ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

April 10, 2026

The Honorable Daniel Aronowitz
Assistant Secretary
Employee Benefits Security Administration
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Washington, D.C. 20210

Mr. Peter Nelson
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Re: Recommended Updates to the Self Compliance Tool

Dear Assistant Secretary Aronowitz, Director Nelson, Ms. Morrison, and Mr. Lindenmuth:

Please accept the recommendations from the Association for Behavioral Health and Wellness (ABHW) to the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, "the Departments") regarding updates to the DOL Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (Self Compliance Tool or the Tool) to improve and streamline the mental health (MH) and substance use disorder (SUD) parity compliance process.

ABHW is the national voice for payers managing behavioral health (BH) insurance benefits. Our member companies provide coverage to 200 million people in the public and private

sectors to treat MH, SUDs, and other behaviors that impact health and wellness. Since its inception, ABHW has been at the forefront of and an advocate for MH and SUD parity and was instrumental in drafting the legislation for the initial Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Our members have worked tirelessly over the past 17 years to implement parity for behavioral health services.

The Self-Compliance Tool remains a helpful resource; however, its practical value has diminished as state and federal regulators now require Non-Quantitative Treatment Limitations (NQTL) comparative analyses that go far beyond the illustrative examples provided. In practice, the Tool no longer reflects the level of specificity, depth, and evidentiary rigor typically expected in state and federal-level MHPAEA reporting.

One of ABHW's primary recommendations is the development of a fully end-to-end sample comparative analysis response for each NQTL. While the Self-Compliance Tool includes helpful scenarios, health plans would benefit significantly from comprehensive examples for each NQTL demonstrating how a complete analysis should be structured, documented, and presented. High-level illustrations alone do not provide sufficient clarity for consistent implementation. A fully developed sample response would promote greater consistency across plans and enable issuers to better anticipate expectations in both federal and state reviews. This would save tremendous resources and guesswork for health plans, insurers, employers, and regulators, ensure that the documentation submitted to the Departments is compliant, and help maintain consistency in future discussions.

To support this effort, ABHW is developing a comparative analysis model response to share with the Departments this year. Our goal is to provide a practical, operational analysis response that reflects how plans apply the regulatory framework in real-world settings and that could serve as a useful reference point for future guidance and oversight.

In addition to the model response, as the Departments update the Self-Compliance Tool, ABHW respectfully requests that the next iteration of guidance include the following enhancements:

- Clearer definitions
- Standardized templates
- Additional examples and, where appropriate, thresholds
- Stronger guidance on data sufficiency, vendor oversight, and documentation
- Practical examples of compliant/non-compliant analyses

Please see below for more detailed information regarding these updates.

I. Definitions & Clarifications

MH/SUD Benefits are Defined as Benefits Generally Delivered to Treat a MH/SUD Condition, Not Based Solely on Diagnosis

ABHW encourages the Departments to adopt a practical approach that provides flexibility for plans to determine reasonable methods to identify and define "MH/SUD benefits." The methodology for defining MH/SUD benefits is foundational to the design and implementation

of Financial Requirements (FRs), Quantitative Treatment Limitations (QTLs), and NQTLs, including regarding the operationalization of cost-sharing for claims administration. ABHW urges the Departments to explicitly permit plans to choose between: (1) defining MH/SUD benefits based on the reported diagnosis on claims and authorization requests (when available and applicable); or (2) defining treatments and services generally used to treat MH/SUD conditions as MH/SUD benefits, with all other benefits treated as medical/surgical (M/S). For example, under the latter option, a health plan to use its annual claims experience to determine its spending on the service in question to determine whether the service should be treated as a MH/SUD benefit or an M/S benefit. Similarly, plans could define M/S and MH/SUD benefits based on reasonable factors such as the type of service and whether the service is primarily used to treat a MH/SUD or M/S condition.

The ability to define MH/SUD benefits as a defined set of treatments and services that are generally used to treat MH/SUD conditions aligns with guidance issued by the Centers for Medicare & Medicaid Services ("CMS") regarding the application of parity to long-term services and supports for Medicaid and CHIP enrollees. The CMS guidance allows health plans to define benefits that can be used to treat either medical or behavioral conditions by means of a reasonable method, such as looking at the services and treatment spend and determining whether the service is predominantly used for a medical diagnosis or a mental health/substance use disorder diagnosis and defining it accordingly.[1]

Outpatient Office Visits v. "Other"

We request clarification on how health plans should define and distinguish between the "office visit" and "other outpatient" benefit classifications for the purposes of MHPAEA compliance. Many behavioral health services, such as neuropsychological or psychological testing, may be furnished in both office and facility settings. Similarly, the 2013 MHPAEA Rule defines "all other outpatient items and services" to include laboratory charges,[2] notwithstanding that certain laboratory services are commonly billed with an office visit place of service. Absent clear guidance, plans face challenges ensuring that financial requirements and treatment limitations are applied in a manner comparable to M/S benefits, as required under MHPAEA. We request that the guidance clarify how these definitions apply to both FR/QTL testing and claims adjudication, including whether cost-sharing and testing may be based on (1) place of service alone, (2) service type alone, or (3) a combination of both.

There is ongoing confusion regarding whether plans should use place of service codes or type of service as the primary method for categorizing services. This distinction is important because certain services, such as applied behavior analysis (ABA) therapy, medication

[1] A variety of LTSS benefits, such as personal care and respite care, could be defined as either MH/SUD or medical/surgical (M/S), depending on the condition of the beneficiary being treated. For these benefits, the state may define the benefit as MH/SUD or M/S for the entire beneficiary population using a reasonable method, such as whether the service is most commonly or frequently provided due to a MH/SUD or M/S condition. For example, if more than 50% of spending on personal care is for beneficiaries who are receiving the service due to M/S conditions, the state may reasonably define personal care services as a M/S benefit for the purposes of the parity analysis.

[2] 29 CFR 2590.712(c)(3)(iii)(C)(2)

management, methadone maintenance, and neuropsychological and psychological testing, may be delivered in either an office or facility setting.

Additionally, some states require that these services, along with their associated cost-sharing structures, be separately identified in plan contracts, which can limit plans' ability to apply different cost-sharing tiers based on site of service (e.g., office versus facility).

Clear guidance on how to categorize services as office-based or facility-based would help promote consistency and ensure more accurate and reliable QTL testing across plans.

II. List of NQTLs

We recommend that the Departments rely on a set list of NQTLs for which health plans are required to provide upon the initial request from the relevant Secretary for a comparative analysis within 10 business days. While we understand the Departments' reluctance to narrowly constrain the universe of NQTLs, the absence of clearer guardrails continues to create confusion, elevates compliance risk, and diverts significant plan resources toward documentation rather than patient care. The current list of NQTL examples remains incomplete and, in some cases, relies on overly broad descriptors (e.g., restrictions on billing codes), making it difficult for health plans to determine whether a particular practice should be treated as an NQTL. We recommend that the Departments utilize the list enumerated from the MHPAEA Interim Final Rule of 2010[3] and referenced in the 2013 MHPAEA Final Rule, published on November 13, 2013.

We encourage the Departments to publicly identify a core set of NQTLs through the Reports to Congress and expect auditors to target only those NQTLs that are the primary focus of DOL audit and enforcement activity each year.

The core NQTLs for which health plans and carriers should be required to proactively document comparative analyses should be:

1. **Medical Management Processes**, such as prior authorization, limit or exclude benefits based on medical necessity or medical appropriateness or based on whether treatment is experimental or investigational.
2. **Network Composition Standards**, such as methods for determining reimbursement rates and credentialing standards.
3. **Exclusions Based on Failure to Complete a Course of Treatment;** and
4. **Out-of-Network Provider Reimbursement Rate Setting Methodology**[4].

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[3] 75 Fed. Reg. 5410 (Feb. 2, 2010), *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*.

[4] We note that we recommend deleting the explanatory phrasing for this NQTL type in the 2024 Rule ("such as allowed amounts; usual, customary, and reasonable charges; or application of other external benchmarks for out-of-network rates"), given the potential for this language to be misinterpreted to define the NQTL type to mean the allowed amounts themselves, rather than the methodology for determining such amounts. Guidance should be clear that reasonable data measures based on allowed amounts may be used to evaluate compliance in operation for the plan or carrier's Out-of-Network Provider Reimbursement Rate-Setting Methodology, but just like data measures for other NQTL types, quantitative comparisons of out-of-network allowed amounts would not be dispositive as to compliance. Instead, disparate outcomes for such data measures would require the plan to

The following are additional NQTL types that the Departments could incorporate into the required set of comparative analyses in future years, should EBSA determine that their inclusion would serve the public interest:

5. **Prescription Drug Formulary Design,**
6. **Network Tier Design** for health plans with multiple tiers such as preferred versus participating provider tiers.
7. **Step Therapy or Fail-First Protocols for** refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective.
8. **Coverage Restrictions based on Geographic Location, Facility Type, Provider Specialty**, or other criteria that limit the scope or duration of benefits for services provided under the plan.

Additionally, we also request guidance to clarify that provider directories are not an independent NQTL type under MHPAEA, as they do not function as limits on the scope or duration of treatment.[5] Provider directories are informational resources, typically required under separate transparency and consumer protection frameworks, and do not independently limit network access or benefits. While we understand that inaccuracies in directories may affect a member's experience in locating care, these issues are more appropriately addressed through directory accuracy and transparency requirements rather than through the NQTL comparative analysis framework. To the extent they are considered in a parity context, they should not be deemed to constitute an independent NQTL type.

Greater clarity is especially needed where regulatory interpretations have varied. For example, both state and federal regulators have taken inconsistent positions on whether, and under what circumstances case management constitutes an NQTL. In these situations, plans are often required to invest substantial time and resources to effectively prove a negative, underscoring the need for timely, clear guidance from the Departments when recurring uncertainty arises.

III. Illustrations and Practical Examples

Provide Operational Examples for Rate Comparability Analyses

ABHW respectfully requests that the Departments provide more practical examples to support rate comparability analyses, particularly for inpatient reimbursement rates.

- **Inpatient Facility Reimbursement Rates:** Existing guidance focuses largely on professional CPT-coded services. Additional examples showing how to assess comparability for inpatient facility reimbursement, where rate structures and contracting approaches differ significantly, would better reflect real-world behavioral health contracting and promote more consistent analysis. That said, comparisons must be made between like services and reimbursement structures. For example, while there

evaluate whether the disparity is caused by a disparity in the factors, sources, or evidentiary standards that are used in the design or application of the NQTL.

[5] 29 U.S.C. § 1185a(a)(3)(B)(iii); 42 U.S.C. § 300gg-26(a)(3)(B)(iii); 26 U.S.C. §9812(a)(3)(B)(iii)

are multiple approaches to inpatient reimbursement, comparing DRG-based rates to per diem rates does not constitute a valid comparison.

Clarify When Case Management is an NQTL

As we discussed above, both federal and state regulators have taken differing positions on whether, and when case management constitutes an NQTL. In the absence of clear guidance, health plans are often required to devote significant resources to demonstrate that their case management practices do not operate as an NQTL. Listing out clear examples that identify the specific characteristics under which Case Management would be determined to impose a limit on the scope or duration of services, and specific circumstances where it would not, would reduce uncertainty and improve consistency.

Provide a Comprehensive "Written vs. Operational" Examples

As ABHW noted in our introduction, we are working to develop a practical, operational comparative analysis response that reflects real-world settings and that could serve as a useful reference point for future guidance and oversight.

In addition to that broader effort, we are specifically looking for examples that help illustrate the difference between the "as written" vs. "in operation" steps of a comparative analysis. Specifically compliant examples of comparability "as-written" should include analysis of Summary Plan Descriptions (SPDs), policies and procedures, and provider network participation contracts. Compliant examples of comparability "in operation" should address the plan's implementation of its "as-written" standards in practice, including with regard to plan operations such as claims processing, authorization determinations, allowed amounts for reimbursement.

In particular, the Departments should:

- Paired "as written" vs. "operational" examples
- An example of sufficient detailed terms for a single NQTL**,** showing the level of specificity that regulators would likely consider adequate.
- Examples of operational metrics that health plans can run to demonstrate that "sufficient" proof of in operation, including cycle time, denial rates, exception review timelines, turnaround times.

IV. Factors & Evidentiary Standards

ABHW encourages the Departments to provide clear and consistent definitions for the regulatory terms "Factors," "Processes," and "Evidentiary Standards." Clear definitions are essential to promote consistent interpretation, reduce compliance uncertainty, and support meaningful implementation.

In particular, the definitions of "Factors" and "Evidentiary Standards" should expressly recognize that:

- Evidentiary standards for qualitative factors may be appropriately based on the exercise of professional judgment by clinical or operational experts rather than measurable thresholds
- Some factors are external to and not within a health plan's control.

ABHW also respectfully urges the Departments to clarify the relationships among the following concepts, which are currently treated inconsistently or blended in ways that create confusion:

- Factor
- Evidentiary Standard
- Sources of the Evidentiary Standard

Clear delineation among these elements would improve transparency, reduce ambiguity in comparative analyses, and better align regulatory expectations with how NQTLs are designed and applied in practice.

V. Defined Protocols for Investigations

ABHW believes that defined investigative frameworks would enhance consistency, clarity, and administrative efficiency for all stakeholders, including the following recommendations:

- Increase the timeframe for health plans to respond to requests for any information that has not been clearly identified in advance in guidance. The current timeframes that are generally allotted to respond to requests for additional information (generally 10-14 days) rarely provide enough time to collect and analyze the requested information.
- Priorities for enforcement should be based primarily on an identified set of substantive compliance concerns that should be updated on an annual or other periodic basis.
- Investigations should be targeted to address issues that will impact substantive findings. For example, factors, sources, and evidentiary standards to determine which benefits are subject to a limit are essentially irrelevant if all benefits in that classification are subject to the NQTL.
- Any requests for additional information following an initial documentation request should identify specific concerns regarding substantive non-compliance to be rebutted or resolved.
- **Clarification of Investigative Procedures Under ERISA.** Additionally, ABHW respectfully requests that the Departments issue guidance clarifying investigative procedures in circumstances where the scope of a mental health parity investigation expands materially beyond the issues initially identified.
    - Specifically, the Departments should establish a clear process to delineate the circumstances under which EBSA should open a new investigation number under ERISA, or otherwise formally document and communicate the scope of the new topics and regulatory requirements that are the basis for the investigation.
    - ABHW believes that clearer procedural guidance in this area would improve consistency in enforcement while supporting the Departments' oversight objectives.

VI. Establish a Consistent, Documented Process for a Preliminary Determination of Non-Compliance

During ABHW's December 11th meeting with EBSA, we presented the idea of establishing an appeals process similar to existing CMS appeals processes (e.g., RADV and RAC audits). While we understand that such an approach may be too burdensome at this time, the establishment of an administrative process to appeal final determinations would provide plans and issuers with a meaningful avenue to challenge alleged insufficiencies or violations, particularly given that the statutory consequences of a noncompliance finding are significant.

As an alternative, more streamlined approach to promote transparency and provide an opportunity to clarify data and address potential misunderstandings, ABHW respectfully recommends that the Departments establish a consistent, documented interim step in the enforcement process by issuing an "Initial Determination of Non-Compliance" prior to a final determination. This process should allow plans to engage with the Departments and respond to preliminary findings before a Final Determination is issued.

Under this approach, health plans would receive written notice of the Departments' preliminary findings and be afforded at least 60 days to respond, supplement the record, or address any identified deficiencies.

Incorporating this step would promote transparency, improve the accuracy of final determinations, and ensure that plans have a meaningful opportunity to clarify data, correct misunderstandings, or implement remediation. We believe this approach would strengthen procedural fairness while also enhancing the efficiency and effectiveness of the enforcement process.

VII. Define Compliance Safe Harbors Based on Specified Outcome Metrics for the Most Investigated NQTL Types.

To further our collective goal of improving access to MH and SUD services, we urge the Departments to create clear compliance safe harbors for the most common types of NQTLs. These safe harbors should outline plan design features and outcome measures that demonstrate when an NQTL is unlikely to create access disparities. If a health plan or issuer meets all the criteria for a safe harbor, regulators could reasonably conclude that further review of that NQTL's comparative analysis is unnecessary.

This approach, similar to how the Office of Inspector General (OIG) administers safe harbors under the Anti-Kickback Statute, will bring needed clarity, reduce administrative burden, and allow the Departments to focus enforcement on actual barriers to care.

Please see ABHW's preliminary recommendations for proposed safe harbor standards related to utilization management (UM) practices.[6]

[6] ABHW submitted this proposal to the Departments in December 2025.

VIII. Create a Safe Harbor for Following Third-Party Accreditation Standards

ABHW urges the Departments to create a safe harbor for health plans and issuers that obtain MHPAEA parity accreditation. Developing a safe harbor for mental health parity accredited entities would be specific to the criteria for which the third-party accredited entity has established standards and the health plan has demonstrated it meets those standards. It would also provide greater certainty for organizations pursuing accreditation aligned with federal and state MHPAEA standards.

These approaches would promote regulatory consistency, enhance transparency, and reduce unnecessary administrative duplication. Importantly, they would also enable the Departments to focus enforcement resources on higher-risk entities, while appropriately acknowledging those that have undergone rigorous, independent, standard-based assessments aligned with federal expectations.

ABHW is committed to working with the Departments to improve behavioral health outcomes for all Americans. We welcome the opportunity to meet with the Departments to discuss these recommendations. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,

Debbie Witchey, MHA
President and CEO