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ERISA Advisory

New DOL Enforcement Focus on Mental Health and Substance Use Disorder Parity

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The Obama Administration's focus on the problems of mental health and substance use disorders continues to intensify. In late 2015, President Obama addressed a presidential memorandum to a number of executive agencies, including the heads of the Departments of Labor (DOL), Treasury, and Health and Human Services (HHS) regarding wide-spread addiction to heroin and prescription drugs and urging the agencies to accelerate their efforts to combat addiction.[1] Both the DOL and HHS are focusing new regulatory and enforcement initiatives on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which became effective January 1, 2014.[2] On June 2, 2016, the DOL released a checklist for MHPAEA compliance.[3]

Under MHPAEA, plan sponsors must ensure that any financial or treatment limitations on benefits under a group health plan are not more stringently applied to mental health and substance use disorder (MH/SUD) benefits than to medical/surgical benefits. The DOL has an expansive view of the scope of a plan sponsor's fiduciary duty to monitor its health care providers and third party administrators for MHPAEA compliance. MHPAEA violations can result in a breach of fiduciary duty under ERISA and an IRS penalty of $100 per covered individual per day.[4]

In a recent talk on the DOL's ERISA Part 7[5] enforcement initiative, a DOL representative noted that many medical plan sponsors must be "reminded" that they are subject to ERISA's fiduciary rules to the same extent as

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1 Memorandum on Addressing Prescription Drug Abuse and Heroin Use, 2015 Daily Comp. Pres. Doc. 743 (Oct. 21, 2015); Office of the Press Secretary, Fact Sheet: Obama Administration Announces Additional Actions to Address the Prescription Opioid Abuse and Heroin Epidemic (Mar. 29, 2016. Both the Presidential Memorandum and the Fact Sheet are available at www.whitehouse.gov/briefing-room.

2The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; H.R. 1424, 110th Cong. (2008) (MHPAEA). MHPAEA amended the following federal statutes: 29 U.S.C. § 1185a, § 712 (ERISA); 42 U.S.C. § 300gg–5, § 2705 (Public Health Service Act); and I.R.C. § 9812 (Internal Revenue Code or Code).

3 DOL, Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance, available at https://www.dol.gov/ebsa/ (hereinafter NQTL Warning Signs).

4 I.R.C. § 4980D(b).

5ERISA Part 7 includes the following federal laws: Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") 29 U.S.C. § 1161 et seq.; Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191, 110 Stat. 1936 (1996); Genetic Information Nondiscrimination Act of 2008 (GINA), Pub. L. 110-233, 122 Stat. 881 (2008); and Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (PPACA). The PPACA was amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010). The resulting combined legislation is referred to as the Affordable Care Act (ACA). MHPAEA is also applicable to individual and small group health plans under the ACA.

retirement plan sponsors, including the duty to monitor service providers.[6] While the DOL's view is not surprising, its description of the scope and level of detail required to monitor Part 7 compliance is troubling. Most plan sponsors traditionally rely heavily on health care providers and third party administrators to ensure operational compliance with ERISA Part 7 and MHPAEA. However, even plan sponsors that actively monitor ERISA Part 7 compliance are often unable to negotiate custom provisions in standard vendor agreements.

For example, in its presentation, the DOL noted that the plan sponsor is responsible for ensuring that the medical provider's explanation of benefits (EOB) is sufficient under ERISA's claims procedure, and, if the plan sponsor determines the language is insufficient, the plan sponsor is responsible for negotiating changes to the provider's EOB language. This, of course, is easier said than done.

Background: MHPAEA's Application to ERISA Medical Benefit Plans

ERISA requires that a medical plan either designate or establish a procedure for designating a "named fiduciary" authorized to control or manage the operation and administration of the plan.[7] The plan may also designate an "administrator" legally responsible for certain administrative and managerial tasks under the plan, such as providing summary plan descriptions and filing Forms 5500 (Annual Return/Report of Employee Benefit Plan). ERISA and most plan documents provide that, if no "named fiduciary" or "administrator" is designated, the responsibility for those roles resides with the plan sponsor.[8]

An "administrator" under ERISA's definition should not be confused with the various providers and third party administrators (TPA) engaged by the plan sponsor or plan committee to run the plan. A provider or TPA can specifically agree to be the "plan administrator" for ERISA purposes, but this liability is more commonly disclaimed. A vendor may accept fiduciary status for a limited purpose, such as claims administration, but, in the same contract, agree to perform non-fiduciary "ministerial" tasks of plan administration. For example, a provider or TPA that disclaims fiduciary status argues that its implementation of a "medical management" protocol is a ministerial act.

The DOL has observed that some medical plan sponsors may not even read their plan documents and have little knowledge of operational compliance with the plan. During an audit, the DOL typically asks for copies of the plan documents and related claims data to test whether the plan is operationally compliant with ERISA Part 7. The DOL has stated that it is using its subpoena power early in the audit process to obtain the information that it requires, and, in contrast to its former practice, is more likely to involve DOL attorneys at the outset of the enforcement process. The DOL asserts that its current enforcement resolution is requiring the re-adjudication of improperly resolved claims, although violations may also result in class action lawsuits or IRS penalties. Depending on what it finds on audit, the DOL may decide to refocus its investigation and subpoena power on a provider.

MHPAEA Compliance for Employer-Provided Group Health Plans

Covered Plans. MHPAEA applies to any group health plan sponsored by an employer or an employee organization, including a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans, which cover both medical/surgical and MH/SUD benefits. Employers with at least two but not more than 50 employees on business days during the preceding calendar year (counting, for

6 ERISA Roundtable, March 24, 2016, Washington D.C.

7 ERISA § 402(a)(1).

8 ERISA § 402(a)(2).

this purpose, all members of the employer's controlled group) are excluded from MHPAEA.[9] Retiree-only plans are also excluded. A group health plan may also be exempt from MHPAEA if a qualified actuary determines that MHPAEA compliance for a full year results in a two percent increase (one percent for subsequent years) in the actual total cost of coverage for medical/surgical benefits and MH/SUD benefits after complying for at least the first six months of the year, provided notice is provided to participants, the DOL, and "appropriate state agencies".

MHPAEA's requirements apply across all plan providers, so that, in a plan using different service providers for MH/SUD and medical/surgical benefits, all benefit combinations are treated as a single group health plan and all such combinations must be in parity under MHPAEA.

MHPAEA Categories. In testing parity under MHPAEA, the plan's health coverage is divided into six categories[10]:

- Inpatient in-network
- Outpatient in-network
- Inpatient out-of-network
- Outpatient out-of-network
- Emergency care
- Prescription drugs

A plan sponsor is still free exclude all MH/SUD benefits from plan coverage, but a covered plan that offers MH/SUD coverage in any category is required to provide MH/SUD benefits in all six categories. There is no violation, however, if the only MH/SUD benefits offered by the plan are employer-paid preventative services (i.e., with no cost-sharing) as required under the Affordable Care Act,[11] such as alcohol misuse screening and counseling, depression screening, and tobacco use screening.

Defining MH/SUD Benefits. Under MHPAEA, the plan sponsor has discretion to define the particular mental health benefits and substance use disorders covered under the terms of the plan (or health insurance policy) as long as such definitions comply with federal and state law. The final rules under the MHPAEA (the "Regulation")[12] merely provide, without much elaboration, that "mental health benefits"

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[9] Self-insured state and local government employee plans can elect to opt out of MHPAEA by following certain administrative steps. However, MHPAEA applies to the individual and small group markets, as well as to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

[10] MHPAEA allows a few of the six categories to be further broken down into subcategories for applying the financial and treatment limitation tests. Outpatient services (both in-network and out-of-network) encompass two subcategories: (1) office visits; and (2) all other outpatient benefits. Prescription drug benefits can be divided into different tiers of prescription drugs, provided the tiers are based on reasonable factors such as cost, efficacy, generic versus brand, and pickup versus mail order, and without regard to whether the drug is generally prescribed for medical/surgical or MH/SUD benefits. 29 C.F.R. § 2590.712(c)(3)(iii). Further subdivision is available to multiple network tiers, e.g., in-network preferred and in-network participating providers, provided the tiers are based on reasonable factors and without regard to whether the drug is generally prescribed for medical/surgical or MH/SUD disorder benefits.

[11] PPACA § 2713, relating to non-grandfathered plans.

[12] Final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008, 78 Fed. Reg. 68240, 68276,(Nov. 13, 2013) (codified at 29 C.F.R. § 2590.712).

means "benefits with respect to items or services for mental health conditions." 29 C.F.R. § 2590.712(a). Additionally, "substance use disorder benefits" means "benefits with respect to items or services for substance use disorders." *Id.* Both benefits definitions require that:

> Any condition defined by the plan or coverage as being or not being a mental health condition [or as a substance use disorder] must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), ICD [International Classification of Diseases] or State guidelines).

"Medical/surgical benefits" under the Regulation means "benefits with respect to items or services for medical conditions or surgical procedures, defined under the terms of the plan or (health insurance policy) and in accordance with applicable federal and state law, but excluding MH/SUD benefits." *Id.* As with MH/SUD benefits, the definition of medical/surgical benefits must be consistent with generally recognized independent standards of current medical practice.

Financial Requirements and Quantitative Treatment Limitations. MHPAEA focuses on three areas of MH/SUD coverage restrictions:

- Financial requirements, such as deductibles, copayments, coinsurance and out-of-pocket limitations. 29 C.F.R. § 2590.712(b)
- Quantitative treatment limitations, including the number of treatments, days of coverage, or office visits in a specified period
- Non-quantitative treatment limitations

Many plan sponsors have managed to identify and eliminate financial requirements and quantitative treatment limits on MH/SUD benefits. The Regulation contains a numeric test that allows a group health plan (or health insurance policy) to preserve limitations on MH/SUD benefits by satisfying a numeric test. 29 C.F.R. § 2590.712(c)(2)(i). Under the test, a group health plan can limit MH/SUD benefits in any classification, provided that the limit is not more restrictive than "the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification." *Id.*[13]

[13] "Predominant" means that the limitation (e.g., the co-payment or coinsurance level) applies to at least one half of the benefits in the classification. 29 C.F.R. § 2590.712(c)(3)(i)(2). "Substantially all" means a treatment limitation that applies to at least two-thirds of the benefits in a classification. 29 C.F.R. § 2590.712(c)(3)(i)(1). For example, assume a group health plan that imposes five levels of coinsurance on inpatient, out-of-network benefits for each of five different coverage units (i.e., self-only coverage, self plus one coverage, family coverage, etc.). The plan, using any reasonable method, first determines the projected dollar amounts expected to be paid under the plan for inpatient, out-of-network medical/surgical benefits for the upcoming year for each coinsurance level:

Coinsurance rate	0%	10%	15%	20%	30%	Total
Projected payments (medical/surgical benefits	$200x	$100x	$450x	$100x	$150x	$1,000x
Percentage of total plan costs	20%	10%	45%	10%	15%	
Percent subject to coinsurance level	N/A	12.5%	56.25%	12.5%	18.75%	
		100x/800x	450x/800x	100x/800x	150x/800x	

The plan projects plan costs for medical/surgical benefits subject to coinsurance of $800x out of total costs of $1,000x (i.e., $100x+$450x+$100x+$150x = $800x), or 80% ($800x/$1,000x) of the projected medical/surgical plan benefit

Non-quantitative Treatment Limitations. Parity for the non-quantitative treatment limitations may not be as easy to identify.[14] Non-quantitative parity requires that, in writing or operation, "any processes, strategies, evidentiary standards, or other factors" resulting in a treatment limitation to MH/SUD benefits in a given classification must be comparable to, and be applied no more stringently than, those applied to medical surgical benefits in the same classification. 29 C.F.R. § 2590.712(c)(4)(i). No numeric test is available to demonstrate parity for non-quantitative treatment limitations.

The Regulation contains a non-exhaustive list of examples of non-quantitative treatment limits, including:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative
- Formulary design for prescription drugs
- For plans with multiple network tiers (such as preferred providers and participating providers), the network tier design
- Standards for provider admission to participate in a network, including reimbursement rates
- Plan 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 based on failure to complete a course of treatment
- 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

26 C.F.R. §2590.712(c)(4)(ii).[15]

Limitations That May Indicate a MHPAEA Violation. While many plan sponsors are aware of or have been alerted to financial limitations and quantitative treatment limitations, the DOL has indicated that plan sponsors must also demonstrate during an audit that non-quantitative treatment limits are in parity. In the NQTL Warning Signs, the DOL published guidance on the types of non-quantitative treatment limitations that may be indicative of a MHPAEA violation. These limits including the following:

- **Application of Evidentiary Standards**. Assuming a plan covers medically appropriate treatments for both medical/surgical and MH/SUD benefits, a plan sponsor may be asked to demonstrate that the evidentiary standard used to determine the medical appropriateness of

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costs are subject to coinsurance. Of the $800x for projected medical/surgical plan benefit costs, 56.25% ($450x/800x) are subject to coinsurance of 15%. In this example, the 2/3 "substantially all" threshold is satisfied because 80% of the cost of inpatient, out-of-network medical/surgical benefits subject to coinsurance, and the 15% coinsurance level is "predominant" because 56.25% (more than ½) of such costs are subject to the 15% level. The plan can impose coinsurance on MH/SUD benefits in the category not more restrictive than 15%. 29 C.F.R. § 2590.712(c)(3)(iv), Example 1.

[14]A group health plan may consider a number of factors in determining medical management procedures consistently applicable to MH/SUD and medical/surgical benefits, including: cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud.

[15]A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for MHPAEA, although it may be impermissible under HIPAA. 29 C.F.R § 2590.712(a).

MH/SUD benefits is applied in a manner no more restrictive than the evidentiary standard applied to medical/surgical benefits.[16] For example, according to the NQTL Warning Signs, a plan that requires the likelihood that inpatient treatment will result in improvement before authorizing residential treatment for MH/SUD, or one that only covers services that result in measurable and substantial improvement within 90 days, may be in violation.

- **Network Quality**. For medical/surgical benefits, a plan sponsor is responsible for ensuring that the plan's list of outpatient in-network providers for MH/SUD benefits is no less robust and provides participants with an equally-wide array of choices as the list of outpatient in-network providers for medical/surgical benefits. A MHPAEA violation may occur if the network of MH/SUD providers is less robust, with fewer treatment opportunities than the network for medical/surgical benefits.
- **Communication Process Quality**. A plan sponsor may be liable for a MHPAEA violation if the plan's explanations for denials of medical/surgical benefits are more complete than the explanations for MH/SUD benefit denials. The plan must apply the claims procedure consistently with respect to MH/SUD and medical/surgical benefits.
- **Cost Projections in Applying the "Predominant/Substantially All" Test**. If the "predominant/substantially all" test is used to determine parity, a MHPAEA violation may occur if the "reasonable method" used to calculate projected plan costs for a year is manipulated against MH/SUD benefits. For example, instead of using the dollar amount of plan payments under the method, there may be a violation if the method is applied using projected costs based on the provider's entire overall book of business for the year, or its book of business in a specific region or state.
- **Classification of Intermediate Services**. The plan sponsor must ensure that intermediate MH/SUD benefits, such as residential treatment, partial hospitalization and intensive outpatient treatment, are not classified in a more restrictive manner than comparable intermediate medical/surgical benefits. For example, a plan that classifies skilled nursing and rehab hospitals for medical/surgical benefits as inpatient benefits would be expected to classify residential treatment facilities for MH/SUD benefits as inpatient benefits. Similarly, a plan that classifies home health care for medical/surgical patients as an outpatient benefit must also classify intensive outpatient mental health/SUD services and partial hospitalization as outpatient benefits.
- **Blanket Prescription Drug Denials**. An MHPAEA violation may occur when a plan in operation excludes from coverage antidepressant drugs that have a Food and Drug Administration "black box" warning[17], but permits "black box" prescriptions for medical/surgical benefits if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for an individual, based on clinically appropriate standards of care.
- **"Step Therapy" Protocol**. Assuming a plan provides for major medical coverage, along with an employee assistance program (EAP), a MHPAEA violation may occur if the plan in operation

[16] For example, the plan may apply an evidentiary standard based on the recommendation of panels of experts with appropriate training and experience in each field of medicine involved. If the evidentiary standards are applied in each field using medically appropriate treatment standards, then no violation of MHPAEA occurs, even if the determination results in a different number of days of treatment for MH/SUD benefits as compared to medical/surgical benefits. If the evidentiary standard for MH/SUD benefits is different that used for medical/surgical benefits, however, a MHPAEA violation may occur.

[17] A "black box" warning is a labeling requirement that informs consumers of significant risks of serious side effects associated with a medication.

requires participants to exhaust the EAP's limited number of substance use disorder counseling sessions before MH/SUD coverage is available under the major medical plan, while applying no similar exhaustion requirement for coverage of medical/surgical benefits under the major medical plan. Similarly, a plan that requires a patient to "fail" (i.e., not make sufficient progress) at a less frequent, non-intensive outpatient treatment program before covering an intensive outpatient treatment for MH/SUD may violate MHPAEA. A violation may also occur if a plan requires a participant to first attempt outpatient treatment or a partial hospitalization treatment program before covering inpatient treatment for MH/SUD.

- **Medical Necessity Determination**. If a plan conditions coverage for both MH/SUD and medical/surgical benefits based on medically necessity, a MHPAEA violation may occur if the plan in operation determines medical necessity using a concurrent review process for MH/SUD benefits (i.e., requiring unique clinical presentation, condition severity, expected course of recovery, quality and efficiency) while using a retrospective review process for medical/surgical benefits. Regardless of whether the concurrent review is more or less stringent than the retrospective review, the violation may occur because the two methods are not "comparable." Additionally, under the NQTL Warning Signs, a provision that delegates review authority for medical/surgical benefits to attending physicians but does not delegate the review for MH/SUD services may be a violation.
- **Prior Approval**. A MHPAEA violation may occur if the plan routinely requires prior approval of medical necessity for certain treatments and penalizes the failure to seek prior approval of MH/SUD treatments with a loss of coverage, whereas the penalty for failing to seek prior approval of medical/surgical treatments is only a 25% reduction in benefits. In the NQTL Warning Signs, the DOL suggests that the following preauthorization requirements may also be indicative of a violation:
    - A preauthorization requirement for all MH/SUD services
    - A precertification requirement for inpatient mental health treatment
    - A preauthorization requirement for all inpatient or outpatient chemical dependency treatments and all inpatient or outpatient treatment of serious mental illness and mental health conditions
    - Recurring authorization requirements (e.g., every 10 days or every three months) for MH/SUD services and prescriptions but not for medical/surgical benefits
    - A pre-notification requirement for MH/SUD services like inpatient services, intensive outpatient program treatment, and extended outpatient treatment that exceeds 45-50 minutes
- **Geographic Limitation**. A MHPAEA violation may occur if a plan generally covers medically appropriate treatments, but tends to exclude from coverage inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center) while covering inpatient treatment outside of a hospital for medical/surgical conditions if the prescribing physician obtains authorization that the treatment is medically appropriate for the individual, based on clinically appropriate standards of care.
- **Written Treatment Plan Requirements**. According to the NQTL Warning Signs, the following written treatment plan requirements as a condition for MH/SUD benefits may be indicative of an MHPAEA violation:
    - A provision that requires a written treatment plan prescribed and supervised by a behavioral health provider

  - A requirement that a treatment plan be developed within a certain time frame (e.g., within seven days) and reviewed for progress on a recurring basis
  - A provision that requires that an individual-specific treatment plan be updated and submitted on a recurring basis
- **Other Potential Violations**. Plan provisions that punish a patient for noncompliance with a treatment plan (e.g., eliminating coverage for chemical dependency treatment if the patient fails to complete the original plan of treatment), provisions that exclude residential treatment for MH/SUD, or plans that require MH/SUD facilities to be licensed while not imposing the same requirement on medical/surgical facilities may violate MHPAEA. *See NQTL Warning Signs* at V.

Plan sponsors may be able to spot disparities written into the terms of the plan for some of these examples, but may overlook restrictions that seem to be in parity based on the plan language but actually result in disparities in operation. Thus, plan sponsors should pay attention to whether their vendors are operating the plan in parity.

Disclosure to Participants and Providers. The Regulation provides that health plans must disclose their criteria for determining whether MH/SUD treatments are medically necessary. Both participants and participants' health care providers have the right to this information.[18] In a set of "Frequently Asked Questions" published on April 20, 2016,[19] the DOL dealt specifically with the information that may be requested regarding non-quantitative treatment limitations:

- A Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans
- The specific plan language regarding the imposition of the non-quantitative treatment limitations (such as a preauthorization requirement)
- The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the non-quantitative treatment limitations will apply to a particular MH/SUD benefit
- Information regarding the application of the non-quantitative treatment limitations to any medical/surgical benefits within the benefit classification at issue
- The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the non-quantitative treatment limitations will apply to any medical/surgical benefits within the benefit classification at issue
- Any analyses performed by the plan as to how the non-quantitative treatment limitations comply with MHPAEA[20]

This information "must be made available to any current or potential enrollee or contracting provider upon request."[21]

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[18] 26 C.F.R. § 54.9812-1(d); 29 C.F.R. § 2590.712(d); 45 C.F.R. §§ 146.136(d) and 147.160.

[19] Available on-line at www.dol.gov/ebsa/faqs/faq-aca31.html.

[20] *Id.*, Q9.

[21] *Id.*, Q10.

These disclosures of course do not exhaust the requirements of ERISA, the MHPAEA and other law, but they do require particular attention. Omissions or inaccuracies can have serious consequences in litigation over claims denials.

Next Steps: Plan Sponsors Should Consider the Following

Allocations of Fiduciary Authority. Review the allocations of fiduciary authority in the plan document, including the plan's designations of "named fiduciary" or "administrator" (or whether the plan provides for the appointment of a plan administrative committee to assume these roles), and ensure that any delegations of authority have been formally documented and accepted by the delegatee.

Medical Plan Vendor Agreements. Review medical plan vendor agreements to address the following:

- Whether the vendor has contractually assumed the role of "named fiduciary" or "plan administrator" for purposes of ensuring MHPAEA compliance in part (e.g., only for the purpose of claims adjudication) or in its entirety
- Whether the vendor is contractually obligated to perform the specific duties required for operational compliance with MHPAEA, and to produce the required documentation and disclosures that MHPAEA requires
- Whether the vendor has an obligation to notify the plan sponsor of any MHPAEA violations and when such violations must be corrected at the vendor's expense
- Whether the agreement limits the vendor's liability for MHPAEA and other Part 7 failures

Plan Amendments. Amend the plan document as necessary to ensure MHPAEA compliance.

Review and Edit Plan Summary. Update the plan's summary plan descriptions and other communications to describe the methods used to ensure MHPAEA compliance and the participants' rights to MHPAEA disclosures.