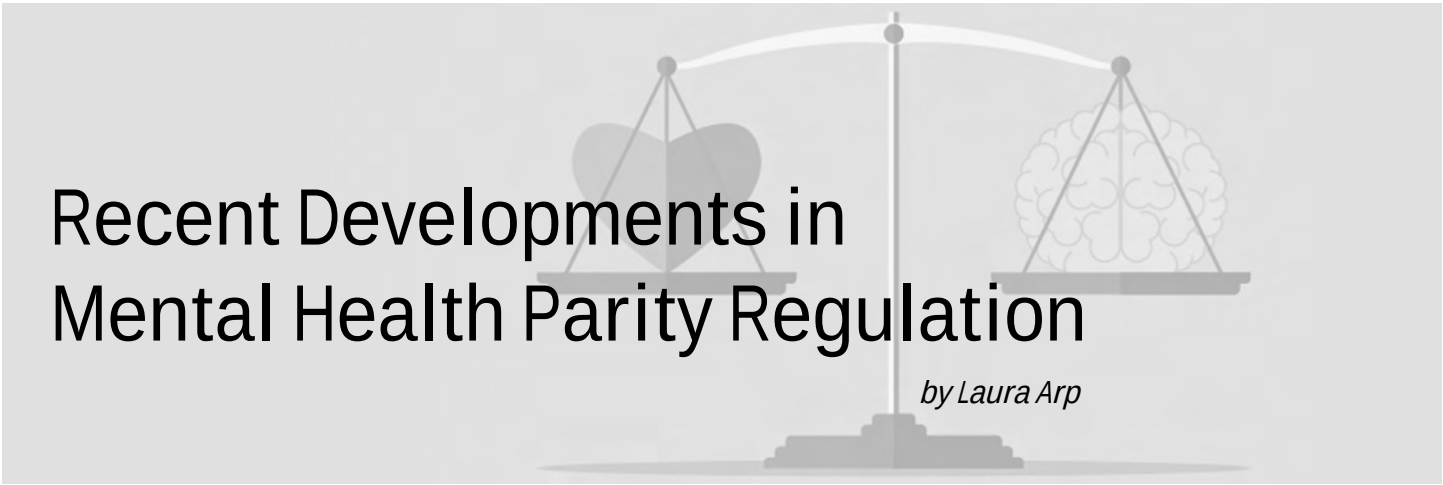

Recent Developments in Mental Health Parity Regulation

by Laura Arp

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.[1] MHPAEA requires parity in benefit limitations that are quantitative, such as copay dollar amounts or visit limits, and non-quantitative treatment limitations, such as preauthorization requirements. If your health plan requires you to take steps or pay money to get access to a mental health or substance use disorder benefit, you have encountered a treatment limitation and MHPAEA likely applies. This article provides an overview of the steps involved in parity analysis and recent developments in parity regulation.

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MHPAEA applies to most employer health plans and individual health insurance.

If mental health or substance use disorder benefits are part of a group health plan, MHPAEA's parity requirements generally apply. Individual and small group health insurance plans are required to provide mental health and substance use disorder benefits as part of the Affordable Care Act's essential health benefits package, and therefore MHPAEA applies to all individual and small group health insurance. The final essential health benefits rules require that mental health and substance use disorder benefits be provided in compliance with the requirements of the MHPAEA rules.[2] Large group health insurance and self-insured ERISA plans are subject to MHPAEA if they provide mental health and substance use disorder benefits in any category described in the MHPAEA final regulation.[3]

A few types of health plans are exempt from MHPAEA.

MHPAEA does not apply to excepted benefit plans—for example, specified disease or hospital indemnity insurance—and MHPAEA does not apply to short-term limited duration health insurance. While MHPAEA applies to most employment-based group health coverage, there are a few important exceptions.[4] Specifically, MHPAEA does not apply to small employers who have fewer than 51 employees.[5] It is worth noting that even though an MHPAEA exception applies to small group health plans, small employers are indirectly subject to MHPAEA requirements if they purchase a small group insurance policy because of the MHPAEA and ACA requirements for small group insurance. There is also an increased cost

exception available to plans that follow guidance issued by the Departments of Health and Human Services, Labor, and the Treasury.[6] Additionally, plans for state and local government employees that are self-insured may opt-out of MHPAEA's requirements if certain administrative steps are taken (such as sending notice to enrollees).[7] Finally, MHPAEA does not apply to retiree-only plans.[8]

MHPAEA compliance analysis under the 2014 final rule

The substantive MHPAEA parity requirements are 14 years old, with final implementing rules effective January 13, 2014.[9] The MHPAEA final regulations classify benefits into six groups:

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.[10]

For outpatient benefits, a plan or insurer is allowed to subclassify benefits so that office visits are their own category, with all other outpatient items and services in a separate category.[11] Sub-classifications for generalists and specialists are not allowed.[12] Pharmacy benefits that tier the cost sharing for drugs, with lower copays for tier one and higher copays for tier two, then an even higher charge for specialty drugs, will be evaluated for parity in tiering.[13] For example, if a drug to treat substance use disorder is in a high cost-sharing tier because it is a brand name drug and there is a less expensive generic version of the drug available, and drugs to treat medical conditions are tiered using the same methodology, the high copay for the substance use disorder drug is not a MHPAEA violation.

Benefits are typically classified by using billing codes. After classification, limitations are evaluated in two groups—quantifiable treatment limitations and nonquantitative treatment limitations.

Two-step MHPAEA analysis for financial requirements and quantitative treatment limitations

Quantifiable treatment limitations involve a number and are evaluated using expected plan spending on medical/surgical benefits. Parity analysis is performed using the "substantially all" and "predominant" tests for financial requirements (deductibles, copayments, coinsurance, and out-of-pocket maximums) and quantitative treatment limitations (limits on the number of treatments, visits, or days of coverage).[14]

For the "substantially all" test, determine if a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of the medical/surgical benefits in a classification.[15] This two-thirds should be calculated using dollars the plan expects to pay within the classification.[16] For example, if the plan expects to pay $1 million in outpatient in-network benefits during the coming plan year, and $800,000 of those benefits are subject to a percentage coinsurance payment, then coinsurance is the financial requirement that applies to substantially all outpatient in-network benefits.

Note that if a type of financial requirement or quantitative treatment limitation does not apply to two-thirds of the medical/surgical benefits in a classification, that financial requirement or quantitative treatment limitation cannot be applied to mental health or substance use disorder benefits in that classification. For example, if copayments did not apply to two-thirds of the benefits (by expected cost) in the outpatient in-network classification, then copayments could not apply to any outpatient in-network mental health and substance use disorder benefits.

Next, the "predominant" test is applied to any limitation that passes the "substantially all" test. There are likely different levels of a financial requirement or quantitative treatment limitation. Levels can be copay dollar amounts—for example, a $15 copay for primary care and a $30 copay for specialists. Levels can also

be a percentage cost share, where the patient pays a specified percentage of the total charge. The level that applies to at least 50% of the benefits is the "predominant" level, which must be applied to mental health and substance use disorder benefits.[17]

Continuing the example above, with $800,000 of outpatient in-network benefits subject to a percentage coinsurance, if outpatient surgery center costs at 10% coinsurance were estimated to be $700,000 of those benefits, and chiropractor costs at 30% coinsurance were estimated to be $100,000 of those benefits, the plan could only impose 10% coinsurance on outpatient in-network mental health and substance use disorder benefits.

Grouping benefits into classifications and performing this two-step analysis corrected for the problem of insurers picking a "comparable" medical/surgical benefit with a high dollar copayment or high percentage coinsurance, then applying that financial requirement to mental health and substance use disorder benefits because the treatment seemed similar. Copayments for physical therapy were frequently used as the comparison point. With the classification methodology, there can be no singling out of a high-dollar comparison point on the medical/surgical side.

The classification methodology was first announced in the MHPAEA interim final rule in 2010. In response, plans and insurers pointed out that for outpatient benefits, it is common to require a copayment for office visits, but charge coinsurance for other outpatient services such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items.[18] For example, where large amounts of outpatient benefit dollars go to outpatient surgery centers for things like knee replacements, and those benefits are subject to coinsurance, then coinsurance is the financial requirement that passes the "substantially all" test. Therefore, coinsurance is the only financial requirement that can be imposed on outpatient mental health and substance use disorder benefits. This resulted in patients being required to pay coinsurance for an office visit to see a mental health professional, instead of the copayment that applied to an office visit for medical services. In response, the rule was modified to allow a subclassification in outpatient benefits for office visits. Insurers have the option, but are not required, to separate office visits from the rest of outpatient benefits when conducting the "substantially all" and "predominant" tests.

Non-quantitative treatment limitations analysis

Non-quantitative treatment limitations (NQTLs) do not involve a dollar amount or absolute limit on number of treatments. Instead, NQTLs are barriers to treatment based on plan requirements that must be satisfied prior to care, typically described as "medical management." Comparison of medical/surgical NQTLs and MH/SUD NQTLs is more diffi-

cult because medical management techniques are typically a response to benefit-specific concerns. For example, an insurer may place extra approval requirements on residential substance use disorder treatment due to a high percentage of fraudulent claims.[19] That concern is unique to substance use disorder—a plan seeking to demonstrate NQTL parity would need to explain its reason for imposing additional requirements for insureds to access residential substance use disorder treatment, then also explain if the same concerns about fraudulent claims had arisen on the medical/surgical side and received the same treatment.

This non-exhaustive list of NQTLs should provide some context for the amount of work involved in NQTL analysis.

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization or ongoing authorization requirements;
- Concurrent review standards;
- Formulary design for prescription drugs;
- Network tier design for plans with multiple network tiers (such as preferred providers and participating providers);
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or issuer methods for determining usual, customary, and reasonable 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);
- Exclusions of specific treatments for certain conditions;
- Restrictions on applicable provider billing codes;
- Standards for providing access to out-of-network providers;
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.[20]

Plans and issuers are now required to document NQTL parity compliance.

The Consolidated Appropriations Act of 2021[21] amended MHPAEA to require that sponsors of group health plans and health insurers perform and document comparative analyses of the design and application of non-quantitative treatment limitations (NQTLs).[22] The required comparative analysis for NQTLs must include the following information, performed in the following steps:[23]

1. Identify in the plan documents all the services to which the NQTL applies in each classification. Note that NQTLs may not be described in the coverage document—some NQTLs are only found in internal guidelines or provider contracts.
2. Identify the factors considered in design of the NQTL. Some examples are excessive utilization of the benefit, recent medical cost escalation, provider discretion in determining diagnosis, lack of clinical efficiency of treatment or service, or high levels of variation in length of stay.
3. Identify the sources used to define the factors identified above to design the NQTL, such as internal claims analysis, medical expert reviews, national accreditation standards, or internal market and competitive analysis. Evidentiary standards can be sources and can include internal plan or insurer standards as well as published standards.

4. Perform a comparative analysis demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are applied no more stringently than they are applied to medical/surgical benefits. Consider whether the plan or insurer has identified a threshold for when the factor will result in imposing an NQTL. For example, high levels in variation in length of stay may be considered as a factor when claims data shows that 25% of patients stayed longer than the median length of stay for acute hospital episodes of care.
5. Specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate noncompliance with MHPAEA, must be documented.[24]

Regulators frequently point out that the NQTLs must be in parity both as written and in operation. Therefore, a plan or insurer's parity analysis must examine how claims were handled to determine if, in operation, the NQTL was applied evenly to MH/SUD when compared to medical/surgical claims. Demonstrating parity could involve an internal claims database analysis to demonstrate that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and medical/surgical benefits subject to the NQTL.

Where a plan or insurer contracts with a third-party administrator to provide behavioral health benefits, if the parity analysis did not involve informing that third-party administrator about the NQTLs that apply to medical/surgical benefits, then regulators may point out that an effective parity analysis was not completed because MH/SUD NQTLs were never compared to medical/surgical NQTLs.

Federal regulators are required to review MHPAEA compliance from a sample of group health plans every year, with corrective action required if plans are found out of compliance.[25] The U.S. Department of Labor, regulating self-insured plans, and U.S. Department of Health and Human Services, regulating non-federal governmental plans as well as the individual and fully insured group markets in some states, must issue an annual report to Congress detailing the results of these reviews.

Federal agencies' first report under the new analysis requirements was recently issued.

The 2022 Report to Congress on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008[26] was issued on January 25, 2022.[27] The report cites specific examples of health plans and health insurance issuers

failing to ensure parity. For example, a health insurance issuer covered nutritional counseling for medical conditions like diabetes but not for mental health conditions such as anorexia nervosa, bulimia nervosa, and binge-eating disorder.[28]

The report summary notes that none of the comparative analyses for NQTLs reviewed to date have contained sufficient information upon initial receipt. The Employee Benefits Security Administration (EBSA) listed common themes from deficient NQTL analyses, including failure to document comparative analysis before designing and applying the NQTL and conclusory assertions lacking specific supporting evidence or detailed explanation.[29]

In 2021, EBSA issued 156 letters to plans and insurers requesting comparative analyses for 216 unique NQTLs across 86 investigations.[30] The Centers for Medicare & Medicaid Services (CMS) issued 15 letters between May and November 2021 to issuers in states where CMS has direct enforcement authority over MHPAEA (Texas, Missouri, and Wyoming) and to non-federal governmental plan sponsors in those and other states.[31]

MHPAEA enforcement at the state level

In states other than Texas, Missouri, and Wyoming,[32] state regulators enforce MHPAEA. States' collaboration with each other and the federal government are facilitated through the National Association of Insurance Commissioners (NAIC) Mental Health Parity and Equity Addiction Act Working Group.[33] In 2018, the NAIC added a MHPAEA examination chapter to the Market Regulation Handbook used by states in conducting market conduct examinations of insurers.[34] The NAIC has begun revising the Market Regulation Handbook MHPAEA Chapter to reflect the additional NQTL analysis requirements enacted in the Consolidated Appropriations Act of 2021.[35] A few states have also developed their own tools for collecting plan information to perform MHPAEA analysis.[36] A 2016 report from the Substance Abuse and Mental Health Services Administration (SAMHSA) provides examples from several states.[37]

Civil class actions as a form of MHPAEA enforcement

Wit v. United Behavioral Health,[38] a class action filed in the Northern District of California and now on appeal to the Ninth Circuit Court of Appeals, is viewed as a landmark MHPAEA case.[39] The court found that United Behavioral Health had developed and implemented flawed "medical necessity" criteria for mental health and substance use disorder treatment services.[40] A significant part of the ruling was based on the findings that United Behavioral Health's utilization review criteria, named the "Level of Care Guidelines," were inconsistent with "generally accepted standards of care."[41] The Findings of Fact and Conclusions of Law provide a unique insight into ways a plan *could* violate MHPAEA.

In March 2021, United Behavioral Health appealed to the Ninth Circuit Court of Appeals, arguing in part that the court usurped United Behavioral Health's authority to set guidelines and interpret plan terms, the court erred by rewriting the plans to require coverage consistent with generally accepted standards, and the court applied the wrong standard of review to United Behavioral Health's clinical judgments about generally accepted standards.[42] This case will be important for plans that set their own medical management standards instead of following standards developed by organizations such as the American Society of Addiction Medicine. The court's findings address mandated standards for levels of care for substance use disorder treatment or determining substance use disorder treatment medical necessity in Illinois, Connecticut, Rhode Island, and Texas,[43] finding that the company was not free to come up with its own criteria to determine which substance use disorder treatment it would cover.

Amicus briefs have been filed by the American Psychiatric Association, the United States Chamber of Commerce, and America's Health Insurance Plans. Notably, the State of California and the U.S. Secretary of Labor filed amicus briefs in support of the Plaintiff-Appellees. Oral arguments were heard on August 11, 2021. The Ninth Circuit had not issued its opinion as of February 28, 2022.

Conclusion and Links to MHPAEA Resources

The complicated and evolving regulatory requirements for MHPAEA compliance indicate that attorneys should seek specialized counsel as they advise insured patients, ERISA plans, or insurance companies. Plans and insurers should utilize the federal compliance tools. The U.S. Department of Labor's Self-Compliance Checklist is updated every two years and provides citations and guidance. A list of links to helpful MHPAEA resources, including the Self-Compliance Checklist, is provided below.

- The Department of Labor's MHPAEA page: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity
- Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf
- For implementation of "Section 203," the new NQTL analysis requirements: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf
- Another helpful FAQ for NQTL analysis: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf (also includes a form to request disclosure of information on a plan's limitations that led to a denial of mental health or substance use disorder benefits)
- FAQ part 38: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf
- FAQ part 34: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf
- CMS Fact Sheets and FAQs (scroll down to "Mental Health Parity") https://www.cms.gov/cciio/resources/fact-sheets-and-faqs#Mental%20Health%20Parity
- Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf

Endnotes

1 *See* U.S. Centers for Medicare & Medicaid Services, online at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.

2 45 CFR 156.115(a)(3); *see also* ACA Implementation FAQs Part XVII, Q6, online at https://www.dol.gov/sites/default/files/ebsa/aboutebsa/our-activities/resource-center/faqs/aca-part-xvii.pdf.

3 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).

4 FAQs for Employees about the Mental Health Parity and Addiction Equity Act (May 18, 2012), online at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/mhpaea-2.pdf.

5 26 CFR 54.9812-1(f)(1), 29 CFR 2590.712(f)(1), 45 CFR 146.136(f)(1). For more information on the small employer exception, *see* Q8 of the FAQs available at http://www.dol.gov/ebsa/faqs/faq-aca5.html.

6 26 CFR 54.9812-1(g), 29 CFR 2590.712(g), 45 CFR 146.136(g).

For more information on MHPAEA's increased cost exemption, *see* Q11 of the FAQs available at http://www.dol.gov/ebsa/faqs/faq-aca5.html.

[7] FAQs for Employees about the Mental Health Parity and Addiction Equity Act (May 18, 2012), online at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/mhpaea-2.pdf. This election was authorized under section 2722(a)(2) of the PHS Act (42 USC § 300gg-21(a)(2)). An employee of a state or local government can ask if a particular employment-based plan has opted out by contacting HHS at 877-267-2323, ext. 61565 or at phig@cms.hhs.gov.

[8] *Id.*; *see* 75 Fed. Reg. 34538 at 34539 (June 17, 2010) for more information on special rules for retiree-only plans.

[9] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240-68296 (November 13, 2013), online at https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act.

[10] 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).

[11] 26 CFR 54.9812-1(c)(3)(iii); 29 CFR 2590.712(c)(3)(iii) 45 CFR 146.136(c)(3)(iii).

[12] 26 CFR 54.9812-1(c)(3)(iii)(C), 29 CFR 2590.712(c)(3)(iii)(C), 45 CFR 146.136(c)(3)(iii)(C).

[13] 26 CFR 54.9812- 1(c)(3)(iii), 29 CFR 2590.712(c)(3) (iii),45 CFR 146.136(c)(3)(iii).

[14] 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).

[15] 26 CFR 9812-1(c)(3)(i)(A), 29 CFR 2590.712(c)(3)(i)(A), 45 CFR 146.136(c)(3)(i)(A).

[16] 26 CFR 54.9812-1(c)(3)(i)(C), 29 CFR 2590.712(c)(3)(i)(C), 45 CFR 146.136(c)(3)(i)(C).

[17] 26 CFR 54.9812-1(c)(3)(i)(B)(1), 29 CFR 2590.712(c)(3)(i)(B)(1), 45 CFR 146.136(c)(3)(i)(B)(1).

[18] *See* MHPAEA FAQ #1 at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/mhpaea-1# ("Until the issuance of final regulations, the Agencies have determined that they will establish an enforcement safe harbor under which the Agencies will not take enforcement action against a plan or issuer that divides 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.").

[19] Press Release, U.S. Attorney's Office for the Southern District of Florida, Florida Doctor Charged In Massive $681 Million Substance Abuse Treatment Fraud Scheme (July 31, 2020), online at https://www.justice.gov/usao-sdfl/pr/florida-doctor-charged-massive-681-million-substance-abuse-treatment-fraud-scheme.

[20] 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), 45 CFR 146.136(c)(4)(ii). For additional examples of plan provisions that may operate as NQTLs see Warning Signs, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/warningsigns-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf.

[21] Pub. L. 116-260 (December 27, 2020).

[22] ACA FAQ Part 45 (April 2, 2021), online at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

[23] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

[24] Internal Revenue Code (Code) section 9812(a)(8)(A)(i)-(iv), ERISA Section 712(a)(8)(A)(i)-(iv) and Public Health Service (PHS) Act section 2726(a)(8)(A)(i)-(iv).

[25] Code section 9812(a)(8)(B)(i), ERISA section 712(a)(8)(B)(i), and PHS Act section 2726(a)(8)(B)(i).

[26] *See* 2022 MHPAEA Report to Congress, online at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

[27] Press Release, U.S. Departments of Labor, Health and Human Services, Treasury Issue 2022 Mental Health Parity and Addiction Equity Act Report to Congress (January 25, 2022), online at https://www.hhs.gov/about/news/2022/01/25/us-dol-hhs-treasury-issue-2022-mental-health-parity-addiction-equity-act-report-to-congress.html.

[28] *Id.*

[29] 2022 MHPAEA Report to Congress at *4, online at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.

[30] *Id.*

[31] *Id.*

[32] Missouri, Oklahoma, Texas, and Wyoming are "CMS Direct Enforcement" states, meaning that CMS, rather than the state, enforces Affordable Care Act market reforms. See CMS Form and Rate Filing Instructions for Plan Year 2022 at https://www.cms.gov/CCIIO/Resources/Training-Resources/Downloads/PY2022-Form-and-Rate-Filing-Instructions.pdf. As noted under instruction 3, in Oklahoma, CMS will identify MHPAEA concerns in ACA filings then share those concerns with the Oklahoma Insurance Department.

[33] *See* NAIC MHPAEA Working Group, online at https://content.naic.org/cmte_b_mhpaea_wg.htm.

[34] The NAIC Market Regulation Handbook is available for purchase at https://content.naic.org/prod_serv_marketreg.htm#mkt_reg_hb. The Texas Department of Insurance has posted the Mental Health Parity Guidance as Adopted by the Market Conduct Examination Standards (D) Working Group on December 19, 2018, online at https://www.tdi.texas.gov/health/documents/naicparityanalysis.pdf.

[35] Agenda for the September 30, 2021, meeting of the Market Conduct Examination Guidelines (D) Working Group, available at https://content.naic.org/sites/default/files/call_materials/10-07.pdf.

[36] *See, e.g.*, Pennsylvania's QTL and Financial Requirement Template Instructions online at https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Documents/2021%20ACA/QTLTemplateInstructions.pdf.

[37] Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States, online at https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4983.pdf.

[38] Wit v. United Behavioral Health, No. 14-cv-02346-JCS, 2019 WL 1033730, Findings of Fact and Conclusions of Law (N.D. Cal. March 5, 2019).

[39] The Kennedy Forum, Wit vs. United Behavioral Health: Where does it stand? (June 25, 2021), online at https://www.thekennedyforum.org/blog/wit-vs-united-behavioral-health-where-does-it-stand/.

[40] *Id.*

[41] *Id.*

[42] Defendant-Appellant's Opening Brief, Nos. 20-17363, 20-17364, 21-15193, 21-15194, 2021 WL 1132483 (9th Cir. March 15, 2021).

[43] 215 Ill. Comp. Stat. 5/370c(b)(3) ("Medical necessity determinations for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity determinations for substance use disorders"); Conn. Gen. Stat. § 38a-591c(a)(3) (2017) (requiring insurers to use ASAM criteria); 27 R.I. Gen. Laws § 27-38.2-1(g) (2015) (same); 28 Tex. Admin. Code § 3.8011 (1991) ((requiring insurers to apply criteria issued by the Texas Department of Insurance ("TDI Criteria" or "TCADA Guidelines") in making medical necessity determinations)).