



The American Psychiatric Association (APA) submits these comments in response to the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) April 23, 2018 joint request for comments on “[Proposed] FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21<sup>st</sup> Century Cures Act Part XX.”

The APA is a medical specialty society representing over 37,000 physicians who specialize in the treatment of mental health conditions and substance use disorders. The APA has have advocated for more than twenty-five years in support of the passage of parity legislation, issuance of regulations, health plan compliance and appropriate oversight and enforcement as appropriate by authorities of jurisdiction. The enactment of MHPAEA marks the establishment of federal law specifically targeted at eliminating discriminatory treatment of individuals and families who seek services for mental health and substance use disorders.

APA commends the Departments for a comprehensive and substantive effort to fulfill the requirements of Section 13001 of the *21<sup>st</sup> Century Cures Act* (PL 114-146) (“CURES”) by issuing the Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act and Model Disclosure Form with the proposed FAQs. Together, these documents are consistent with and reinforce prior guidance released by the Departments clarifying that health plans are required to conduct these types of compliance analyses for each non-quantitative treatment limitation (NQTL), both in writing and in operation, the methods for conducting such analyses, and the evidence and documentation relating to such compliance analyses that plans must disclose to beneficiaries and their authorized representatives.

APA works closely with the Coalition for Whole Health (CWH) and the Parity Implementation Coalition (PIC) in our efforts to ensure appropriate health plan compliance and enforcement by regulatory authorities as necessary. APA is a cosigner of the comments submitted and worked with PIC principals respecting their formal comments. APA strongly endorses the recommendations contained therein and the accompanying rationale which supports them. APA thinks it is

essential that these all be implemented including special consideration for the following:

- New and intensified MHPAEA education and technical assistance efforts designed to overcome barriers state authorities with responsibility for enforcement currently encounter and promote compliance review uniformity. These should be targeted toward: 1) helping states operationalize the algorithms of the new Self-Compliance guide in a manner which permits execution compatibility with prevailing state review protocols and technology and 2) facilitating state understanding that the documentation elements respecting NQTLs which must be disclosed to consumers are essential data they should be seeking as well.
- Due consideration to establishing a new round of grants to states to continue the development of their MHPAEA compliance reviews and evaluation efforts.
- Further clarification that claim denial rates and other measures of outcomes are essential in analyzing NQTL rule compliance especially regarding the “in operation” component of the regulatory test. This includes the need for further identification of quantitative data (e.g., out- of- network service utilization respecting network adequacy) that are probative of in operation compliance.
- Establish an appropriate group to study what if any the role of accreditation standards implemented by nongovernmental entities can contribute to health plan practices regarding compliance with MHPAEA and enabling more efficient and substantive review by authorities of jurisdiction.
- Issuance of new FAQs on current key MHPAEA NQTL issues which includes health plan network adequacy and provider reimbursement rates
- Explicit endorsement by the Center for Consumer Information and Insurance Oversight of the new MHPAEA Self Compliance Guide issued by the Department of Labor. It is our view that it is not always clear in the states that this compliance approach is “authoritative” guidance for and applicable to their MHPAEA responsibilities as well as to self- funded health plans.

We have accumulated considerable experience with state regulators involved with MHPAEA compliance over the last couple of years. Some of this has been directly related to the grants issued in the fall of 2016 and other interactions have involved states interested in furthering their MHPAEA oversight efforts independent of any federal grant activity.

Most state regulators are ready, willing, and able, but face a number of practical and substantive hurdles in approaching assurance of MHPAEA compliance: filing

systems, forms and procedures that do not facilitate in-depth reviews at the pre-market stage; insufficient resources for comprehensive reviews ; limited clinical expertise for parity issues that arise at the post-market stage involving medical management and criteria which also represents an expansion of their traditional regulatory role; and wariness of instructing issuers to amend their plans for fear of legal challenges, among others. Most realize that they cannot rely on simple compliance attestations without verification through documentation to truly assure compliance but remain uncertain as to how to operationalize their baseline analyses. The National Association of Insurance Commissioner's (NAIC) Market Regulation Handbook offers little guidance as to standards for health plan MHPAEA reviews. MHPAEA compliance evaluation is not binary and yet most health plan approval systems are geared toward simple yes/no kinds of questions. These infrastructure hurdles cannot be ignored if we are going to advance improved oversight and enforcement. Further collaboration with state regulators to assess the need for federal guidance as to how to organize for and optimize compliance reviews is essential.

In this regard we have three items to offer for the Departments' future consideration especially as it concerns working with states albeit it is applicable to federal oversight efforts as well. The first concerns a conceptual model for health plan accountability for MHPAEA compliance and regulatory oversight. The principles embeded in the model can be readily operationalized and the newly issued Self Compliance guide is completely compatible with the recommended approach. See Attachment A. We think federal technical assistance would benefit from specifically modeling an approach such as that outlined in the model description. We would be happy to discuss this further.

The second matter concerns the NAIC Market Regulation Handbook (Handbook) which as you know is the reference manual for state regulators respecting market conduct examinations. The current standard for MHPAEA is not sufficient in our view to facilitate comprehensive compliance reviews and hence does not provide sufficient guidance to those charged with conducting examinations. It is our understanding that the NAIC is presently in the process of making revisions to the Handbook including the current MHPAEA standard. APA has collaborated with others to produce a draft set of standards which incorporates all of MHPAEA's essential requirements. The standards are consistent with the those set forth in the DOL guide. See Attachment B. We urge the Departments' to give due consideration to these draft standards and actively participate as we think these new standards would establish an appropriate and much needed reference point for regulators.

The third matter concerns the DOL Self Compliance Guide. We are recommending explicit endorsement by the Center for Consumer Information and Insurance Oversight of the new MHPAEA Self Compliance Guide issued by the Department of Labor. It is our view that it is not always clear in the states that this compliance approach is “authoritative” guidance for and applicable to their MHPAEA responsibilities as well as to self- funded health plans. In our view this is a best practice benchmark or set of standards that would substantively assist states in formulating their MHPAEA market review activities.

Thank you for the opportunity to comment on the important work you have promulgated. Any questions concerning these comments can be directed to me at [imus@psych.org](mailto:imus@psych.org).

Irvin L. Muszynski, JD, MCM  
Senior Policy Advisor and Director,  
Parity Implementation and Enforcement Policy  
American Psychiatric Association

## Attachment A- American Psychiatric Association FAQ 39 Comments

### A Working Model Toward Health Plan Accountability for MHPAEA Compliance and Regulatory Oversight

We understand that regulators face a number of practical hurdles in achieving their parity compliance objectives: filing systems, forms, and procedures that do not facilitate in-depth reviews at the pre-market stage (MHPAEA compliance evaluation is not binary); insufficient staff resources; limited technical or clinical expertise for parity issues that arise at the post-market stage involving medical management and criteria, reimbursement rates, formulary issues, etc. which also represents an expansion of their traditional regulatory role; and wariness of instructing issuers to amend their plans for fear of legal challenges, among others. However, it is possible to move beyond simple compliance attestations without verification and transition to defined plan documentation requirements and audit procedures that enable regulators to confidently and efficiently discharge their parity compliance responsibilities.

The operational aspects of our model's compliance protocols are well suited to these tasks and are guided by three essential principles:

- 1) Compliance oversight must be comprehensive. MHPAEA is a clearly defined and comprehensible set of rules, tests and documentation requirements, and sub-regulatory guidance. Compliance can only be assured when there is complete insurer fidelity to all applicable requirements and documentation that substantiates that all required parity analyses have been performed and are readily available;
- 2) Compliance review must be meaningful; i.e., beyond reliance on issuer's attestations, and yet efficient for regulators; and
- 3) **The burden for primary compliance analyses is on the insurer, not the regulator.** MHPAEA compliance is fundamentally different than other types of insurer compliance procedures. MHPAEA requires, as a fundamental component of compliance, that the insurer perform and document its analytical approaches and processes to substantiate compliance in detail and that this documentation be submitted as requested for regulatory review and decision-making as to whether further independent evaluation is needed.

Our approach stipulates the establishment of pre-market protocols that specifically require plans not only attest to compliance with all MHPAEA's applicable rules and tests, but also details the required documentation which evidences their analytical basis for compliance be made available as requested within 5-7 business days. This enables regulators to develop feasible audit protocols that permit efficient targeted or spot reviews on selected key parity issues to test the credibility of the issuer's assertions through review of the plan's parity documentation. The foundation for our approach is the Six-Step NQTL Compliance Guide ( which is completely compatible with the new MHPAEA Self Compliance issued by DOL) created by the American Psychiatric Association, The Kennedy Forum, and the Parity Implementation Coalition.

Regulator substantiation, or no substantiation, respecting one or more key MHPAEA compliance matters enables movement beyond reliance on unilateral attestations toward confidence of compliance without comprehensive review at the pre-market filing stage and/or enables a demand for appropriate corrective action by a plan. This also creates efficiencies for post-market reviews or conduct exams that may be derivative of a consumer complaint or standard operating procedure since the documentation that will be necessary to review should already be available based on the pre-market requirements.

Just as important, however, is this approach's ability to harness the so-called Sentinel Effect as part of the any state parity compliance enterprise. The Sentinel Effect posits that behavior change is more likely when those being observed realize that they may be evaluated in addition to merely being observed. The types of protocols noted above move those responsible for parity compliance from the realm of simply being observed with little potential for evaluation (i.e., unilateral attestations which are taken at face value) into the realm of being observed with a meaningful potential for evaluation. The Sentinel Effect's impact on performance is well documented and policy respecting parity audit protocols should incorporate it as this model does to harness its incentives and become a fundamental tool for parity compliance.

The final product of this approach has an important added benefit in that it unifies and integrates the pre- and post- market approval and exam functions, thereby achieving an important efficiency, which, in our view, is lacking in most current approaches. This is critical in that inadequate pre-market form filing requirements and documentation attestations do not hold insurers accountable to the law, decrease confidence and reliability of the required compliance, and make the task of market conduct examinations more difficult because the material needed for review and evaluation was never required to be submitted in the first place. It is also essential to review consumer complaint intake and disposition processes for investigation and how it is integrated into a state's overall compliance procedures. Consumer complaints are an essential input component for monitoring of post-market insurer activity. How to properly categorize a consumer complaint as a parity issue and dispositioning it with the insurer or triaging it for internal investigation is a key task. Effective state-sponsored consumer parity education programs are also essential to this undertaking and an integral part of this model.

# **Attachment B to American Psychiatric Association comments on FAQ 39 – Draft MHPAEA Standards for revisions to the NAIC Market Regulation Handbook**

## **Chapter 20B—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination**

### **Introduction**

The intent of Chapter 20B—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination in the *Market Regulation Handbook* is primarily to provide guidance when reviewing insurers whose business includes major medical policies offering mental health and/or substance use disorder coverage.

The examination standards in Chapter 20—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, whereas Chapter 20B strictly applies to examinations related to the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 found at 42 U.S.C. 300gg-26 and its implementing regulations found at 45 CFR 146.136 and 45 CFR 147.160.

When developing an examination or review plan related to MHPAEA compliance, it is important to consider examination standards as applicable from Chapter 20, Chapter 20A and Chapter 20B, as well as Chapter 16. In the event of duplication or conflict of examination standards between the chapters, the examination standards and review criteria located in Chapter 20B—Conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) Related Examination will generally take precedence, barring applicable state or federal laws to the contrary.

Regardless of which chapter is used in the *Market Regulation Handbook*, the examiner will also need to reference Chapter 16—General Examination Standards for general examination standards that apply to all insurers.

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. To help ensure strong consumer protections remain in place, state insurance regulators are developing new tools and methods for comprehensive oversight of the health insurance marketplace. Examination standards continue to be developed for MHPAEA.

### **IMPORTANT NOTE:**

**The standards set forth in this chapter are based on established procedures and/or NAIC models, not on the laws and regulations of any specific jurisdiction. This handbook is a guideline 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. Further**

**important information on this and how to use this handbook is included in Chapter 1—  
Introduction.**

# Mental Health and Substance Use Disorder Parity

## 1. Purpose

The mental health and substance use parity portion of the examination is designed to ensure that all companies are in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 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 require companies to demonstrate compliance in terms of defining mental health or substance use disorder benefits, classifying benefits, financial requirements, quantitative treatment limitations (QTLs), and nonquantitative treatment limitations (NQTLs).

## 2. Definitions

For purposes of this chapter, except where the context clearly indicates otherwise, the following terms have the meanings indicated: Defined terms will be capitalized throughout the text of this chapter.

***Aggregate Lifetime Dollar Limit*** means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or health insurance coverage offered in connection with such a plan) for any Coverage Unit (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 group health plan (or health insurance coverage offered in connection with such a plan) for any Coverage Unit (45 CFR 146.136(a)).

### ***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 this section (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 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 (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 NQTLs, which 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 the standards of MHPAEA. 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. There must be clear documentation of how mental health conditions, substance use disorders, and medical/surgical conditions were defined and then how they were assigned to benefit classifications.

### **4. Tests and standards**

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.

**Standards**  
**Mental Health and Substance Use Disorder Parity**

**Standard 1**

**The health carrier shall define mental health benefits or substance use disorder benefits to mean items or services for the treatment of a mental health condition or substance use disorder, as defined by the health carrier or applicable state law. Any condition or disorder defined as not a mental health condition or substance use disorder must be consistent with generally recognized independent standards of current medical practice. (45 CFR 146.136(a)).**

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

**Priority:** Essential

**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. DMS 5, Merck Manual, etc.)
- \_\_\_\_\_ List of specific conditions by diagnosis excluded from coverage as stated in the policy documents
- \_\_\_\_\_ Company claim procedure manuals and bulletins/communications
- \_\_\_\_\_ Claims processor and customer service MHPAEA training materials
- \_\_\_\_\_ Internal company claim audit reports specific to mental health or substance use disorders
- \_\_\_\_\_ 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 Utilization Review Management files (prospective, concurrent and retrospective)
- \_\_\_\_\_ Health carrier complaint/grievances/appeals 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 Disorder
- \_\_\_\_\_ Applicable external appeals register/logs/files related to concerning Mental Health and/or Substance Use Disorder, external appeal resolution and associated documentation

### **Others Reviewed**

Mental Health Parity Act of 1996  
Mental Health Parity and Addiction Equity Act of 2008  
04 - 42 U.S. Code § 300gg–22, 23, and 26  
ERISA 104(b) (29 U.S.C. 1024(b)) Mental Health and Substance Use Disorder Parity Compliance Assistance Materials Index – Published by CCIIO at [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Compliance\\_Assistance\\_Materials\\_Index\\_10-25-16\\_4-40pm.pdf](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Compliance_Assistance_Materials_Index_10-25-16_4-40pm.pdf)

### **NAIC Model References**

n/a

### **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 health carrier shall identify how it identifies items or services as mental health benefits, substance use disorder benefits, or medical/surgical benefits, particularly for items and services that are sometimes used for the both mental health or substance use disorders and medical/surgical conditions (e.g. occupational therapy).

**Standards**  
**Mental Health and Substance Use Disorder Parity**

**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

**Priority:** Essential

**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 claim procedure manuals and bulletins/communications
- \_\_\_\_\_ Claims processor and customer services MHPAEA training materials
- \_\_\_\_\_ Internal company claim audit reports specific to mental health or substance use disorders
- \_\_\_\_\_ 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 Utilization Review Management files (prospective, concurrent and retrospective)
- \_\_\_\_\_ Mental Health and/or Substance Use Disorder complaint files

**Others Reviewed**

Mental Health Parity Act of 1996  
Mental Health Parity and Addiction Equity Act of 2008  
04 - 42 U.S. Code § 300gg-22, 23, and 26

ERISA 104(b) (29 U.S.C. 1024(b))

Mental Health and Substance Use Disorder Parity Compliance Assistance Materials Index – Published by CCIIO at [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Compliance\\_Assistance\\_Materials\\_Index\\_10-25-16\\_4-40pm.pdf](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Compliance_Assistance_Materials_Index_10-25-16_4-40pm.pdf)

## **NAIC Model References**

n/a

## **Review Procedures and Criteria**

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

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<sup>1</sup> (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.

The health carrier shall identify the standards used to determine which classification of benefits (or applicable sub-classification) a particular benefit was assigned and 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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<sup>1</sup> 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**  
**Mental Health and Substance Use Disorder Parity**

**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

**Priority:** Essential

**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)
- \_\_\_\_\_ 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)
- \_\_\_\_\_ Company claim procedure manuals and bulletins/communications
- \_\_\_\_\_ Claims processor and customer services MHPAEA training materials
- \_\_\_\_\_ Internal company claim audit reports specific to mental health or substance use disorders
- \_\_\_\_\_ 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 Utilization Review Management files (prospective, concurrent and retrospective)
- \_\_\_\_\_ 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 Disorder

\_\_\_\_\_ Applicable external appeals register/logs/files related to concerning Mental Health and/or Substance Use Disorder, external appeal resolution and associated documentation

### **Others Reviewed**

Mental Health Parity Act of 1996

Mental Health Parity and Addiction Equity Act of 2008

04 - 42 U.S. Code § 300gg–22, 23, and 26

ERISA 104(b) (29 U.S.C. 1024(b))

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### **NAIC Model References**

n/a

### **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).

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)).

**Standards**  
**Mental Health and Substance Use Disorder Parity**

**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

**Priority:** Essential

**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)
- \_\_\_\_\_ 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)
- \_\_\_\_\_ Company claim procedure manuals and bulletins/communications
- \_\_\_\_\_ Claims processor and customer services MHPAEA training materials
- \_\_\_\_\_ Internal company claim audit reports specific to mental health or substance use disorders
- \_\_\_\_\_ 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 Utilization Review Management files (prospective, concurrent and retrospective)
- \_\_\_\_\_ Health carrier complaint, grievance and appeals 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 appeals/grievance files concerning Mental Health and/or Substance Use Disorder
- \_\_\_\_\_ Applicable external appeals register/logs/files related to concerning Mental Health and/or Substance Use Disorder, external appeal resolution and associated documentation

### **Others Reviewed**

Mental Health Parity Act of 1996

Mental Health Parity and Addiction Equity Act of 2008

04 - 42 U.S. Code § 300gg–22, 23, and 26

ERISA 104(b) (29 U.S.C. 1024(b))

Mental Health and Substance Use Disorder Parity Compliance Assistance Materials Index – Published by CCIIO at [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Compliance Assistance Materials Index 10-25-16 4-40pm.pdf](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Compliance_Assistance_Materials_Index_10-25-16_4-40pm.pdf)

### **NAIC Model References**

n/a

### **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 QTL (or subject to any level of a QTL) 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 QTL) (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 (eg it applies the QTL to all medical/surgical benefits within the classification).

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 QTL 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)).

**Standards**  
**Mental Health and Substance Use Disorder Parity**

**Standard 5**

**The health carrier shall apply 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, as written and in operation, are comparable to, and applied no more stringently than, 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)).**

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

**Priority:** Essential

**Documents to be Reviewed**

- \_\_\_\_\_ Applicable state and federal statutes, rules, regulations, and published sub-regulatory guidance
- \_\_\_\_\_ A list of all NQTL 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 NQTL.
- \_\_\_\_\_ Utilization management manuals and utilization review documents such as: utilization review criteria; criteria hierarchy for performing utilization review; case management referral criteria; initial screening scripts and algorithms; 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
- \_\_\_\_\_ Internal company claim audit reports specific to mental health or substance use disorders

- \_\_\_\_\_ 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 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)
- \_\_\_\_\_ Mental Health and/or Substance Use Disorder complaint files
- \_\_\_\_\_ Documentation demonstrating that within each of the 6 classifications of benefits, the as written and in operation processes, strategies, evidentiary standards, or other factors used in applying a NQTL is not applied more stringently to mental health or substance disorder benefits than to medical/surgical benefits in the classification.

### **Others Reviewed**

Mental Health Parity Act of 1996  
 Mental Health Parity and Addiction Equity Act of 2008  
 04 - 42 U.S. Code § 300gg-22, 23, and 26  
 ERISA 104(b) (29 U.S.C. 1024(b))  
 Mental Health and Substance Use Disorder Parity Compliance Assistance Materials Index – Published by CCIIO at [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Compliance\\_Assistance\\_Materials\\_Index\\_10-25-16\\_4-40pm.pdf](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Compliance_Assistance_Materials_Index_10-25-16_4-40pm.pdf)

### **NAIC Model References**

n/a

### **Review Procedures and Criteria**

The health carrier shall file with the commissioner documentation demonstrating that within any classification of benefits, as written and in operation, the process, strategies, evidentiary standards, or

other factors used in applying a 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:

- Identify any factors used to determine an NQTL will apply to a benefit, including factors considered but rejected.
- Identify evidentiary standards used to define factors and any other evidence relied upon in designing the NQTL.
- Comparative analyses performed to determine that the processes and strategies used to design the NQTL, as written, for mental health and substance use disorder benefits are comparable to, and are applied no more stringently, than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.
- Comparative analyses performed to determine that the processes and strategies used to apply the NQTL, in operation, to mental health and substance use disorder benefits are comparable to, and are applied no more stringently, than the processes and strategies used to apply the NQTL, in operation, to medical/surgical benefits.
- Detailed summary explaining how the information and analyses required above demonstrate compliance with 45 CFR 146.136(c)(4).

**Standards**  
**Mental Health and Substance Use Disorder Parity**

**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 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.

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

**Priority:** Essential

**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 services

Sample adverse benefit determination letters

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

**Others Reviewed**

45 CFR 146.136 (d)

ERISA 104

29CFR 2520.104b-1

29 CFR 2560.503-1

29 CFR 2590.715-2719

**NAIC Model References**

n/a

**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.

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 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, 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)

**Standards**  
**Mental Health and Substance Use Disorder Parity**

**Standard 7**

**The health carrier shall ensure to manage 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

**Priority:** Essential

**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

**NAIC Model References**

n/a

**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.