistance activities; 3)

providing participant assistance; and 4) enforcing the law and regulations. EBSA is also conducting internal training and quality control as well as commissioning research studies to reinforce each Strategy and ensure EBSA accomplishes its mission of helping the marketplace understand MHPAEA and benefit from it, as intended.

Further, EBSA has developed relationships and established an informal process for meetings and communication with stakeholders to gain ongoing feedback regarding the successes and challenges that have and will arise in the ongoing MHPAEA implementation process. With this framework in place, the Departments are well positioned to continue working to ensure a full and meaningful implementation of the MHPAEA protections available to America's workers, children, and families through employment-based group health plan coverage.

B. FUTURE REPORTS TO CONGRESS

As discussed earlier, before it could deploy its enforcement efforts to determine the extent of compliance with MHPAEA and the interim final rules, DOL needed to initially develop a MHPAEA infrastructure focusing on the first three Strategies of Implementation: 1) issuing interpretive guidance; 2) conducting external outreach and compliance assistance activities; and 3) providing participant assistance. As these first three Strategies are successfully launched into FY 2012, DOL has and will continue to evaluate compliance with the law and regulations.

Moreover, after the preliminary findings from the compliance study related to financial requirements and quantitative treatment limitations have been examined and analyzed, DOL will work to, if appropriate, submit a supplemental report to this Report to Congress with analysis of the data and results from any enforcement actions and the compliance study commissioned by HHS as they relate to compliance with MHPAEA and the interim final rules by large group health plans and issuers. DOL intends to continue collecting and analyzing compliance data (including as they relate to NQTLs) as it becomes available and will supplement the analysis of the preliminary findings of this Report, if possible, in advance of the next report to Congress due on January 1, 2014.