Milliman

Employer Guide for Compliance with the Mental Health Parity and Addiction Equity Act

Developed by Milliman, Inc. in conjunction with the Partnership for Workplace Mental Health

Partnership for Workplace Mental Health™
A program of the American Psychiatric Foundation

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Preface

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[1] requires group health plans and health insurance issuers to have parity between mental health and substance use disorder (MH/SUD) benefits and medical/surgical benefits with respect to financial requirements and treatment limitations. This law and its implementing regulations, the Interim Final Rule (IFR)[2], are very detailed and contain many complex concepts that can be confusing and can make MHPAEA compliance a difficult and time-consuming task.

This Guide was developed to provide a reference document for employers who provide MH/SUD benefits as part of their health plans, informing them of certain key requirements of MHPAEA, the IFR, and other guidance provided in the industry and providing them with a reasonable approach to MHPAEA compliance. The Guide presumes a basic familiarity with the law and regulations and directs the reader to sources where more detailed information can be obtained. (*See Endnotes as appropriate.)* It is our hope that this Guide will aid the reader in understanding the parity requirements and how to assess compliance with the parity tests and standards embedded in the law and regulations.

The Guide was prepared by Milliman, Inc. (Milliman) at the request of the Partnership for Workplace Mental Health (the Partnership), a subsidiary of the American Psychiatric Association (APA). As the law develops, we intend to periodically update this document and welcome feedback and questions.

Known for its technical and business acumen, Milliman provides expert consultation on both the financing and delivery of healthcare. Milliman's clients include most of the leading health insurers, Blue Cross plans, and HMOs, as well as providers, employers and sponsors, government policymakers, pharmaceutical companies, and foundations. Milliman consultants include actuaries, clinicians, and information-technology specialists—offering a diversity of experience to help organizations cost-effectively manage their businesses without compromising quality of care. Milliman has more health insurance actuaries (220) that are members of the Society of Actuaries than any other consulting firm in the United States. Milliman actuaries have worked extensively in the area of behavioral healthcare, including significant work evaluating MHPAEA compliance.

The Partnership for Workplace Mental Health works with businesses to ensure that employees and their families living with mental illness, including substance use disorders, receive effective care. It does so in recognition that employers purchase healthcare for millions of American workers and their families. The Partnership promotes the business case for quality mental health care, including early recognition, access to care and effective treatment. The Partnership also identifies and highlights the successful

approaches employers are already taking to address mental health. The Partnership's network includes more than 5,000 employers and related purchasing stakeholders. For more information, see www.workplacementalhealth.org.

Milliman and the Partnership (along with the APA) worked to provide employers and the industry with the benefit of our collective knowledge and experience in implementing MHPAEA.

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Introduction: MHPAEA, the IFR, and Supporting Guidance

MHPAEA prohibits health plans that cover more than 50 employees and offer MH/SUD benefits from imposing financial requirements or treatment limitations on MH/SUD benefits that are more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits covered by the health plan. MHPAEA also prohibits separate financial requirements or treatment limitations applicable only to MH/SUD benefits.[3] MHPAEA was passed into law on October 3, 2008, with a general effective date for plan years beginning on or after October 3, 2009. The exception to this date is collectively bargained plans whose effective date for compliance is (i) the first day of the plan year beginning on or after the later of either July 1, 2010, or (ii) the date of the termination of the last collective bargaining agreement entered before October 3, 2008. Noncompliance with the requirements of MHPAEA poses a significant financial risk for employers. Penalties can be as high as $100 per member per day of noncompliance.

On February 2, 2010, the IFR was published by its sponsoring departments, the Department of Labor (DOL), the Department of the Treasury, and the Department of Health and Human Services, and is generally applicable for the plan years that began on or after July 1, 2010.[4] The intent of MHPAEA and its IFR is to end the discrimination between medical/surgical and MH/SUD benefits, which existed in some group health plan designs for both fully insured and self-insured products.[5] Both MHPAEA and its IFR will be referred to collectively hereafter in this Guide as "MHPAEA."

The DOL's Employee Benefits Security Administration (EBSA) has issued a series of Frequently Asked Questions (FAQs) about MHPAEA Implementation.[6] The EBSA has also provided the Self-Compliance Tool for Subpart 7 of ERISA: HIPAA and Other Health-Care Related Provisions ("Self-Compliance Tool")[7], which is useful in determining whether a health plan is in compliance with certain provisions of Part 7 of ERISA, including HIPAA. These FAQs and the Self-Compliance Tool provide additional guidance for employers beyond the law and the IFR.

Independent of the EBSA, the Utilization Review Accrediting Commission (URAC) has published compliance standards for health plans with respect to MHPAEA and that are discussed in this Guide.[8] URAC's standards require that health plans document their basis for compliance with MHPAEA. It should be noted that URAC includes important standards around consumer and employer plan information disclosure.

Purpose of This Guide

Milliman has found that many employers have limited knowledge of the details of MHPAEA requirements, even though it is the employer who is liable for non-compliance and subject to any penalties. The primary purpose of this Guide is to provide employers with the benefit of our collective experience in evaluating and implementing MHPAEA so they have a resource that they can use to determine whether their health plan(s) is complying with all aspects of MHPAEA. This Guide is based on the many questions Milliman has received while working with insurers and employers regarding MHPAEA compliance and it is intended to supplement the FAQs and the Self-Compliance Tool and highlight the pertinent standards promulgated by URAC.

This Guide provides a series of questions that the employer should ask in connection with compliance testing. The health plan or whichever entity that performs MHPAEA compliance testing (e.g., a contractor to the health plan, such as a managed behavioral carveout) can use the questions set forth in this Guide to assist it in a thorough assessment of the health plan's compliance with MHPAEA.

This Guide may also be used by appropriate state agencies, such as Departments of Insurance or State Attorneys General, for their reviews of MHPAEA compliance with health plans or by any other entity that is charged with assuring compliance with aspects of the law (e.g., external review entities).

It is recommended that employers ensure that their health plan(s) keep a detailed, written record of each MHPAEA compliance test and that this record be available for the employer to review as needed. A more detailed analysis and a more comprehensive rationale to explain any differences in the treatment of benefits offered increases the likelihood that a plan will be found MHPAEA compliant if challenged. Further, it may be necessary for a plan to repeat certain recommended MHPAEA compliance analyses on a yearly, or even more frequent basis if the policies or procedures have changed for medical/surgical benefits, because medical/surgical practices are the basis of comparison for determining what is allowable in providing or managing the MH/SUD benefit.

There are four parts to this Guide:

Part 1: Determining Classifications of Benefits and Coverage Requirements

Part 2: Complying with Parity Standards Regarding Financial Requirements and Quantitative Treatment Limitations

Part 3: Complying with Parity Standards Regarding Non-Quantitative Treatment Limitations

Part 4: URAC Standards Requiring Documentation of Compliance with MHPAEA

Limitations of This Guide

MHPAEA and its rules are very complex, and neither the law nor the IFR have been interpreted by the courts as of the date of this publication. We have done its best to simplify this subject matter and to provide an interpretation of MHPAEA that is consistent with the intent and letter of the law. This Guide was written based on our best understanding of the provisions of MHPAEA (as of the date of publication) and our belief as to how they will be enforced by the applicable sponsoring departments and state agencies. Because the IFR has been in effect less than two years for most plans, there is still some uncertainty as to how the sponsoring departments, applicable state agencies, and courts will interpret some of its provisions.

This Guide is not a substitute for, is not designed to, and does not provide legal advice. The authors shall not be liable to users or any third party if readers of this Guide disregard professional legal advice, or delay in seeking such advice, because of something they have read in this Guide. The authors shall not be liable to the reader or to any third party if readers rely on information in this Guide in place of seeking professional, legal advice, or conducting their own legal research. RELIANCE ON ANY INFORMATION CONTAINED IN THIS GUIDE IS SOLELY AT THE READER'S OR USER'S OWN RISK.

PART 1: DETERMINING CLASSIFICATIONS OF BENEFITS AND COVERAGE REQUIREMENTS

MHPAEA and the IFR set forth a general parity requirement, which prohibits health plans and health insurance issuers from: (a) applying any financial requirement or treatment limitation to MH/SUD benefits in any benefits classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same benefits classification, and (b) imposing separate financial requirements or treatment limitations that are applicable only with respect to MH/SUD benefits.[9] Based on this general requirement and as described in more detail below, the IFR provides specific rules for determining benefits classifications that must be analyzed in order to: (1) apply the general requirement and other parity standards to financial requirements and treatment limitations,[10] and (2) determine appropriate MH/SUD benefits coverage requirements.[11]

Classification of Benefits

The IFR acknowledges that health plans vary financial requirements and treatment limitations imposed on benefits based on whether a treatment is provided on an inpatient, outpatient, or emergency basis, whether a provider is a member of the plan's network; or whether the benefit is for a prescription drug. Therefore, in order to apply MHPAEA's parity standards with respect to financial requirements and treatment limitations (whether quantitative or non-quantitative), the IFR establishes six benefits classifications, as follows:

1. Inpatient, In-Network;
2. Inpatient, Out-of-Network;
3. Outpatient, In-Network;
4. Outpatient, Out-of-Network;
5. Emergency Care; and
6. Pharmacy.[12]

According to the IFR, the parity standards for financial requirements and treatment limitations are applied on a classification-by-classification basis and these classifications are the only classifications used for purposes of satisfying MHPAEA.

The IFR does not provide definitions for these benefits classifications. It does state, however, that the terms (e.g., inpatient, in-network or outpatient, out-of-network) are subject to plan design and their meanings may differ from plan to plan. Nevertheless, health plans must apply definitions for benefits classifications in a uniform manner to both MH/SUD and medical/surgical benefits. The IFR, while recognizing that there must be parity in types and levels of benefits within each classification, did not address parity requirements regarding the scope of services within each classification and invited comments regarding the extent to which MHPAEA addresses scope of services and continuum of care.[13]

Benefits Coverage

The IFR also provides that benefits classifications must be used for all financial requirements and treatment limitations to the extent that a plan provides benefits in a classification and imposes any separate financial requirement or treatment limitation for benefits in the classification. While a health

plan is not required to provide MH/SUD benefits, if it provides benefits coverage for an MH/SUD in one classification, it must also provide coverage in other classifications if a corresponding medical/surgical benefit exists in that classification.[14] For example, if coverage for MH/SUD is provided in the outpatient, in-network classification, it cannot offer medical coverage for the inpatient, in-network classification and not provide coverage for inpatient, in-network MH/SUD care.[15]

Questions for Analysis of Benefits Classifications and Benefits Coverage

What follows are key questions regarding these benefits classifications and benefits coverage requirements to ask the person(s)/entity(ies) performing MHPAEA compliance testing. While the IFR is not clear on the scope of services required in each benefits classification, these questions can help in the evaluation of whether a plan complies with the requirement to cover MH/SUD services in each classification where medical/surgical benefits are covered, especially since the sponsoring departments are inviting comment on the extent to which MHPAEA addresses scope of services and continuum of care:

1. How does the health plan determine the required types and levels of treatment services for MH/SUD benefits for each benefits classification under the IFR? How was it determined that benefits are provided for covered MH/SUDs in every benefits classification in which medical/surgical benefits are provided, including in-network and out-of network benefits?

2. Were there any differences in how MH/SUD treatment types or levels of care were defined as compared to medical/surgical treatment types or levels of care? As many health plans use different definitions for treatment programs for medical/surgical benefits as opposed to MH/SUD benefits, the following link provides additional useful information for defining and comparing similar levels and types of service definitions and benefit options between MH/SUD services and medical/surgical services: http://www.workplacementalhealth.org/scopeofservices.

3. Were there any treatment types and/or levels of care that have been offered to medical/surgical conditions, but were excluded for MH/SUDs? For example, is a range of diagnostic lab tests covered for medical/surgical benefits, but not for MH/SUD benefits? Does the health plan cover different types of inpatient and hospital levels for medical/surgical conditions, like sub-acute, non-hospital, 24-hour, inpatient services (Intermediate Care Facilities), but exclude coverage for sub-acute, 24-hour, inpatient residential treatment services for MH/SUDs? Does the health plan offer coverage for specialty medical/surgical hospitals (that are not part of a general hospital), but exclude coverage for MH/SUD specialty inpatient programs (that are not part of a general hospital)?

4. If emergency benefits varied between in-network versus out-of-network providers, how was this handled in the testing?

PART 2: COMPLYING WITH PARITY STANDARDS REGARDING FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

As stated above, MHPAEA and the IFR set forth a general parity requirement that prohibits health plans and health insurance issuers from: (a) applying any financial requirement or treatment limitation to MH/SUD benefits in any benefits classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same benefits classification, and (b) imposing separate financial requirements or treatment limitations that are applicable only with respect to MH/SUD benefits. The IFR addresses the application of this general parity requirement to financial requirements and quantitative treatment limitations.[16]

The IFR includes and defines key concepts fundamental to MHPAEA compliance: financial requirements and two types of treatment limitations, quantitative and non-quantitative. Financial requirements are defined in the IFR as aspects of the plan design that outline cost sharing between the plan and the enrollee (including copays, coinsurance, deductibles, and out-of-pocket limits).[17] Treatment limitations, on the other hand, can be quantitative or non-quantitative. Quantitative treatment limitations (QTLs) are defined to include treatment limitations that are expressed numerically, such as calendar year limits on the number of office visits or inpatient days, or lifetime limits on the coverage of benefits.[18] Non-quantitative treatment limitations (NQTLs) are treatment limitations that are not necessarily numerically expressed. NQTLs are further defined and explained below in Part 3 of this Guide.

In order to determine compliance of a financial requirement or QTL with the general parity rule, as is discussed above in Part 1 of this Guide, a health plan must first divide benefits into the six (6) benefits classifications. Then, the health plan must determine if the applicable financial requirement or QTL applies only to MH/SUD benefits and not to medical/surgical benefits. If it only applies to MH/SUD benefits and not to medical/surgical benefits, the financial requirement or QTL is a separate treatment limitation and, by virtue of the statute, prohibits application to MH/SUD benefits.[19] On the other hand, if the financial requirement or QTL applies to both MH/SUD benefits and medical/surgical benefits, then the health plan must determine if the applicable financial requirement or QTL meets the substantially all rule and the predominant test.[20] The details of this testing are set forth below.

Measuring Plan Benefits

The IFR requires that in order to determine compliance with the general parity rule, each financial requirement or QTL within a coverage unit must be analyzed separately within each benefits classification. The IFR states that the portion of plan payments subject to a financial requirement or QTL is based on the dollar amount of all plan payments for medical/surgical benefits in the classification that are expected to be paid for in the plan year.[21] If a health plan provides benefits in a benefits classification and imposes a financial requirement or QTL for benefits in a benefits classification, the parity standards related to financial requirements and QTLs (described below) apply.

Generally, with a couple of exceptions, health plans cannot split a benefits classification into sub-classifications when applying parity standards under MHPAEA and the IFR. For example, separate sub-classifications for generalists and specialists are not permitted.[22] Despite the general rule with respect to sub-classifications, a health plan that provides prescription drug benefits may comply with MHPAEA and

the IFR if it has a multi-tiered prescription drug benefit.[23] The IFR provides that a health plan is still in compliance with MHPAEA if the health plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors (e.g., cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up) and without regard to whether the drug is generally prescribed for medical/surgical or MH/SUD treatments.[24]

In addition, the sponsoring departments enforcing MHPAEA have established an enforcement safe harbor for outpatient benefits (in-network and out-of-network). This safe harbor provides that no enforcement action will be taken against a health plan or health insurance issuer that divides outpatient benefits into two sub-classifications for the purpose of applying financial requirements and treatment limitations, as follows: (i) office visits, and (ii) all other outpatient items and services (the "Outpatient Safe Harbor").[25] Once the sub-classifications are created, the health plan or health insurance issuer may not impose a financial requirement or a quantitative treatment limitation on MH/SUD benefits in any sub-classification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification.

It should be noted that employers can meet the parity requirements for financial requirements and treatment limitations if they design all of their MH/SUD benefits to be at least as rich as the richest medical/surgical benefit in each benefits classification. Additionally, MHPAEA compliance can be achieved by providing 100% benefit coverage without limits for all MH/SUD benefits in each classification.

The following are key questions regarding these benefits classifications requirements to ask the person(s)/entity(ies) performing MHPAEA compliance testing:

1. How were detailed medical/surgical benefits costs divided into each of the six benefits classifications?

2. Were healthcare costs considered on a paid-dollar basis or on an allowed-dollar basis?

3. Did the plan develop health care costs for each classification in total or for different services categories within each classification?

4. What percentages of medical/surgical benefits within each benefits classification are subject to each type of financial requirement or QTL for each benefit design tested?

5. If a plan's in-network benefits have different cost sharing for a subset of in-network providers, how was this handled in the testing? Were the Outpatient Safe Harbor benefit sub-classifications used for outpatient benefits? If so, how were MH/SUD benefits and medical/surgical benefits classified into these sub-classifications?

Applying the General Parity Rule

Once the benefits are separated into the six benefits classifications and it is determined that there is a financial requirement or QTL that applies within a benefits classification, the health plan must first determine if the financial requirement or QTL only applies to MH/SUD benefits. If that is the case, the

analysis ends, since a financial requirement or treatment limitation that only applies to MH/SUD benefits is a separate treatment limitation and violates MHPAEA.

If the financial requirement or QTL applies to both MH/SUD benefits and medical/surgical benefits, the health plan must determine if the financial requirement or QTL applies to "substantially all" of the medical/surgical benefits within the same classification.[26] A financial requirement or QTL is considered to apply to substantially all medical/surgical benefits in a benefits classification if it applies to at least two-thirds of all medical surgical benefits in that classification. This two-thirds rule can be calculated using a reasonable method and should be based on the dollar amount of plan payments for the year.

If a type of financial requirement or QTL does not apply to substantially all of the medical/surgical benefits in that benefits classification, that type of financial requirement or QTL cannot be applied to the MH/SUD benefits in that classification.

If the type of financial requirement or QTL applies to substantially all of the medical/surgical benefits in that classification, then the health plan must apply the "predominant" test.[27] In other words, the health plan must determine the level of the type of financial requirement or QTL that is the predominant level in a classification of benefits. The predominant level means that the financial requirement or QTL applies to more than half of the medical/surgical benefits in that benefits classification based on plan costs.

If a single level of a type of financial requirement or QTL applies to more than one-half of the medical/surgical benefits subject to the financial requirement or QTL within a benefits classification (based on plan costs), the health plan cannot apply that financial requirement or QTL to MH/SUD benefits at a level that is more restrictive than the predominant level.[28] However, if there is no one level that applies to more than half of the medical/surgical benefits subject to the financial requirement or QTL in a benefits classification, the health plan can combine levels (starting with the most restrictive level and then combining with the next most restrictive level) until the combination of levels applies to more than half of medical/surgical benefits subject to the financial requirement or QTL in the classification, and be in compliance with the general parity rule as long as it does not apply the financial requirement or QTL to MH/SUD benefits at a level that is more restrictive than the least restrictive medical/surgical level within the combination.[29]

The following are key questions regarding these quantitative testing requirements to ask the person(s)/entity(ies) performing compliance testing:

1. Are there financial requirements or QTLs applied to MH/SUD benefits that are not applied to medical/surgical benefits? If so, have they been removed?

2. Describe the financial model that was used to test for MHPAEA compliance related to financial requirements and QTLs for MH/SUD benefits. What claims data was used in the model? What calendar period was used to develop the claims data? What level of detail was used for different healthcare benefits and service categories? Can a copy of the financial cost model used for the "substantially all" and "predominant" testing by benefits classification be provided?

3. What percentages of medical/surgical benefits within each classification are subject to each type of financial requirement or QTL for each benefit design tested? Have the types of financial requirements or QTLs that did not pass the "substantially all" test been removed from MH/SUD benefits? Or, have the types of financial requirements or QTLs that apply to MH/SUD benefits that did not pass the "substantially all" test been added to enough of the medical/surgical benefits to pass the "substantially all" test?

4. What is the predominant level of financial requirement or QTL for each type of financial requirement or QTL that passed the "substantially all" test within each classification of benefits for each benefit design tested? Is the level of financial requirement or QTL that applies to MH/SUD benefits within each classification less than or equal to the predominant level? Or, has the level of financial requirement or QTL for medical/surgical benefits been raised on enough of the medical/surgical benefits such that it is greater than or equal to the level that applies to MH/SUD benefits?

5. How were single copayments that apply to all services during an office visit (e.g. evaluation and management services, lab services, radiological services, etc.) treated in the testing?

6. Does the plan vary cost sharing for pharmacy benefits based on whether the drug is for a medical/surgical condition versus a MH/SUD condition? If so, have these differences been removed?

Cumulative Financial Requirements and Quantitative Treatment Limitations

The IFR also states that a plan cannot apply any cumulative financial requirements or cumulative QTLs to MH/SUD benefits in a classification that accumulates separately from any financial requirement or QTL established for medical/surgical benefits within the same benefits classification. [30] For purposes of this prohibition, cumulative financial requirements include deductibles and out-of-pocket maximums, but do not include aggregate lifetime or annual dollar limits.[31] Cumulative QTLs include annual or lifetime day or visit limits.[32]

The following are key questions regarding separately accumulating financial requirements and QTLs to ask the person(s)/entity(ies) performing compliance testing:

1. If the plan applies accumulating financial requirements to plan benefits, have the accumulating financial requirements been aggregated so that both medical/surgical and MH/SUD benefits accumulate to satisfy the same financial requirement?

2. If the plan applies accumulating QTLs to plan benefits, have the accumulating QTLs been aggregated so that both medical/surgical and MH/SUD benefits accumulate to satisfy the same QTL?

3. If the plan had separate accumulating financial requirements or QTLs, what technological systems changes have been made to ensure that the integrated accumulation of medical/surgical and MH/SUD benefits, as described above, is occurring on a timely and accurate basis?

Aggregate Lifetime and Annual Dollar Limits

MHPAEA extends the parity requirements with respect to aggregate lifetime and annual dollar limits in the prior law[33] to all MH/SUD benefits, including substance use disorder benefits.[34] In order to help determine compliance with this requirement, the following question should be addressed:

1. Have the annual dollar limits been removed from all MH/SUD benefits (including substance use disorder benefits) or have they been matched to comparable medical/surgical limits by classification?

Coverage Unit

A coverage unit refers to the way a plan groups individuals for the purpose of determining benefits, premiums, or contributions.[35] The IFR states that if a plan provides benefits for more than one coverage unit and applies different levels of financial requirements or QTLs to coverage units within a classification, then the health plan must determine the "predominant" level of a financial requirement or QTL for each coverage unit separately.[36] For example, if a health plan has different co-payments for employee-only and family coverage units, then the health plan must determine the predominant level of the co-payment for employee-only and for family coverage units separately. In order to help determine compliance with this requirement, the following question should be addressed:

1. When the plan was tested, was it tested at the coverage unit level (employee-only, employee plus spouse, family, etc.)?

PART 3: COMPLYING WITH PARITY STANDARDS REGARDING NON-QUANTITATIVE TREATMENT LIMITATIONS

The IFR recognizes that health plans impose treatment limitations that are not numerical in nature, but otherwise may limit the scope or duration of MH/SUD benefits. The IFR calls these treatment limitations non-quantitative treatment limitations (or NQTLs)[37] and prohibits the imposition of such NQTLs to MH/SUD benefits, unless the health plan can demonstrate that certain requirements are met.[38]

The general parity requirements described above apply to NQTLs. As with financial requirements and QTLs, a health plan cannot impose NQTLs that only apply to MH/SUD benefits. NQTLs that apply only to MH/SUD benefits are separate treatment limitations and per se violations of MHPAEA.[39]

As noted in the IFR, the substantially all and predominant tests that apply to financial requirements and QTLs also apply to NQTLs; however, they are applied somewhat differently. [40] Specifically, the IFR provides for NQTLs that apply to both MH/SUD benefits and medical/surgical benefits, that any processes, strategies, evidentiary standards, or other factors used in applying NQTLs to MH/SUD benefits in any benefits classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical/surgical benefits in the same benefits classification.[41] There is one exception to this general rule with respect to NQTLs. The IFR allows for a more stringent and/or non-comparable application of an NQTL to the extent that the health plan can demonstrate that a recognized clinically appropriate standard of care justifies greater restrictions on MH/SUD benefits as compared to medical/surgical benefits.

In other words, to be in compliance with the IFR, health plans must follow this analysis when comparing the provision of medical/surgical benefits and MH/SUD benefits within the same benefits classification. The analysis provides that a covered health plan cannot impose an NQTL with respect to MH/SUD benefits in any classification unless:

> (1) the non-quantitative treatment limitation is comparable to a non-quantitative limitation for medical/surgical benefits; AND
>
> (2) the non-quantitative treatment limitation is applied no more stringently to the MH/SUD benefits than to the medical/surgical benefits; UNLESS
>
> (3) there is a recognized clinically appropriate standard of care that permits an exception (i.e., more stringent or non-comparable application) to parts 1 and 2 of the NQTL test above (i.e., a valid exception permits an NQTL which is non-comparable and more stringent).

A common area of confusion in many plans is whether an NQTL may be applied to the MH/SUD benefit, if it does not apply to some minimum level of medical/surgical benefits in the same classification. Clearly, if an NQTL applies only to MH/SUD benefits and never to medical/surgical benefits in a classification, this is a separate treatment limitation and not in compliance with MHPAEA or the IFR.[42]

Some health plans are taking the position that any NQTL that is applied to the medical/surgical benefit, even if it is applied to a very small percentage of the medical spending (e.g., 2%), can then be applied to *all or most* of the MH/SUD benefit. However, if the NQTL applies to most MH/SUD benefits, but only to a small percentage of medical/surgical benefits in a classification, it would likely be noncompliant unless the health plan can demonstrate that such a variation were permitted by a recognized clinically appropriate standard of care that calls for differential treatment. The FAQs provide some guidance, stating that if the quantitative imbalance is too great between the application of the NQTL to medical/surgical benefits and to MH/SUD benefits, then these NQTLs would not be considered to be "comparable" or "no more stringent than."[43] Given the lack of clarity in the IFR and FAQs, employers should consider this issue carefully and undertake a clear analysis as to why such a quantitative difference would be deemed parity compliant.

NQTL Illustrations in the IFR

In order to assist health plans in determining if a treatment limitation is an NQTL, the IFR provides an illustrative (but not exhaustive) list, which includes: (A) medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; (B) formulary design for prescription drugs; (C) standards for provider admission to participate in a network, including reimbursement rates; (D) plan methods for determination of usual, customary, and reasonable charges; (E) refusal to pay for higher cost therapies until it can be shown that a lower cost therapy is effective (i.e., fail-first policies or step therapy protocols); and (F) exclusions based on failure to complete a course of treatment.[44]

We provide a further look at these illustrations below and set forth key questions related to compliance testing. Keep in mind that the following questions are applicable both to medical/surgical benefits and MH/SUD benefits, and that you must consider each NQTL within each benefits classification separately. You must also ask if the NQTLs are comparable. Are there differences in processes, strategies, evidentiary standards, or other factors used to manage medical/surgical and MH/SUD benefits? Are NQTLs applied to MH/SUD benefits that are not applied to medical/surgical benefits? Are there differences in how stringently NQTLs are applied to medical/surgical benefits as opposed to MH/SUD benefits? Is there a properly documented, recognized clinically appropriate standard of care that justifies a more stringent or non-comparable application of NQTLs to MH/SUD benefits?

Regarding the illustrations, the following are key questions regarding the NQTL illustrations to ask the person(s)/entity(ies) performing compliance testing.

Illustration A: Medical Management Standards

1. Utilization management practices (e.g., preauthorization, concurrent review, and retrospective review).
    - Is utilization review prospective, concurrent, or retrospective and does this differ between medical/surgical benefits and MH/SUD benefits?
    - What is the total annual allowed cost of services (each for medical/surgical and MH/SUD treatment separately) subject to utilization review for each type of utilization management

practice, including but not limited to preauthorization requirements and concurrent review? This should be provided for each benefits classification.

- How is utilization review performed? Are any published standards/manuals used to guide decisions? Ask to be provided with any protocols that are used to guide the application of these processes. The DOL has issued some limited guidance on whether a plan's utilization review processes meet the requirements of MHPAEA and the IFR.[45] A plan's utilization review processes are NQTLs, which must be conducted in compliance with MHPAEA and the IFR. These utilization review or management approaches (i.e., when to conduct review processes) must be analyzed in addition to a plan's medical necessity criteria, which are also NQTLs.
- Do the same personnel perform utilization review for medical/surgical benefits and MH/SUD benefits? If not, what steps are taken to ensure that policies are being administered in a comparable manner, and not more stringently for MH/SUD benefits in each classification?
- For both medical/surgical and MH/SUD benefits, how often does utilization review result in denials or limitations?
- If a type of utilization review (e.g., prior authorization) is not sought by covered members as may be required under the plan design, what are the penalties for not doing so, and do the penalties differ between medical/surgical benefits and MH/SUD benefits?
- If a plan is applying NQTLs to only a few medical/surgical services while applying these same NQTLs to most or all MH/SUD services, then this may appear to be non-complaint (as this is non-comparable and more stringent). An example of this would be doing concurrent review for all psychotherapy visits under the MH/SUD benefit, while only doing concurrent review for physical therapy and occupational therapy under the medical/surgical benefit.

2. Medical necessity criteria.

- For each of the six classifications of benefits, what are the plan's standards for determining whether a treatment is medically necessary for both MH/SUD benefits and medical/surgical benefits? A plan's medical necessity criteria are an NQTL and subject to the requirements of MHPAEA and the IFR and a separate analysis, regardless of whether the criteria are applied and/or used as part of a plan's utilization review processes.
- For each classification of benefits (i.e., MH/SUD and medical/surgical) and type of medical necessity criteria, how often is a request for payment denied on the grounds that the service is not medically necessary?
- How are the criteria (and protocols used to implement the criteria) utilized in determining medical necessity under the plan made available to any current or potential participant, beneficiary, or contracting provider upon request? The DOL has issued guidance that information on medical necessity criteria (e.g., "processes, strategies, evidentiary standards, and other factors") must be disclosed for both medical/surgical and MH/SUD benefits to both providers and plan participants.[46] A compliance analysis is required for both the actual medical

necessity criteria and protocols and how and when the medical necessity criteria and protocols are applied (e.g., through a utilization review process).

3. Experimental treatment exclusions.

   - Is "experimental" and/or "investigational" defined identically or separately for both medical/surgical and MH/SUD treatments?
   - What level of evidence is needed for a treatment to be considered non-experimental or non-investigational? For each type of benefit?
   - Has the plan analyzed what portion of both the medical/surgical and MH/SUD benefits in each classification has met the minimum standard for a non-experimental treatment?
   - Does the plan use the same scientific criteria for medical/surgical and MH/SUD services and are these criteria applied in the same manner? For example, if a medical or surgical service or diagnostic test is considered non-experimental because two random assigned controlled research (RCT) studies have been completed, is this the same criterion applied for determining that a MH/SUD service is non-experimental?
   - In addition, the compliance analysis should include how these scientific criteria are applied in each benefits classification. For example, what portion of the spending in the outpatient, in-network classification has met the scientific criteria above for medical/surgical services, as compared to the portion of spending for MH/SUD services? What is the health plan's basis, if a large portion (e.g., 50%) of medical/surgical services in a classification is reimbursed even though they would be considered experimental or investigational by the health plan's definition, but a small portion (e.g., only 10 %) of the MH/SUD services judged to be experimental or investigational are reimbursed?

4. Primary Care Physicians or other gatekeeping (referral requirements).

   - Does the health plan require a referral to specialty care from a primary care provider? What is the total annual allowed cost of services (each for medical/surgical and MH/SUD benefits) subject to this type of requirement for each benefits classification?
   - What steps are taken to ensure that members comply with referral requirements? Is the level of monitoring consistent between medical/surgical benefits and MH/SUD benefits?
   - If a referral is not obtained when required, what are the penalties and do they differ between medical/surgical benefits and MH/SUD benefits in each classification?

5. Written/advance treatment plan requirements.

   - Does the health plan require any type of advance written treatment plan in order for a service (or series of services) to be covered? What is the total annual allowed cost of services (each for medical/surgical and MH/SUD benefits) subject to this type of requirement in each classification?

- If this type of requirement applies, who reviews the treatment plans? How often are requests for services denied due to lack of a suitable treatment plan?

Illustration B: Formulary Design for Prescription Drugs

1. Approval of drugs.
    - What portion of all FDA-approved prescription treatments for MH/SUD conditions are listed on the formulary? How does this compare to the portion of drugs for medical/surgical disorders? How are MH/SUD drugs identified?
    - What are the evidentiary standards for inclusion on the formulary? Are there any differences between these standards for medical/surgical and MH/SUD drugs?
    - What are the plan's rules for covering drugs prescribed off-label? Do these rules differ if a drug is being used off-label for a MH/SUD condition?
    - Are branded drugs (for which no generics are available) approved for MH/SUD conditions as covered benefits? If not, are they approved for medical/surgical conditions?

2. Placement of drugs on formulary tiers.
    - Is there any consideration of a drug being used to treat MH/SUD conditions when making formulary tier placement decisions?
    - If cost, generic substitutability, or other factors are generally used in the formulary decision-making process, are the standards the same for medical/surgical and MH/SUD drugs?
    - How are MH/SUD prescription drugs distributed on the formulary tiers? Are they disproportionately on the more expensive tiers as compared to medical/surgical drugs?

3. Generic substitution/therapeutic interchange and/or substitution.
    - Does the plan require generic substitution if a generic version of a drug is available? If so, are the rules different depending on whether the drug is for a medical/surgical condition or MH/SUD condition?
    - Does the plan cover branded versions of drugs for which generics are available? If so, does it do so irrespective of whether the drug is for a medical/surgical or MH/SUD condition?

Illustration C: Standards for Provider Admission to Participate in a Network (Including Reimbursement Rates)

NQTLs include standards for provider admission to participate in a provider network. In other words, the contractual requirements for network providers to participate in a network providing medical/surgical services must be comparable to the contractual requirements for network providers to participate in a

network providing MH/SUD services, and the contractual requirements must be applied in a no more stringent manner to network providers providing MH/SUD services than the contractual requirements are applied to network providers providing medical/surgical services. These contractual requirements specifically include the reimbursement rates provided to network providers, which are set forth in provider contracts and/or provider contract fee schedules.

1. What credentials are required to be an in-network provider? Are there any differences between the standards used for medical/surgical providers as opposed to MH/SUD providers? If non-MD/DO providers can be in-network providers for medical/surgical care, are non-psychiatrist, non-psychologist providers permitted to be in-network providers for MH/SUD care?

2. What are the administrative requirements to join the network? For example, does the plan rely on state licensure standards and/or national accreditation standards for medical/surgical and MH /SUD or do they apply other internal or external standards?

3. How does the plan determine how many providers to admit to its network by type of provider or specialty?

4. What is the typical wait time for a member to obtain an appointment with a primary care provider for medical services? How does this vary between emergency services and routine services? How does this compare to wait times to obtain a behavioral care appointment from a MH/SUD provider? Is this different for rural versus urban areas?

5. Are specialty inpatient facilities included in the provider network for treatment of specific medical/surgical conditions? If so, are specialty inpatient psychiatric and substance use treatment facilities available in the network? Are those facilities that are not contracted as network providers comparably covered out-of-network, separately for medical/surgical and MH/SUD conditions?

6. What are the fees paid to MH/SUD specialty physicians for medical evaluation and management (E&M) services? What are the fees for these same E&M services paid to other physicians?

7. Do you have analyses that demonstrate comparability for fee levels between medical/surgical providers and MH/SUD providers by benefits classification? For example, how do fees for non-E&M services for MH/SUDs (e.g. CPT codes 90785– 90899) compare to non-E&M fees for surgical services (CPTs 10021 – 69990)? For radiology services (CPTs 70010 – 79999)? For pathology services (CPTs 80047 – 89398)? For dialysis services (CPTs 90935 – 90999)? For gastroenterology services (CPTs 91010 – 91299)? For cardiovascular services (CPTs 92950 – 93799)? What is the methodology used to support a conclusion of comparability?

8. Are there major variances in contract reporting and documentation obligations for MH/SUD in-network/out-of-network providers as compared to medical/surgical in-network/out-of-network providers (e.g., reporting requirements on quality, patient outcome measures, etc.)?

Illustration D: Plan Methods for Determining UCR Charges

NQTLs include the determination of usual, customary, and reasonable (UCR) fee amounts for providers (e.g., facility and professional services for both in-network and out-of-network providers). While there is no standard analysis to determine that MH/SUD fees and medical/surgical fees are comparable, one such approach is to complete an analysis of the fee levels relative to an accepted standard such as Medicare allowable levels. Provider payments can be calculated for each classification separately (i.e., MH/SUD services and medical/surgical services), using a combination of fee schedules and utilization rates by service, and compared to a recognized benchmark (e.g., Medicare payment schedules). For example, It could be determined that outpatient office visits for medical/surgical services are paid at a level comparable to X% of Medicare allowable levels, and that outpatient office visits for MH/SUD services are paid at a level comparable to Y% of Medicare allowable levels. These two levels could then be evaluated to determine whether provider payments for MH/SUD and medical/surgical benefits were comparable.

Consider the following questions separately for each classification (whether you are addressing reimbursement rates for in-network providers or UCR to determine allowable rates for out-of-network providers) as applicable to medical/surgical and MH/SUD provider rates:

1. How are fee schedules and reimbursement rates determined for medical/surgical providers as compared to MH/SUD providers? How do the processes vary between in-network and out-of-network allowable rates for medical/surgical providers as compared to MH/SUD providers?

2. Is there a common benchmark fee schedule (e.g., Medicare) or methodology used in developing allowed fee levels? If so, how do rates vary between medical/surgical and MH/SUD providers (as a percentage of the benchmark fee schedule) for each benefits classification?

3. When reimbursement is on the basis of usual, reasonable, or customary (U&C) charges (most commonly for out-of-network services), what methods does the plan use to determine usual, reasonable, and customary charges, separately for medical/surgical services and MH/SUD services?

4. If there is a standard process or procedure for determining U&C charge levels, are exceptions ever made? Are exceptions more or less frequent with respect to medical/surgical services or MH/SUD services? Do exceptions result in higher or lower allowed amounts for medical/surgical services and MH/SUD services in each benefits classification?

5. Is there a difference in how often an inflation adjustment is given for medical/surgical providers as compared to MH/SUD providers?

Illustration E: Fail-First Policies (Also Known as Step Therapy Protocols)

Fail-first policies or step therapy protocols are most commonly applied for prescription drugs and/or for behavioral health inpatient and residential treatment. An example of a fail-first policy is a policy

requiring a member to use a generic antidepressant first without treatment success before a single-source brand antidepressant will be covered. Another example of a fail-first policy is a policy denying inpatient treatment for a covered condition until outpatient treatment is attempted and is found unsuccessful.

1. Standards for requiring fail-first policies.
    - What is the basis for determining whether fail-first policies will be required? Is it based solely on the cost of therapy, regardless of the condition being treated?
    - Are there exceptions (e.g., fail-first not required for a particular treatment even though the treatment is sufficiently expensive)? If so, what are the bases for these exceptions?

2. Results of applying standards.
    - For which MH/SUD services and for which medical/surgical services must a member try and fail at a lower-cost therapy first? What is the total annual allowed cost of services subject to fail-first policies, separately for medical/surgical and MH/SUD services, and for each of the six benefits classifications?
    - When lower-cost therapy is attempted, how often does a member "progress" to the next step (the more expensive therapy)? Are there differences between this rate for medical/surgical conditions and MH/SUD conditions?

3. Denial of higher cost therapies.
    - How frequently in each benefits classification is a patient denied a higher-cost therapy based on fail-first policies for medical as compared to MH/SUD conditions?

Illustration F: Exclusions Based on Failure to Complete a Course of Treatment

1. Employee Assistance Plans (EAPs).
    - Does coverage for insured MH/SUD services only begin after all EAP benefits have been exhausted for MH/SUDs?
    - Does the health plan require referral from an EAP in order to receive coverage for MH/SUD care?
    - Are there any requirements similar to this for medical/surgical benefits?

2. Requirements to attend classes or programs.
    - Does the health plan cover smoking cessation prescription drugs, but only for members who participate in a class, support group, or similar program?

- Does the health plan require attendance at AA or similar programs as a condition of receiving inpatient or outpatient care for alcoholism or other substance use disorders?
- Are there any medical/surgical conditions with similar requirements?

3. Visit minimums.
    - Does the health plan deny coverage for psychotherapy or other behavioral services unless the member attends a minimum number of sessions?
    - Does the health plan impose penalties if the member misses a psychotherapy visit, fails to timely refill a prescription related to a MH/SUD condition, etc.?
    - If a member leaves a hospital or other inpatient facility against medical advice while being treated for a MH/SUD, does the plan impose any penalties (such as not paying for the hospital stay or for follow-up care)? Are there any similar penalties for leaving against medical advice during a medical/surgical stay?
    - Are there any medical/surgical conditions with similar requirements? For example, will the health plan refuse inpatient treatment for a diabetic patient in the emergency room who meets criteria for admission, but who has been noncompliant with outpatient visits to a primary care physician, has not taken medications consistently, and has not lost weight when recommended by the primary care physician?

Recognized Clinically Appropriate Standards of Care – The Exception

MHPAEA provides an exception to the NQTL rule that allows a health plan to apply NQTLs in a non-comparable and more stringent manner to MH/SUD benefits than to medical/surgical benefits, if the health plan can demonstrate that there is a "recognized clinically appropriate standard of care" that permits a difference in the management of the benefits. This exception is not in MHPAEA, but appears only in the IFR, and is an exception that can be used only with respect to the NQTL rule. This exception does not apply to the statutory prohibition against separate treatment limitations and an exception cannot be raised by a health plan to apply treatment limitations (including NQTLs) only to MH/SUD benefits and not to medical/surgical benefits.

While neither MHPAEA nor the IFR provides a definition of "recognized clinically appropriate standard of care," there is guidance which suggests that the use of an exception would be inappropriate for distinguishing between all medical/surgical benefits and all MH/SUD benefits and can only be used in individual cases or for specific types of services where it can be supported by clinical evidence.[47] In addition, the EBSA has stated that a health plan's exception should be documented.[48]

The use of this exception allows a plan to bypass the NQTL rule requirements of the IFR and places a significant burden on an employer or plan to justify why this is necessary. In order to avoid a compliance challenge and/or lawsuit, a health plan should provide a detailed analysis of how and why the

"recognized clinically appropriate standard of care" was developed, as well as what the standard of care is. It should be noted that the exception language refers to clinical "standards of care," not cost effectiveness issues or standards or administrative conveniences. In addition to a careful analysis of how these standards of care were developed, a plan needs to provide a careful analysis of how and why these clinical standards for MH/SUD services are different from those for medical/surgical clinical services.[49]

The following are key questions regarding recognized clinically appropriate standards of care to ask the person(s)/entity(ies) performing compliance testing:

1. Does the health plan use this clinical exception standard to justify applying any NQTL to MH/SUD benefits more restrictively as compared to the medical/surgical benefit?

2. Has the plan conducted an analysis of what the "recognized" clinical standard is and how it was developed? For example, was this a standard developed internally by the plan or its managed behavioral healthcare organization? Or is the standard based on a nationally recognized set of clinical best practices or developed by a group of national recognized panel of experts outside of employees of the plan or its managed behavioral healthcare organization? A one-sentence declaration that the plan has a clinical exception is probably not sufficient.

3. Has the plan disclosed to beneficiaries and eligible providers upon request what the clinical exception standard is, how it was developed, and why it permits a more stringent application of a NQTL?

4. If the health plan contends that a recognized clinically appropriate standard of care justifies imposition of noncomparable NQTLs to MH/SUD benefits, has the health plan clearly documented the origin and applicability of the standard of care?

Availability of Plan Information

MHPAEA and the IFR include provisions that allow for the disclosure of information about the health plan. The plan administrator of a health plan or the health insurance issuer is required under the IFR to make available the criteria used for medical necessity determinations made in connection with MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request.[50] In addition, the plan administrator or health insurance issuer must make available the reason for denial of reimbursement or payment of services with respect to MH/SUD benefits to any participant or beneficiary in accordance with the claims procedure rule.[51] If the denial is based on medical necessity, the medical necessity criteria for the MH/SUD benefits and the medical/surgical benefits at issue must also be provided within 30 days of a request to a participant, beneficiary, provider, or authorized representative of a beneficiary or participant.[52]

The following are key questions regarding availability of plan information to ask the person(s)/entity(ies) performing compliance testing:

1. Does the health plan make available the criteria used for medical necessity determinations made in connection with MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request?

2. Does the health plan provide the reason for denial of reimbursement or payment of services with respect to MH/SUD benefits to any participant or beneficiary in accordance with the claims procedure rule?

3. If a denial is based on medical necessity, does the health plan provide the medical necessity criteria for the MH/SUD benefits and the medical/surgical benefits within 30 days of a request to a participant, beneficiary, provider, or authorized representative of a beneficiary or participant?

PART 4 – URAC STANDARDS REQUIRING DOCUMENTATION OF COMPLIANCE WITH MHPAEA

In 2011, URAC released standards for accreditation of health plans that incorporated the requirements of MHPAEA and the IFR and requires health plans to ensure they are in compliance.[53] URAC provides another reference for employers to consider in formulating questions about their health plans compliance with MHPAEA. Fundamental to the URAC standards is that health plans have written documentation to substantiate the analysis discussed in Parts 2 and 3 of this Guide. Employers should be aware that these requirements also apply to any contractor that separately administers the MH/SUD benefit (e.g., a carveout) or provides MH/SUD services to the health plan. A key component of the URAC standards is that the analysis upon which compliance is based be properly documented and as the purchaser, employers should have access to this documentation.

The URAC parity-related standards are addressed in various sections as summarized below. The parenthetical identifying the standard (e.g., P-NM 4) is the URAC designated identifier.

Regulatory Compliance (Core 4).

Core 4 of URAC's standards requires that the health plan implement a regulatory compliance program that:

1. Tracks applicable laws and regulations in the jurisdictions where the organization conducts business;
2. Ensures the organization's compliance with applicable laws and regulations; and
3. Responds to detected problems and takes corrective action as needed.

Core 4 applies to both state and federal regulations, and includes provisions specific to MHPAEA.

Compliance Program: Internal Controls (P-CP 1).

P-CP 1 complements URAC's Core 4 standards and provides that in order to effectively monitor adherence to laws and regulations, the health plan must implement internal controls, including (i) designating a compliance officer; (ii) periodic review and update of the compliance program in the organization's training and education; (iii) periodic internal monitoring and auditing; (iv) periodic review and analysis to determine any changes in its benefits, policies and procedures, and utilization management protocols that impact compliance and communication to delegated contractors regarding changes impacting compliance (including parity of health care services such as MH/SUD parity); and (v) performance of a thorough review of state and federal laws and regulations related to privacy and security (including HIPAA), parity of health care services, including mental health parity and MHPAEA, and fraud, waste, and abuse.

Analysis of Compliance with MHPAEA (P-MHP 1).

P-MHP 1 provides that for each health benefit plan product that provides MH/SUD services, the health plan must provide written documentation of one of the following:

(a) An affirmative declaration, signed by a principal of the organization, indicating that the identified product is in "exempt status" with regards to MHPAEA, including the statutory/regulatory basis for the exempt status; or

(b) If not exempt, a detailed analysis of the identified product documenting its compliance with MHPAEA, demonstrating that for the MH/SUD services provided, including applicable pharmacy benefits, the organization does not have more restrictive:

    (i) Financial requirements;

    (ii) QTLs; or

    (iii) NQTLs.

URAC requires a comparative analysis to the medical/surgical benefit for each NQTL that is applied to the MH/SUD benefit. As part of its analysis, if there is medical or scientific evidence or clinical practice guidelines permitting a difference in management of MH/SUD benefits as compared to medical/surgical benefits (i.e., more stringent or non-comparable application of NQTLs), the health plan needs to include such evidence or guidelines as part of its analysis and state why this standard allows more stringent or non-comparable management. A statement that they have the evidence and guidelines is not sufficient to meet the URAC documentation requirement.

The standards also acknowledge that pharmacy benefits are a benefits classification under MHPAEA and must be compliant with the IFR. Formulary structure and the management of the formulary should also be in compliance with the IFR regarding financial requirements, QTLs and NQTLs. Documentation that a compliance analysis was performed with a clear rationale supporting compliance is required.

The URAC standards also state that if a health plan provides MH/SUD services through other mental health providers (e.g., a primary care physician), then MHPAEA applies, even if MH/SUD benefits are not provided as part of the health plan.

MH/SUD Parity Addressed in Contractor Written Agreements (P-MHP 3).

P-MHP 3 provides that a health plan that enters into written agreements with contractors providing MH/SUD benefits must obtain documentation as described above from such contractors regarding MHPAEA compliance. This includes MH/SUD benefits for each of the six benefits classifications included in the IFR and compliance with all of the following:

    (i) Financial requirements;

    (ii) QTLs; and

    (iii) NQTLs.

URAC will examine client-specific documentation showing that mental health parity is addressed in contracts between the health plan and contractors for MH/SUD services. This standard applies not only to contracts between health plans and contractors of MH/SUD services, but also to delegation of pharmacy benefit management services.

Consumer and Employer Purchaser Information Disclosure (P-MR 2).

P-MR 2 addresses the health plan's disclosure to consumers and employer purchasers of information about a health plan's products, which includes descriptions of the processes that the health plan uses to ensure compliance with regulatory health care parity requirements (including the IFR). This includes condition-specific criteria for benefits and descriptions of the processes that the health plan uses to ensure compliance with regulatory requirements, including the MHPAEA regulations. The information provided should be enough to allow a consumer to understand any benefits provisions that affect, in this case, a specific MH/SUD condition.

UM Protocols Applied to MH/SUD Benefits (P-MHP 2).

P-MHP 2 states that for all utilization review protocols or NQTLs applied to MH/SUD benefits, the health plan must provide a detailed analysis showing that the utilization management protocols do not have more restrictive treatment limitations. URAC does not judge whether the analysis is valid. URAC does require a reasoned analysis to meet the intent of the standard.

UM protocols must be comparable to, and applied no more stringently than, those used for medical/surgical benefits and the health plan must provide a written analysis supporting its conclusion regarding compliance. A one sentence declaration that the employer plan is MHPAEA-compliant with NQTLs is not acceptable as evidence.

If a UM protocol does not meet the tests related to comparability and stringency, it must show that it has recognized, clinically appropriate medical or scientific evidence and/or clinical practice guidelines that permit a difference to the treatment of MH/SUD benefits. If the health plan has such a standard of care that permits differential treatment, the health plan must document the evidence to support its conclusion.

Health Utilization Management; Review Criteria Requirements (P-HUM 1).

P-HUM 1 provides that when MHPAEA is applicable, medical necessity criteria made under a group health plan with respect to MH/SUD benefits (or health insurance coverage offered in connection with the health plan with respect to such benefits) must be made available in accordance with the IFR by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request. When MHPAEA is applicable, health plans and entities that provide utilization management services must comply with this regulation under the Core 4 standards.

Out of Network and Emergency Services (P-NM 4).

P-NM 4 provides that: (i) organizations must ensure that all out-of-network MH/SUD benefits are compliant with MHPAEA; and (ii) a health plan that provides MH/SUD benefits in any classification of benefits must provide them in every classification in which medical/surgical benefits are provided, including out-of-network classifications for emergency services. URAC provides a reminder that to be effectively implemented, a health plan's written policies and procedures must be understood by

network management staff and any employee of the health plan who may be called upon to explain to a consumer the policy regarding access to emergency services or out-of-network providers.

Written Notice of Upheld Non-Certifications (P-HUM 37)

P-HUM 37 provides that when MHPAEA applies, it requires the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment of services related to MH/SUD benefits in the case of a participant or beneficiary, must be made available upon request or as otherwise required by the plan administrator (or health insurance issuer offering such coverage) to the participant or beneficiary in accordance with the IFR. Health plans and contractors that provide utilization management services must comply with this regulation under the Core 4 standards.

Filing a Complaint

If an employer or consumer has issues with an accredited health plan's compliance with the URAC standards that an employer cannot resolve with the health plan directly, an employer can make a written complaint to URAC. The complaint can be filed through URAC's webpage.

Conclusion

This document strives to provide an understandable and comprehensive guide to compliance with MHPAEA. As the IFR finalized and subregulatory guidance is issued and we obtain additional information we deem helpful in compliance efforts, we will periodically update this Guide. We welcome questions and/or suggestions regarding the content of this document. Inquiries should be directed to Steve Melek at steve.melek@milliman.com, Clare Miller at cmiller@psych.org, or Sam Muszynski at imuszynski@psych.org.

[1] 29 USC 1185a.

[2] 29 CFR 2590.712 et.al.

[3] 29 USC 1185a(a)(3)(A).

[4] For the text of the IFR, see http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=23511&AgencyId=8&DocumentType=2.

[5] 75 FR 5421-5425. *See also Coalition for Parity, Inc. v. Sebelius, 709 F.2d 10, __ (D.D.C. 2010).*

[6] To review the FAQs related to MHPAEA, see http://www.dol.gov/ebsa/mentalhealthparity/ under the subheading "Guidance".

[7] To review the Self-Compliance Tool for Subpart 7 of ERISA: HIPAA and Other Health-Care Related Provisions, see http://www.dol.gov/ebsa/pdf/cagappa.pdf.

[8] See http://workplacementalhealth.org/urac2 for a summary of the key issues related to the URAC parity standards.

[9] See 29 USC 1185a(a)(3)(a) and 29 CFR 2590.712(c)(2).

[10] 29 CFR 2590.712(c)(2)(ii)(A).

[11] 29 CFR 2590.712(c)(2)(ii)(B).

[12] 29 CFR 2590.712(c)(2)(ii)(A)(1)-(6).

[13] The IFR specifically states that the regulating departments recognize that not all treatments and treatment settings for MH/SUD correspond to those for medical/surgical conditions. The IFR invites comments on "whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage." *See 75 FR 5416.*

[14] The IFR provides definitions for medical/surgical and MH/SUD benefits. Medical/surgical benefits are benefits for medical or surgical services (as defined under the terms of the health plan) and do not include MH/SUD services. MH/SUD benefits, on the other hand, are benefits with respect to services for mental health conditions and substance abuse disorders (as defined under the terms of the health plan and in accordance with applicable federal and state laws). Health plan terms that define whether the benefits are medical/surgical or MH/SUD must be consistent with "generally recognized independent standards of current medical practice." An example of a generally recognized independent standard of current medical practice is the most current version of the International Classification of Diseases (ICD) or applicable state guidelines. *See 75 FR 5412 and 29 CFR 2590.712(a).*

[15] For an explanation of these benefits coverage requirements and other examples of benefits coverage requirements, see 75 FR 5413.

[16] 29 CFR 2590.712(c). See also, 75 FR 5414.

[17] 29 CFR 2590.712(a).

[18] 29 CFR 2590.712(a).

[19] See 29 USC 1185(a), which prohibits the imposition of separate treatment limitations. While the IFR addresses how to apply the substantially all and predominant tests, it does not eliminate the requirement that a health plan cannot impose a financial requirement or treatment limitation on MH/SUD benefits, if it does not impose them on medical/surgical benefits.

[20] 29 CFR 2590.712(c)(3).

[21] To determine how to calculate the portion of medical/surgical benefits in a classification, see 29 CFR 2590.712(c)(3)(i)(C), (D), and (E). See also 75 FR 5414.

[22] 75 FR 5413.

[23] 29 CFR 2590.712(c)(3)(iii).

[24] See also 75 FR 5415.

[25] See http://www.dol.gov/ebsa/faqs/faq-mhpaea.html#.UIgVZVH3Bok for FAQ About Mental Health Parity and Addiction Equity Act explaining Outpatient Safe Harbor.

[26] 29 CFR 2590.712(c)(3)(i)(A).

[27] 29 CFR 2590.712(c)(3)(i)(B)(1).

[28] 29 CFR 2590.712(c)(3)(i)(B)(1).

[29] See also 75 FR 5414-5415.

[30] 29 CFR 2590.712(c)(3)(v).

[31] 29 CFR 2590.712(a).

[32] 29 CFR 2590.712(a).

[33] Congress initially passed legislation to address mental health parity in 1996, called the Mental Health Parity Act of 1996 (MHPA 1996). This law generally required group health plans and health insurance issuers that offer mental health benefits to have aggregate annual and lifetime dollar limits on mental health benefits that were no more restrictive than those for all medical/surgical benefits. Under MHPA 1996, substance use disorder benefits were not included in mental health benefits. MHPA 1996's effects were limited. To address MHPA 1996's limitations, Congress amended MHPA 1996 by enacting MHPAEA. Congress intended to improve access to MH/SUD benefits by "eliminating discrimination that existed with respect to these benefits after MHPA 1996." *See 75 FR 5421-5422.*

[34] See 75 FR 5412 and 29 CFR 2590.712(b).

[35] 29 CFR 2590.712(c)(1)(iv).

[36] 29 CFR 2590.712(c)(3)(ii).

[37] 29 CFR 2590.712(a).

[38] 29 CFR 2590.712(c)(4). See also 75 FR 5416.

[39] See 29 USC 1185(a), which prohibits the imposition of separate treatment limitations. While the IFR addresses how to apply the test related to NQTLs, it does not eliminate the requirement that a health plan cannot impose a financial requirement or treatment limitation on MH/SUD benefits, if it does not impose them on medical/surgical benefits.

[40] "For this purpose, the general parity requirement of MHPAEA applies separately for each type of financial requirement or treatment limitation… The test is applied somewhat differently to nonquantitative treatment limitation, as discussed later in this preamble." *See 75 FR 5413.*

[41] 29 CFR 2590.712(c)(4).

[42] See http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UIgaelH3Bok for a copy of FAQ #2.

[43] See http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UIgaelH3Bok for a copy of FAQ #5.

[44] 29 CFR 2590.712(c)(4)(ii).

[45] See FAQs about Affordable Care Act Implementation Part VII and Mental Health Parity Implementation, FAQs 2-6 at http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UIgaelH3Bok.

[46] See FAQs about Affordable Care Act Implementation Part V and Mental Health Parity Implementation, Dec. 22, 2010, FAQ #10.

[47] See 29 CFR 2590.712(c)(4)(iii), Example 1. See also http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UIgaelH3Bok for a copy of FAQ #3.

[48] This requirement is set forth in Question 42 of the Self-Compliance Tool on pages 27-28. See http://www.dol.gov/ebsa/pdf/cagappa.pdf for a copy of the Self-Compliance Tool.

[49] See summary of URAC Standards in Part 4 of this Guide.

[50] 29 CFR 2590.712(d)(1).

[51] 29 CFR 2590.712(d)(2). See 29 CFR 2560.503-1 for the claims procedure rule.

[52] 29 CFR 2590.712(d)(1). See also http://www.dol.gov/ebsa/faqs/faq-aca5.html#.UKFDp6X3Bok for ACA Implementation FAQ Part V, Question 10.

[53] To review a summary of the key issues related to URAC mental health parity standards, see http://workplacementalhealth.org/urac2.