Chapter 24B—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination

Introduction

The purpose of this chapter, Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination, is to provide guidance for examiners when reviewing insurers whose business includes major medical policies offering mental health and/or substance use disorder coverage.

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group and large group insurance markets. The examination standards in Chapter 24—Conducting the Health Examination of the *Market Regulation Handbook* provide guidance specific to all health carriers that may or may not include offering mental health and/or substance use disorder coverage. Chapter 24, Section G Claims, Standard 3 applies to examinations related to the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 found at 42 U.S.C. § 300gg-26.

This guidance found in this chapter recognizes that when developing an examination or review plan related to MHPAEA compliance, it is important to consider examination standards as applicable from Chapter 24 and Chapter 24A—Conducting the Affordable Care Act (ACA) Related Examination, as well as Chapter 20.

Regardless of which chapter is used in the *Market Regulation Handbook,* the examiner will also need to reference Chapter 20—General Examination Standards for general examination standards that apply to all insurers.

The standards set forth in this chapter are intended to mirror established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This guide is a template to assist examiners in the examination process. Since it is based on NAIC models, use of the handbook should be adapted to reflect each state's own laws and regulations with appropriate consideration for any bulletins, audit procedures, examination scope and the priorities of examination**.**

Mental Health and Substance Use Disorder Parity

1. Purpose

Mental health and substance use disorder parity compliance examinations should be designed to ensure that all companies are in compliance with all the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (as amended by the Consolidated Appropriations Act of 2020) found at 42 U.S.C. § 300gg-26 and its implementing regulations found at 45 CFR § 146.136 and 45 CFR § 147.160.

These standards set forth herein require companies to demonstrate compliance in terms of defining mental health or substance use disorder benefits, classifying benefits, financial requirements, quantitative treatment limitations (QTLs), nonquantitative treatment limitations (NQTLs), required disclosures and vendor coordination.

2. Definitions

For purposes of this Guide, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate Lifetime Dollar Limit means a dollar limitation on the total amount of specified benefits that may be paid under a health plan (45 CFR § 146.136(a)).

Annual Dollar Limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a health plan (45 CFR § 146.136(a)).

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Classifications of benefits used for applying parity rules:

(1) Inpatient, In-network. Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage (45 CFR § 146.136(c)(2)(ii)(A)(1)).

(2) Inpatient, Out-of-network. Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes inpatient benefits under a plan (or health insurance coverage) that has no network of providers (45 CFR § 146.136(c)(2)(ii)(A)(2)).

(3) Outpatient, In-network. Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage. See special rules for office visits and plans with multiple network tiers in paragraph (c)(3)(iii) of 45 CFR §146.136 (45 CFR § 146.136(c)(2)(ii)(A)(3)).

(4) Outpatient, Out-of-network. Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers (45 CFR § 146.136(c)(2)(ii)(A)(4)).

(5) Emergency Care. Benefits for emergency care (45 CFR § 146.136(c)(2)(ii)(A)(5)).

(6) Prescription Drugs. Benefits for prescription drugs (45 CFR § 146.136(c)(2)(ii)(A)(6)).

Coverage Unit refers to the way in which a plan (or health insurance coverage) groups individuals for purposes of determining benefits, or premiums or contributions. For example, different Coverage Units include self-only, family, and employee plus-spouse (45 CFR § 146.136(a)).

Cumulative Financial Requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.) (45 CFR § 146.136(a))

Cumulative Quantitative Treatment Limitations are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits (45 CFR § 146.136(a)).

Expected Plan Payments are payments expected to be paid under the plan for the plan year (45 CFR § 146.136(c)(i)(C)). 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 QTL (45 CFR § 146.136(c)(3)(i)(E).

Plan Payment is the dollar amount of plan payments and is based on the amount the plan allows (before enrollee cost sharing) rather than the amount the plan pays (after enrollee cost sharing) because payment based on the allowed amount covers the full scope of the benefits being provided (45 CFR § 146.136(c)(i)(D)).

Financial Requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits (45 CFR § 146.136(a)).

Medical/Surgical Benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice

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(for example, the most current version of the International Classification of Diseases (ICD) or State guidelines) (45 CFR § 146.136(a)).

Mental Health Benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition 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), the most current version of the ICD, or State guidelines) (45 CFR § 146.136(a)).

Substance Use Disorder Benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being 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 DSM, the most current version of the ICD, or State guidelines) (45 CFR § 146.136(a)).

Treatment Limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition (45 CFR § 146.136(a)).

3. Techniques

To evaluate compliance with MHPAEA, examiners must request that the carrier submit the analyses and other underlying documentation that it has performed to determine that it meets all of the standards of MHPAEA. There must be specific documentation of how mental health conditions, substance use disorders and medical/surgical conditions were defined and how they were assigned to benefit classifications. There are specific mathematical analyses that the carrier must have performed in order to determine that it satisfies the MHPAEA requirements for financial requirements and quantitative treatment limitations QTLs. There are separate analyses the carrier must have performed in order to determine that it satisfies the MHPAEA requirement for NQTLs, which entail analyses for the "as written" component and analyses for the "in operation" component.

4. Standards and the Regulatory Tests

The mental health and substance use disorder parity review includes, but is not limited to, the following standards related to MHPAEA. The sequence of the standards listed here does not indicate priority of the standard.

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Standards for
Mental Health and Substance Use Disorder Parity Compliance

Standard 1
The health carrier shall define all covered services as mental health or substance use disorder benefits or as medical or surgical benefits. Mental health benefits or substance use disorder benefits must be defined to mean items or services for the treatment of a mental health condition or substance use disorder, as defined by the terms of the health plan and applicable state and federal law. Any definition of a condition or disorder as being or as not being a mental health condition or substance use disorder must be consistent with generally recognized independent standards of current medical practice or state guideline. (45 CFR § 146.136(a)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ Type of generally recognized independent standards of current medical practice, state law or guidance, used to define mental health conditions, substance use disorders and medical/surgical conditions (e.g., the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD code), etc.)

_____ List of specific mental health conditions or substance use disorders by diagnosis excluded from coverage as stated in the policy documents

_____ Mental health and/or substance use disorder and medical/surgical claim files

_____ Health carrier complaint/grievances/appeals records concerning mental health and/or substance use disorders (supporting documentation, including, but not limited to: written and phone records of inquiries, call center scripts, complaints, complainant correspondence and health carrier response)

_____ Internal department appeals/grievance files

_____ Applicable external appeals register/logs/files, external appeal resolution and associated documentation

Others Reviewed

Enforcement of the Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg–23

Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self Compliance Tool: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

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U.S. Department of Labor Frequently Asked Questions Guidance: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity

Review Procedures and Criteria

The health carrier shall identify which independent standards were used to define mental health conditions, substance use disorders and medical/surgical conditions.

The health carrier shall specify applicable state statutes or guidelines that stipulate the standard or definition of mental health conditions, substance use disorders, or medical/surgical conditions.

The carrier shall identify excluded diagnoses and stipulate that such exclusions are not prohibited by state or federal law.

The health carrier shall identify how it defines items or services as mental health benefits, substance use disorder benefits, or medical/surgical benefits, including items and services that are sometimes used for the treatment of mental health or substance use disorders and medical/surgical conditions (e.g., nutritional counseling, occupational therapy).

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Standards for
Mental Health and Substance Use Disorder Parity Compliance

Standard 2
The health carrier must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits in determining the classification in which a particular benefit belongs (or applicable sub-classification) (45 CFR § 146.136(c)(2)(ii)(A)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ All policy documents (e.g., if group or association, request master policy and a sample of each certificate type issued during the examination scope)

_____ Documentation as to how the carrier demonstrates assignment to the six classifications of benefits (and applicable sub-classifications) and the standard used

_____ Company and vendor claim procedure manuals and bulletins/communications (if a carrier uses a behavioral health claims vendor for processing MH/SUD claims or for providing utilization management services

_____ Internal company claim audit reports for both mental health or substance use disorders and medical/surgical services

_____ Provider contracts, instructions, communications and similar documents regarding coding instructions, code changes, etc.

_____ Utilization review and managed care guidelines and procedure manuals

_____ Mental health and/or substance use disorder and medical/surgical claim files

_____ Mental health and/or substance use disorder and medical/surgical complaint and grievance files

Others Reviewed

Enforcement of the Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg–23

Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self Compliance Tool: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

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U.S. Department of Labor Frequently Asked Questions Guidance: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity

Review Procedures and Criteria

The health carrier shall provide a list that specifies to which classification (or applicable sub-classification) all benefits were assigned.

The health carrier shall identify which, if any, benefits were classified into sub-classifications. Please note that the only permissible sub-classifications are: multiple tiers for prescription drugs benefits that are based on reasonable factors[1] (45 CFR § 146.136(c)(3)(iii)(A)); multiple network tiers that are based on reasonable factors within the inpatient in-network and outpatient in-network classifications (45 CFR § 146.136(c)(3)(iii)(B)); outpatient office visits and outpatient other services within the outpatient in-network and outpatient out-of-network classifications (45 CFR § 146.136(c)(3)(iii)(C)). The carrier shall retain sub-classifications for all parity analyses and testing for financial requirements, quantitative treatments limitations and nonquantitative treatment limitations.

The health carrier shall identify the standards used to determine which classification of benefits (or applicable sub-classification) a particular benefit was assigned to and indicate that the same standards were used for assigning medical/surgical benefits and mental health or substance use disorder benefits.

The health carrier shall demonstrate that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are covered.

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[1] Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up (45 CFR § 146.136(c)(3)(iii)(A)

Standards for Mental Health and Substance Use Disorder Parity Compliance

Standard 3
The health carrier shall not apply any financial requirement on mental health or substance use disorder benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant financial requirement of that type applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification) (45 CFR § 146.136(c)(2)(i)).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ Health carrier list of all financial requirements applied to mental health or substance use disorder benefits and medical/surgical benefits in each classification (or applicable sub-classification) (this will include schedules of benefits and other policy documents)

_____ Health carrier documentation of the reasonable method used to determine expected plan payments for medical/surgical benefits within each classification of benefits (or applicable sub-classification), including documentation and communications with vendors engaged to provide assistance with analyses

_____ Documentation demonstrating the predominant and substantially tests performed by the health carrier for each applicable financial requirement applied to all benefits

_____ Internal company claim audit reports specific to mental health or substance use disorders

_____ Mental health and/or substance use disorder and medical/surgical claim files

_____ Health carrier complaint records concerning mental health and/or substance use disorder (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, complainant correspondence and health carrier response)

_____ Internal department appeals/grievance files concerning mental health and/or substance use disorders

_____ Applicable external appeals register/logs/files related to concerning mental health and/or substance use disorder, external appeal resolution and associated documentation

Others Reviewed

Enforcement of the Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg–23

Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

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The Federal Parity Self Compliance Tool: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

Review Procedures and Criteria

Financial requirements include deductibles, copayments, coinsurance and out-of-pocket maximums (45 CFR § 146.136(c)(1)(ii)). A financial requirement is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/ surgical benefits in that classification (45 CFR § 146.136(c)(3)(i)(A)). The level of the financial requirement that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement (45 CFR § 146.136(c)(3)(i)(B)). The determination of the portion of medical/ surgical benefits in a classification of benefits subject to a financial requirement (or subject to any level of a financial requirement) 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 (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement) (45 CFR § 146.136(c)(3)(i)(C)).

The health carrier shall demonstrate the reasonable method used to perform the analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. A carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

The health carrier shall demonstrate that any type of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). If no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the financial requirement to all medical/surgical benefits within the classification). No financial requirements shall apply only to mental health or substance use disorder benefits.

The health carrier shall demonstrate that the level of financial requirement applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is comparable and no more restrictive than the level of financial requirement that applies to more than one-half of expected plan payments that are subject to the financial requirement within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)). The carrier shall demonstrate how it combined levels of the financial requirement to satisfy the predominant test if there is no single level that applies to more than one-half of medical/surgical benefits in the classification (45 CFR § 146.136(c)(3)(i)(B)(2).

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Standards for
Mental Health and Substance Use Disorder Parity Compliance

Standard 4
The health carrier shall not apply any QTL on mental health or substance use disorder benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant QTL of that type applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification) (45 CFR § 146.136(c)(2)(i).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ Health carrier list of all QTLs applied to mental health or substance use disorder benefits and medical/surgical benefits in each classification (or applicable sub-classification) (this will include schedules of benefits and other policy documents)

_____ Health carrier documentation of the reasonable method used to determine expected plan payments for medical/surgical benefits within each classification of benefits (or applicable sub-classification), including documentation and communications with vendors engaged to provide assistance with analyses

_____ Documentation demonstrating the predominant and substantially tests performed by the health carrier for each applicable financial requirement applied to all benefits

_____ Internal company claim audit reports

_____ Mental health and/or substance use disorder and medical/surgical claim files

_____ Health carrier complaint, grievance and appeals records (supporting documentation, including, but not limited to: written and phone records of inquiries, complaints, call center scripts, complainant correspondence and health carrier response)

Others Reviewed

Enforcement of the Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg–23

Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self Compliance Tool: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

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Review Procedures and Criteria

QTLs include annual, episode, and lifetime day and visit limits. (45 CFR § 146.136(c)(1)(ii)). A QTL is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/ surgical benefits in that classification (45 CFR § 146.136(c)(3)(i)(A)). The level of the QTL that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the QTL (45 CFR § 146.136(c)(3)(i)(B)). The determination of the portion of medical/ surgical benefits in a classification of benefits subject to a quantitative treatment limitation (or subject to any level of a 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 (or for the portion of the plan year after a change in plan benefits that affects the applicability of the quantitative treatment limitation) (45 CFR § 146.136(c)(3)(i)(C)).

The health carrier shall demonstrate the reasonable method used to perform the analysis that determines expected plan payments within each classification of benefits (or applicable sub-classification) for medical/surgical benefits. A carrier must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice (ACA FAQ 34 Q3).

The health carrier shall demonstrate that any type of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification) (45 CFR § 146.136(c)(3)(i)(A)). If no cost analysis was relied upon within this demonstration, the carrier shall specify how it concluded that the substantially all test was satisfied (e.g., it applies the quantitative limitation to all medical/surgical benefits within the classification). No quantitative treatment limitations shall apply only to mental health or substance use disorder benefits.

The health carrier shall demonstrate that the level of QTL applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) is no more restrictive than the level of QTL that applies to more than one-half of expected plan payments that are subject to the quantitative treatment limitation within that classification for medical/surgical benefits (45 CFR § 146.136(c)(3)(i)(B)(1)). The carrier shall demonstrate how it combined levels of the QTL to satisfy the predominant test If there is no single level that applies to more than one-half of medical/surgical benefits in the classification (45 CFR § 146.136(c)(3)(i)(B)(2)).

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Standards for
Mental Health and Substance Use Disorder Parity

Standard 5
The health carrier shall apply non-quantitative treatment limitations (NQTLs) to mental health or substance use disorder benefits within a classification of benefits (or applicable sub-classification) so that any processes, strategies, evidentiary standards, or other factors used to apply a limitation, 1) as written and 2) in operation, are comparable to the processes, strategies, evidentiary standards, or other factors used to apply the limitation to medical/surgical benefits within the classification (or applicable sub-classification) (45 CFR § 146.136(c)(i)). The health carrier shall perform and document comparative analyses of the design and application of NQTLs in accordance with 42 U.S.C. § 300gg-26(a)(8)(A).

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage.

Documents to be Reviewed

_____ Applicable state and federal statutes, rules, regulations and published sub-regulatory guidance

_____ A list of all NQTLs imposed upon mental health or substance use disorder benefits within each classification of benefits (or applicable sub-classification), including the methodology used to determine those NQTLs. A state may focus its review on a subset of NQTLs rather than all NQTLs. (See reference link to DOL Self-Compliance Tool for a non-exhaustive list)

_____ Utilization management manuals and utilization review documents such as: utilization review criteria; criteria hierarchies for performing utilization review; case management referral criteria; initial screening scripts and algorithms; policies relating to reviewer discretion; processes for identifying and evaluating clinical issues and utilizing performance goals

_____ Notes and/or logs kept during utilization review, such as those describing: peer clinical review; telephonic consultations with attending providers; consultations with expert reviewers; clinical rationale used in approving or denying benefits; the selection of information deemed reasonably necessary to make a medical necessity determination; adherence to utilization review criteria and criteria hierarchy; professional judgment used in lieu of utilization review criteria; actions taken when incomplete information is received from attending providers

_____ Company claim procedure manuals and bulletins/communications

_____ Claims processor and customer services MHPAEA training materials

_____ Company fraud, waste, and abuse policies and procedures

_____ Internal company claim audit reports

_____ Prescription drug formulary for each product/plan design

_____ Prescription drug utilization management documentation

_____ Fail-first policies or step therapy protocols

_____ Network development/contracting policies and procedures

_____ Standards for provider admission to participate in a network, including credentialing requirements

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_____ Standards for determining provider reimbursement rates

_____ Samples of provider/facility contracts in use during the exam period

_____ Plan methods for determining usual, customary and reasonable charges for each product/plan design

_____ Mental health and/or substance use disorder and medical/surgical claim files.

_____ Mental health and/or substance use disorder and medical/surgical utilization review

_____ Management files (prospective, concurrent and retrospective)

_____ Complaint files, logs and disposition notes

_____ Documentation, including but not limited to comparative analyses, demonstrating that within each of the 6 classifications of benefits (and applicable sub-classifications), the as written and in operation processes, strategies, evidentiary standards, or other factors used in applying a NQTL are comparable to and applied no more stringently to mental health or substance disorder benefits than to medical/surgical benefits in the classification.

Others Reviewed

Enforcement of the Public Health Services Act
42 U.S. Code § 300gg–22

Preemption relating to the Public Health Services Act
42 U.S. Code § 300gg–23

Mental Health Parity and Addiction Equity Act of 2008
42 U.S. Code § 300gg–26

Publication of summary plan description
ERISA 104(b) (29 U.S.C. § 1024(b))

The Federal Parity Self Compliance Tool: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (ACA FAQ 45): https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf

Review Procedures and Criteria

The health carrier shall perform and document comparative analyses demonstrating that within any classification of benefits, as written and in operation, the process, strategies, evidentiary standards, or other factors used in applying an NQTL to mental health or substance disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. The comparative analyses shall include the following, for each NQTL applied to mental health or substance use disorder benefits, separately for each classification of benefits (42 U.S.C. § 300gg-26(a)(8)(A):

- The specific coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which such NQTL applies in each respective benefits classification;

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- The factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits;
- The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits;
- The comparative analyses demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification; and
- The specific findings and conclusions reached by the health carrier with respect to the health insurance coverage, including any results of the analyses described in 42 USC 300gg-26(a)(8)(A) that indicate that the health carrier is or is not in compliance with 45 CFR 146.136(c)(4).

The health carrier's analyses must contain the following, at a minimum (ACA FAQ 45 Q2):

1. A clear description of the specific NQTL, plan terms and policies at issue;
2. Identification of the specific mental health or substance use disorder and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as mental health or substance use disorder and which are treated as medical/surgical;
3. Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both mental health or substance use disorder benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination;
4. To the extent the health carrier defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources;
5. The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the health carrier between mental health or substance use disorder and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation;
6. If the application of the NQTL turns on specific decisions in administration of the benefits, the health carrier should identify the nature of the decisions, the decision maker(s), the timing of the decisions and the qualifications of the decision maker(s);
7. If the health carrier's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the health carrier ultimately relied upon each expert's evaluations in setting recommendations regarding both mental health or substance use disorder and medical/surgical benefits;
8. A reasoned discussion of the health carrier's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the health carrier is or is not in compliance with MHPAEA; and
9. The date of the analyses and the name, title and position of the person or persons who performed or participated in the comparative analyses.

The health carrier shall avoid the following practices and procedures when responding to a request for comparative analyses (ACA FAQ 45 Q3):

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
3. Identification of processes, strategies, sources and factors without the required or clear and detailed comparative analysis;
4. Identification of factors, evidentiary standards and strategies without a clear explanation of how they were defined and applied in practice;

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5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; and
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

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Standards for
Mental Health and Substance Use Disorder Parity Compliance

Standard 6
The health carrier shall ensure that it complies with all availability of plan information and related disclosure obligations regarding: 1) criteria for medical necessity determinations; 2) reasons for denial of services; 3) information relevant to medical/surgical, mental health and substance use disorder benefits; 4) rules regarding claims and appeals, including the right of claimants to free reasonable access to and copies of documents, records and other information including information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards and other factors used to apply a NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan, including any analyses performed by the carrier as to how the NQTL complies with MHPAEA.

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Documents to be Reviewed

_____ Plan policies and procedures for responding to participant requests for medical necessity criteria for either or both mental health and substance use disorder services and medical/surgical services

_____ Plan policies and procedures for responding to requests for information on the processes, strategies, evidentiary standards and other factors used to apply a NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan

_____ Sample adverse benefit determination letters

_____ Sample letters responding to disclosure requests for medical necessity criteria and information on NQTLs

_____ Policies and procedures for classifying denials as administrative or medical necessity

_____ Internal and external appeals files for mental health and substance use disorder services adverse benefit determinations

_____ Log of disclosure requests, including date requested, date responses was provided, samples of documents sent in response

Others Reviewed

45 CFR § 146.136(d)
ERISA 104
29 CFR § 2520.104b-1
29 CFR § 2560.503-1
29 CFR § 2590.715-2719

Review Procedures and Criteria

The health carrier shall demonstrate the method by which it makes available to any current or potential participant, beneficiary, or contracting provider upon request the medical necessity criteria used to make mental health or substance use disorder medical necessity determinations (45 CFR § 146.136(d)(1)). This shall include a reporting of how the health carrier ensures prompt release of the criteria upon request.

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The health carrier shall demonstrate that it provides the reason for any denial of reimbursement for mental health or substance use disorder benefits (45 CFR § 146.136(d)(2)). This shall include a reporting of how the health carrier ensures prompt delivery of the reason for the denial to the beneficiary.

The health carrier shall demonstrate its method for responding to requests for all documents, records and other information relevant to the claimant's claim for benefits after an adverse benefit determination (45 CFR § 146.136(d)(3)). This shall include the health carrier's protocol for ensuring that it discloses medical necessity criteria for both medical/ surgical benefits and mental health and substance use disorder benefits, as well as disclosures pertaining to the processes, strategies, evidentiary standards and other factors the health carrier used to apply a NQTL with respect to medical/ surgical benefits and mental health or substance use disorder benefits under the plan, when those specific items are requested. This shall also include a reporting of how the health carrier ensures prompt disclosure of all information requested.

The carrier must demonstrate that all claims processing and disclosure regarding adverse benefit determinations complies with the federal claims and appeals regulations. (45 CFR § 147.136)

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Standards for
Mental Health and Substance Use Disorder Parity Compliance

Standard 7
The health carrier as the entity is responsible for parity compliance. The health carrier shall ensure that management of mental health and substance use disorder benefits coverage as a whole complies with the applicable provisions of MHPAEA, including any vendor relationships. The carrier shall provide or require sufficient information in terms of plan structure and benefits to or from any vendor to ensure that the mental health and substance use disorder benefits are coordinated with the medical/surgical benefits for purposes of compliance with the requirements of MHPAEA.

Apply to: Certain group and individual health carriers offering mental health and substance use disorder coverage

Documents to be Reviewed

_____ Contractual agreements between the carrier and vendors having administrative, claims and/or medical management responsibilities

_____ Policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with MHPAEA

_____ A narrative summary outlining how the vendor and the carrier coordinate benefit design and application to ensure compliance with MHPAEA

_____ Any written communications between the carrier and the vendor in regard to the administration of mental health and substance use disorder benefits

Others Reviewed

29 CFR § 2590.712(e).
75 FR § 5426
78 FR § 68250

Review Procedures and Criteria

The health carrier shall provide documentation of the protocols and procedures in place to ensure that any contracted vendor that provides mental health or substance use disorder benefits is collaborating with the health carrier to satisfy compliance with MHPAEA. This shall include explanation of how both the design of benefits and the application of benefits, in operation, are compliant with MHPAEA.

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