

IMPROVING HEALTH COVERAGE FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER PATIENTS

**Including Compliance with the
Federal Mental Health and Substance Use
Disorder Parity Provisions**

REPORT TO CONGRESS



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U.S. Department of Labor

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I. IMPROVING COVERAGE FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER PATIENTS

EXECUTIVE SUMMARY

Mental health and substance use disorder services are an essential and sometimes lifesaving component of health coverage. Since the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA), the Departments of Labor, Treasury and Health and Human Services have enforced the law, assisted consumers, and continuously clarified the responsibility of plan sponsors and insurance companies providing mental health and substance use disorder coverage. Many challenges remain, but the Departments have made great strides in implementing the vision of MHPAEA. Through investigations of employment-based plans, regulations and guidance, and outreach, the Departments strive to ensure that coverage for mental health and substance use disorder treatment is provided comparably with that offered for other medical care.

Enforcement of MHPAEA

Since October 2010, the Department of Labor's Employee Benefits Security Administration (EBSA) has conducted 1,515 investigations related to MHPAEA and cited 171 violations. In one case, EBSA helped a person whose plan imposed different copayment amounts and coverage levels on mental health benefits than on medical/surgical benefits. EBSA staff determined the plan was not in compliance with the law, and explained as much to plan officials. As a result, the plan was amended, claims were reprocessed, and \$59,000 in previously denied benefits were paid. EBSA investigations are rooting out illegal practices such as preauthorization requirements that prevent mental health patients from receiving immediate, potentially life-saving, treatment.

More than 100 Benefits Advisors located across the country provide expert-level assistance with MHPAEA and other benefits questions and complaints. These advisors are a direct link to the Department, and assist participants by seeking voluntary compliance from plans, both at an individual and plan-wide level. When necessary, informal complaints made to these advisors are referred to EBSA investigators for formal investigation.

Large nationwide insurance companies are paying attention to EBSA enforcement actions and making changes when problems are found in individual plans. EBSA is authorized to investigate employment-based group health plans and sue for equitable relief, but, as with most other Federal laws related to health insurance, the agency does not have the authority to directly take action against health insurance issuers. Instead the law provides for State government enforcement with respect to issuers with HHS as a fallback.¹ EBSA nonetheless has been able to work collaboratively with issuers to ensure widespread corrections by issuers and third-party administrators for thousands of plans. In addition, EBSA has worked closely with state insurance departments to ensure that the law's requirements are understood. Granting the Department of Labor the statutory authority to take action against insurance providers would have been a more direct means of enforcing the law at the federal level. But the Department's actions at the plan level, and its work with state insurance commissioners are having a positive impact.

¹ In addition, the IRS is authorized to impose excise taxes with respect to group health plans for MHPAEA violations and EBSA can make referrals to IRS. Individuals also maintain a private right of action through ERISA against plans and issuers for MHPAEA violations as well.

Regulations and Guidance

Regulations are the cornerstone of the Departments' efforts to implement MHPAEA. Since the law was passed, the Departments have published final regulations implementing mental health and substance use disorder parity. These rules were crafted through a public notice and comment process and reflect true collaboration among stakeholders. The Departments also issue subregulatory guidance in response to questions raised by plan sponsors, insurance providers and advocates. Such guidance allows the Departments to respond swiftly to developing issues. Many of the Departments' FAQs were eventually incorporated into regulation during the rulemaking process, and subsequent ones have provided additional clarifications regarding the Departments' interpretation of the law. The issuance of FAQs and other sub-regulatory guidance is an ongoing and ever-evolving effort that is done in concert with stakeholders and that has positive outcomes for covered individuals with mental health and substance use disorders.

Outreach and Publications

Regulations set the stage for proper implementation of a law, and enforcement ensures that bad actors are rooted out. But for every plan, plan sponsor or provider intentionally skirting the law, there are a great many more that simply need accurate, timely information to properly implement mental health and substance use disorder parity.

Between 2010 and 2015, EBSA staff made parity presentations at over 30 Health Benefit Education Campaign (HBEC) seminars across the country. In 2015 alone, agency staff conducted HBEC seminars in Austin, Texas; Hartford, Connecticut; Indianapolis, Indiana; Anchorage, Alaska; Omaha, Nebraska; West Columbia, South Carolina and Philadelphia, Pennsylvania. EBSA has also conducted a number of well-received consumer webcasts on MHPAEA, some of which are now available online. EBSA has also participated in a number of stakeholder calls soliciting feedback on the implementation of the law, allowing the agency to further refine its enforcement actions, educational campaigns and legal interpretations.

Outreach events are a critical component of ensuring compliance with healthcare laws and regulations and lead to plans making corrections voluntarily. In this sense, investing in outreach and education is an efficient and effective means of implementing the law by ensuring education and understanding of its requirements among those plans and sponsors who may otherwise unintentionally run afoul of it. Disseminating timely information can put a stop to problems before they start, and mean that fewer consumers will face coverage problems when seeking mental health and substance use care.

Equally important to these efforts are the many publications maintained by EBSA and aimed at plan sponsors and healthcare consumers. The agency has developed a total of nine consumer publications, online tools, and compliance assistance materials designed to promote better understanding of the MHPAEA requirements. The agency fulfilled 56,105 requests for these publications during 2015.

Looking Ahead

Those seeking mental health and substance use disorder treatment depend on their health insurance to be there when they are at their most vulnerable. The needs of these individuals guide the Departments as they seek to increase enforcement, refine guidance, and provide information on mental health and substance use disorder parity to an ever wider audience. This report includes examples of situations where EBSA was able to intervene on behalf of participants and ensure that participants received coverage for the healthcare they needed. These results will no doubt be replicated and built upon in coming years as the agency continues to identify, respond to, and correct MHPAEA violations and minimize the opportunity for future violations through effective outreach and regulation.

II. INTRODUCTION

Mental health and living without a substance use disorder are essential to leading a healthy life and to the development and realization of a person's full potential. In the wake of increasing medical evidence of the efficacy of mental health treatment and tragedies due to the lack of mental health treatment,² the Department of Labor (the Department) recognizes that unnecessary and serious consequences occur as a result of untreated mental health conditions and substance use disorders. The Department has been devoting extensive efforts to advance access to employer-sponsored coverage for mental health and substance use disorder benefits.

In 2014, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness, 1.7 million of whom were aged 18-25. Furthermore, 15.7 million adults (aged 18 or older) and 2.8 million youth (aged 12-17) had a major depressive episode during the past year. In 2014, an estimated 22.5 million Americans aged 12 and older self-reported needing but not receiving treatment for alcohol or illicit drug use, and 11.8 million adults self-reported needing but not receiving mental health treatment or counseling in the past year.³ These disorders are among the top conditions that cause disability and carry a high burden of disease in the United States, resulting in significant costs to families and employers.⁴ The Department is a leader in protecting American families' access to quality mental health and substance use disorder benefits. Preventing mental and/or substance use disorders and related problems in children, adolescents, and young adults is critical to Americans' health.

The Department is committed to full implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)⁵ through (1) using all applicable interpretive authority to achieve the statute's requirements, (2) vigorous enforcement, and (3) an active outreach program. The Department believes these efforts will improve coverage of mental health conditions and substance use disorders in employment-based group health plans to help address the tragic losses caused by untreated conditions.

On October 3, 2008, Congress enacted MHPAEA,⁶ which supplemented the Mental Health Parity Act of 1996.⁷ The law generally applies to group health plans sponsored by private and public sector employers (whether self-insured or fully-insured) with more than 50 employees and to health insurance coverage offered in connection with these group health plans. The 1996 law provided for parity in the application of aggregate lifetime dollar limits and annual dollar limits between mental health benefits and medical/surgical benefits.⁸ MHPAEA extended the parity protections of the 1996 law to substance use disorder benefits. MHPAEA also expanded the parity requirements to apply beyond aggregate dollar limitations to include financial requirements and treatment limitations.

² See "Now is the Time: the President's Plan to Reduce Gun Violence," available at https://www.whitehouse.gov/sites/default/files/docs/wh_now_is_the_time_full.pdf.

³ See Results from the 2014 National Survey on Drug Use and Health: Mental Health Detailed Tables, available at <http://www.samhsa.gov/data/sites/default/files/NSDUH-MHDetTabs2014/NSDUH-MHDetTabs2014.htm#tab1-36a>

⁴ See "Prevention of Substance Abuse and Mental Illness" at www.samhsa.gov/prevention.

⁵ MHPAEA supplemented the MHPA 1996, which required parity in aggregate lifetime and annual dollar limits for mental health and medical/surgical benefits. In general, MHPAEA extended the dollar limit protections to include substance use disorder benefits and also requires parity in the application of any financial requirements and treatment limitations on mental health and substance use disorder benefits with medical/surgical benefits. The Departments develop and jointly issue regulations under parallel provisions, consistent with the tri-agency Memorandum of Understanding (MOU) that implements section 104 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 64 FR 70164 (December 15, 1999).

⁶ See 75 FR 5409 (Feb. 2, 2010); US DOL-EBSA. Fact Sheet: The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), available at <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>.

⁷ Initially, MHPA 1996 amended only ERISA and the PHS Act (Pub. L. 104-204). The Taxpayer Relief Act of 1997 (Pub. L. 105-34) was enacted on August 5, 1997, and added provisions substantively similar to those in MHPA 1996 in the Code.

⁸ 29 USC 1185a(a)(1), (2).

MHPAEA amended the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code) with parallel provisions.⁹ Accordingly, MHPAEA is subject to joint interpretive jurisdiction by the Departments of Labor, Health and Human Services, and the Treasury.¹⁰ Regulatory and subregulatory guidance is developed jointly by the Departments to ensure consistency. The Department of Labor enforces ERISA with respect to approximately 2.3 million private-sector, employment-based group health plans. The Department of Labor is precluded by law from enforcing the Health Insurance Portability and Accountability Act (HIPAA) and related Acts, such as MHPAEA against a health insurance issuer.¹¹ With respect to plan fiduciaries, the Department has the authority to file law suits for fiduciary violations and to directly impose fines with respect to plan administrators. The Department of Health and Human Services (HHS) administers the PHS Act and has direct enforcement jurisdiction with respect to nonfederal governmental plans¹². In addition, under PHS Act 2723¹³, if a State notifies HHS that it does not have statutory authority to enforce or that it is not otherwise enforcing one or more provisions in Part A of Title XXVII of the PHS Act, or if HHS determines that the State is not substantially enforcing the requirements, HHS enforces them on group and individual market issuers and has the authority to impose a civil monetary penalty on issuers that fail to comply with the relevant sections of the PHS Act in that State. Under the Internal Revenue Code, the Treasury has authority over group health plans (including church plans) and their sponsors, and IRS enforces the requirements of HIPAA and related Acts, such as MHPAEA, through the imposition of an excise tax. Participants and beneficiaries may also bring private action against a plan under section 502 of ERISA.

This report summarizes the Department's active role in issuing regulations and subregulatory guidance and interpreting MHPAEA and other Federal laws, as appropriate, to maximize access to quality mental health and substance use disorder benefits; enforcing the law; and assisting plans, issuers, medical providers, plan participants and beneficiaries, and States in understanding their rights and responsibilities. EBSA has

- Published both interim and final rules for the MHPAEA;
- Published seven sets of FAQ-style subregulatory guidance in prompt response to issues and questions as they arose;
- Conducted 1,515 MHPAEA-related investigations from FY 10-15, citing plans for nearly 200 violations;
- Worked with several large insurance companies to remove impermissible barriers to mental health benefits, ensuring that hundreds of thousands of plans are no longer imposing these requirements;
- Answered 1,079 inquiries on MHPAEA and, through informal inquiries, successfully achieved voluntary compliance for plans that have been found to be in violation;
- Conducted an education and outreach campaign focused on the requirements of MHPAEA;
- Created consumer publications and web events to publicize these protections and assist with compliance with these requirements; and
- Met with stakeholders to further understand the challenges of parity and inform EBSA how best to ensure that plans fully implement the law.

⁹ See ERISA section 712, PHS Act section 2726, and Code section 9812. MHPAEA initially amended PHS Act section 2705, which was moved by the Affordable Care Act to section 2726.

¹⁰ See section 104 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Pub. Law 104-191). See also the Departments Memorandum of Understanding (MOU), published at 64 FR 70163 (Dec. 15, 1999).

¹¹ ERISA section 502(b)(3).

¹² 42 USC 300gg-22(b)(1)(B).

¹³ 42 USC 300gg-22(a).

MHPAEA requires the Secretary of Labor to submit a report to the appropriate committees of Congress on compliance of group health plans (and health insurance coverage offered in connection with such plans) with its requirements by January 2012, and every two years thereafter.¹⁴ This Report summarizes actions to support full parity implementation since the Department's 2014 Report to Congress, and provides a roadmap to its vision for the future.

The following timeline shows the milestones accomplished on the Departments' road to implementing MHPAEA thus far:

¹⁴ See ERISA section 712(f).

Time Line

10-03-08	<p>MHPAEA enacted</p> <ul style="list-style-type: none"> • Expands MHPA '96 to address substance use disorder benefits • Expands MHPA '96 to address financial requirements and treatment limitations
04-28-09	<p>Request for Information (RFI) published</p> <ul style="list-style-type: none"> • Solicits comments generally and on nine specific issues
10-03-09	<p>Statutory provisions, which are self-implementing, become applicable.</p>
01-29-10	<p>MHPAEA Fact Sheet is published.</p>
02-02-10	<p>The Departments publish the interim final rule (effective PY on or after 07/01/10)</p> <ul style="list-style-type: none"> • Establishes 6 classifications of benefits • Sets out mathematical formula for analyzing financial requirements and quantitative treatment limitations (FR & QTLs) • Prohibits separate cumulative FR and QTLs for mental health and substance use disorders • Establishes standards for nonquantitative treatment limitations (NQTLs) • Clarifies ERISA disclosure requirements to supplement MHPAEA
05-2010	<p>DOL posts comments received on MHPAEA to its webpage.</p>
06-30-10	<p>Subregulatory Guidance (SRG) issued</p> <ul style="list-style-type: none"> • FAQ regarding treatment of office visits released
09-30-10	<p>End of FY2010</p> <ul style="list-style-type: none"> • Closed 336 investigations of group health plans, of which 83 were subject to MHPAEA (i.e., the plan sponsor has more than 50 employees). • Answered 230 inquiries on MHPAEA • Delivered over 20 presentations on MHPAEA to employers, consumers and other stakeholders
12-22-10	<p>Subregulatory Guidance issued</p> <ul style="list-style-type: none"> • FAQ on the Affordable Care Act & MHPAEA Part V, emphasizing disclosure protections of MHPAEA and clarifying exemption of small employers
06-24-11	<p>Amendment to Interim Final Rule (IFR) issued on internal claims and appeals and external review</p> <ul style="list-style-type: none"> • Clarifies that claims concerning NQTL limitations subject to federal external review.
09-30-11	<p>End of FY 2011</p> <ul style="list-style-type: none"> • Closed 438 investigations of GHP, of which 91 were subject to MHPAEA (i.e., the plan sponsor has more than 50 employees). • Answered 163 inquiries on MHPAEA • Delivered over 20 presentations on MHPAEA to employers, consumers and other stakeholders
11-17-11	<p>SRG issued</p> <ul style="list-style-type: none"> • FAQ on ACA & MHPAEA Part VII issued, explains NQTLs and provides examples, as well as rules for specialists.
02-08-12	<p>HHS study on MHPAEA released</p> <ul style="list-style-type: none"> • <i>Short-Term Analysis to Support Mental Health and Substance Use Disorder Parity Implementation.</i>
05-09-12	<p>DOL MHPAEA dedicated webpage launched</p>
08-02-12	<p>Mental Health Parity Compliance Assistance Webcast</p>

9-30-12	<p>End of FY 2012</p> <ul style="list-style-type: none"> • Closed 483 investigations of GHP, of which 242 were subject to MHPAEA • Answered 137 inquiries on MHPAEA • Delivered over 20 presentations on MHPAEA.
02-25-13	<p>HHS essential health benefits final rule issued</p> <ul style="list-style-type: none"> • Requires issuers of non-grandfathered individual and small group plans to provide EHB in compliance with MHPAEA regulations, expanding MHPAEA's protections to an additional 62 million individuals.
09-30-13	<p>End of FY 2013</p> <ul style="list-style-type: none"> • Closed 639 investigations of GHP, of which 361 were subject to MHPAEA • Answered 136 inquiries on MHPAEA • Delivered over 20 presentations on MHPAEA
11-13	<p>HHS study on effects of MHPAEA released</p> <ul style="list-style-type: none"> • <i>Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008</i>
11-08-13	<p>MHPAEA Final Rules published (effective Plan Year on or after 07/01/14)</p> <ul style="list-style-type: none"> • Eliminates exception from the NQTL parity requirement • Addresses scope of services. Explains intermediate levels of care are subject to the parity requirements and that restrictions that might otherwise limit the scope or duration of benefits for services as NQTLs are subject to parity requirements.
11-08-13	<p>Subregulatory Guidance issued</p> <ul style="list-style-type: none"> • FAQ on ACA & MHPAEA Part VII, which summarizes the final rules and solicits comments on additional steps.
12-10-13	<p>DOL/SAMHSA video presentation</p>
01-09-14	<p>Subregulatory Guidance issued</p> <ul style="list-style-type: none"> • FAQs on ACA & MHPAEA Part XVIII issued further clarifying the effect of the ACA on MHPAEA
05-29-14	<p>Health Benefits Laws Compliance Assistance Webcast</p> <ul style="list-style-type: none"> • Includes presentation on MHPAEA final rules.
09-30-14	<p>End of FY 2014</p> <ul style="list-style-type: none"> • Closed 777 investigations of GHPs, of which 464 were subject to MHPAEA • Answered 119 inquiries on the protections of MHPAEA • Delivered over 20 presentations on MHPAEA.
11-19-14	<p>DOL updated Compliance Assistance Guide and Self-Compliance Tool on its website to include section on MHPAEA compliance published.</p>
March-May 2015	<p>DOL/ SAMHSA series of targeted stakeholder calls</p>
05-28-15	<p>DOL Webcast: Mental Health Parity - Important Information About Your Health Coverage</p>
09-30-15	<p>End of Fiscal year 2015.</p> <ul style="list-style-type: none"> • Closed 445 investigations of GHPs, of which 274 were subject to MHPAEA • Answered 139 inquiries on MHPAEA • Delivered over 20 presentations on MHPAEA.
10-23-15	<p>Subregulatory Guidance issued</p> <ul style="list-style-type: none"> • FAQ on ACA & MHPAEA Part XXIX, explaining that information is not proprietary in nature and plans must disclose this information.

III. REGULATORY ACTIONS: FUTHERING PARTICIPANTS' AND BENEFICIARIES' RIGHTS

The Department has consistently employed its interpretive authority to strengthen the rights of participants and beneficiaries with respect to coverage for mental health conditions and substance use disorders. In addition to promulgating regulations, the Department often employs its interpretive authority by issuing subregulatory guidance as a way to swiftly respond to newly emerging issues.

A. The Departments Address Nonquantitative Treatment Limitations

Regulatory Accomplishments At-a-Glance:

- April 28, 2009 – The Departments published a request for information, requesting feedback on over 9 specific questions and soliciting comments generally.
- February 2, 2010 - The Departments published interim final rules, which were effective for plan years on or after July 1, 2011.
- November 13, 2013 – The Departments published final rules, which were effective for plan years beginning on or after July 1, 2014.

The interim final rules affirmed that non quantitative treatment limitations (NQTLs) must also be at parity. Specifically, the interim final rules provided that any processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, those used in applying the limitation with respect to medical/surgical

benefits. The interim final rules only allowed for an exception to the extent that recognized clinically appropriate standards of care permitted a difference.

Based on stakeholder and clinical experts' feedback, as well as in light of data obtained through both the NQTL/SOS study¹⁵ and the MHPAEA Compliance Study¹⁶, the final rules eliminate the exception in the interim final rules permitting variation in such treatment limitations "to the extent that recognized

The final rules included examples of NQTLs that must be at parity:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether a treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for admission to plan provider networks, including reimbursement rates;
- Plan methods used to determine usual, customary, and reasonable fee charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that might otherwise limit the scope or duration of benefits.

¹⁵ Subsequent to the interim final rules, HHS commissioned a short-term research study to acquire additional real-life information on NQTLs and scope of services to help inform future guidance. The study focused on the use of NQTLs by group health plans and issuers and the implications on parity with respect to intermediate level services. See *U.S. Department of Health and Human Services' Study: Short-Term Analysis to Support Mental Health and Substance Use Disorder Parity Implementation*, available at <http://aspe.hhs.gov/daltcp/reports/2012/mhsud.shtml>.

¹⁶ The Assistant Secretary for Planning and Evaluation (ASPE) of HHS contracted with National Opinion Research Center (NORC) at the University of Chicago to study how health plans and insurers have responded to MHPAEA in the first years after its effective date. NORC led a research team (that included Milliman Inc., Aon Hewitt, Thomson Reuters/Truven Health Analytics, and George Washington University) to perform an analysis of adherence to MHPAEA and the interim final rules among ERISA-governed employer-sponsored group health plans and health insurance coverage offered in connection with such group health plans. See *Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 Final Report*, available at <http://www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf>.

clinically appropriate standards of care may permit a difference.”¹⁷ The Department eliminated this exception to address concerns that this exception could be read too broadly and be subject to abuse. Specifically, HHS convened a panel of experts in mental health and substance use disorder treatment as well as general medical treatment. These experts were unable to identify situations for which the clinically appropriate standard of care exception was warranted, in part because of the flexibility inherent in the NQTL standard itself. Plans and issuers continue to have the flexibility contained in the NQTL requirements to take into account clinically appropriate standards of care when determining whether and to what extent medical management techniques and other NQTLs apply to medical/surgical benefits and mental health and substance use disorder benefits.

B. The Department Addresses Scope of Services

Another question brought to the Department’s attention related to what scope of services was covered under MHPAEA. In the interim final rules, the Department solicited 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. The final rules required intermediate levels of care covered under the plan to be included in MHPAEA’s parity analysis. The final rules also include additional examples illustrating the application of the NQTL rules to plan exclusions affecting the scope of services provided under the plan. The new examples clarify that plan or coverage restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services must comply with the NQTL parity standard under the final rules.¹⁸

C. The Department Ensures Full Disclosure

The statute made clear that the criteria for plan medical necessity determinations with respect to mental health or substance use disorder benefits be made available by the plan administrator to any current or potential participant, beneficiary, or contracting provider upon request in accordance with regulations. MHPAEA also requires that the reason for any denial under the plan of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available on request or as otherwise required by the plan administrator to the participant or beneficiary in accordance with regulations.

¹⁷ 75 FR 5410, 5443 (Feb. 2, 2010).

¹⁸ 78 FR 68240, 68282 (Nov. 13, 2013).

The interim final rules clarified what information and documentation must be disclosed to participants, beneficiaries, providers, or authorized representatives and the timing of such disclosures. In the final rule, in order to prevent abuse and promote robust disclosure under MHPAEA, the Department highlighted multiple sources of authority under other parts of ERISA to make clear that proper disclosure includes information on both mental health and substance use disorder benefits and medical and surgical benefits. The Department also clarified that the participant should have “reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits.” The Departments also made clear that participants are entitled to request and receive the processes, strategies and evidentiary standards that plans rely on in imposing NQTLs on both mental health and substance use disorder benefits and medical/surgical benefits, as well as the reason for benefit denials and information regarding medical necessity determinations.¹⁹ These important clarifications issued by the Department illustrate the requirements of full disclosure necessary to ensure parity.

Contemporaneous with the publication of the final rules, the Departments published another set of MHPAEA FAQs,²⁰ which, among other things, solicited comments on whether and how to accomplish greater transparency and compliance. The Departments received comments that participants and beneficiaries were being denied access to all the documents necessary to perform a parity analysis due to arguments that such documents were considered “proprietary.” The Departments issued subregulatory guidance interpreting the underlying statute and regulations stating that plans may not deny participants information needed to verify that a plan is following the parity requirements of MHPAEA on the grounds that it is “proprietary.”

To date, the Departments have issued the following subregulatory guidance regarding MHPAEA:

- FAQ About MHPAEA Outpatient Classifications
- FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation
- FAQs About Affordable Care Act Implementation Part VII and Mental Health Parity Implementation
- FAQs on Understanding Implementation of MHPAEA
- FAQs about Affordable Care Act Implementation Part XVII and Mental Health Parity Implementation
- FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation
- FAQs about Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation

¹⁹ See 29 CFR 2590.712(d)(3); 78 FR 68239, 68283 (November 13, 2013).

²⁰ See FAQs about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation, available at <http://www.dol.gov/ebsa/faqs/faq-aca17.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs17.html.

D. Other Efforts Reflecting Ongoing Support of Access to Quality Mental Health and Substance Use Disorder Benefits

The Department has consistently supported efforts to improve the coverage of mental health and substance use disorder benefits through other consumer protection laws, including the Patient Protection and Affordable Care Act (the Affordable Care Act, Pub. Law. 111-148).

- **Essential Health Benefits.** The statutory provisions of the MHPAEA, as initially enacted, did not apply to employers with fewer than 50 employees. The Affordable Care Act extended MHPAEA to individual market insurance and requires that non-grandfathered plans in the individual and small group markets offer a comprehensive package of items and services, known as Essential Health Benefits (EHBs).²¹ HHS regulations implementing the EHB requirements now require that non-grandfathered individual and small group plans cover certain mental health and substance use disorder benefits, and provide those benefits in accordance with the parity requirements of MHPAEA.²² As a result of the Affordable Care Act, mental health and substance use disorder benefits and federal parity protections were expanded for more than 60 million Americans.²³
- **Elimination of Annual and Lifetime Dollar Limits.** The Affordable Care Act's prohibition on annual and lifetime dollar limits for essential health benefits²⁴ strengthens the protections of the Mental Health Parity Act, eliminating completely annual and lifetime dollar limits on mental health and substance use disorder benefits that are essential health benefits.
- **Internal claims and appeals.** The Affordable Care Act provides that that non-grandfathered plans and issuers in the group and individual market must have an effective appeals process, which includes both an internal appeal and external review.²⁵ The Departments' implementing regulations on internal claims and appeals and external review extend the requirements of the Department's claims procedure, including the disclosure requirements, to all non-grandfathered individual and group plans and issuers, including church plans and non-federal governmental plans. Plans are now required to disclose the denial code and the standard used in denying a claim on the face of the denial, and must disclose the diagnoses and treatment codes upon request.
- **External review.** In implementing the requirement of the Affordable Care Act that plans and issuers must have an effective external review process,²⁶ the Departments made clear that denials that involve a question as to whether the plan is complying with the non-quantitative treatment limitations of MHPAEA constitute claims involving medical judgment, which make these claims eligible for the federal external review, extending the protections of external review to those who seek mental health benefits through a self-insured plan as well through insured coverage subject to an external review

²¹ 42 USC § 18022; 42 USC § 300gg-6. The statute requires the Secretary to define essential health benefits in 10 statutory categories, including ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

²² 78 FR 12834 (Feb. 25, 2013) (effective for plans years beginning in 2014); 45 CFR 156.115.

²³ See <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/health-insurance-and-mental-health-services/index.html>.

²⁴ PHS Act § 2711. Section 715 of ERISA provides that "the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans" as if the provisions were included in part VII of ERISA, excepting section 2716 and 2718.

²⁵ PHS Act § 2719

²⁶ PHS Act § 2719(b).

process that meets federal requirements.²⁷ Furthermore, the application of many NQTLs, such as whether a treatment is medically necessary, experimental or investigational, or whether a certain level of care is appropriate, are separately eligible for federal external review, ensuring that participants can request review of both the accuracy of the determination and whether the plan is processing determinations in a manner that complies with the parity requirements.

- **Summary of Benefits and Coverage.** Current and potential participants must be provided with a short, plain-language Summary of Benefits and Coverage (SBC) and a Uniform Glossary of common terms used in health coverage and medical care.²⁸ The SBC must provide a brief, general description of the coverage for each category of benefits in the plan. Under regulations promulgated by the Departments, the plan is also required to provide web addresses for network and participating provider information, as well as an address for the underlying policy.²⁹ Participants are therefore able to effectively compare options when shopping for coverage and have an easy-to-understand summary of the benefits, including the mental health and substance use disorder benefits, their plan provides.
- **Excepted benefits.** In September of 2014, the Departments released final rules amending the excepted benefits requirements, including those that apply to employee assistance programs.³⁰ Employee assistance programs (EAPs) are typically programs offered by employers that can provide a wide-ranging set of benefits to address circumstances that might otherwise adversely affect employees' work and health. EAP benefits may include short-term substance use disorder or mental health counseling or referral services, provided free of charge. These regulations allow employers to continue sponsoring these plans as excepted benefits, while ensuring that these plans are free to the employees, do not act as gatekeepers to the primary health plan and do not take the place of primary coverage.
- **Network adequacy.** The Department supports HHS's recent proposal of continuity of care provisions in its rules for network adequacy for plans in the Marketplace.³¹ The issuer would be required to allow an enrollee in active treatment with a provider who was terminated without cause to continue treatment at in network, cost-sharing rates, until the treatment is complete or for 90 days, whichever is shorter.
- **Transparency reporting.** The Affordable Care Act contains provisions to ensure reporting by health plans and issuers on their efforts to ensure quality of care. The Departments are working to implement the transparency reporting provisions.

²⁷ 76 FR 37208 (Jun 24, 2011).

²⁸ PHS Act § 2715.

²⁹ 80 FR 34292, 34298, 34306 (June 16, 2015).

³⁰ 79 FR 59130 (Sept. 9, 2014).

³¹ 80 FR 75487, 75549 (Dec. 02, 2015); 45 CFR 156.230.

IV. ENFORCEMENT EFFORTS

a. Health Plan Results

i. Consumer Support and Enforcement

Making sure individuals receive the benefits to which they are entitled is the heart of EBSA's work. To accomplish this mission, the Department employs approximately 110 Benefits Advisors throughout the country who answer inquiries from and provide technical assistance to participants' and beneficiaries' regarding the provisions of ERISA, including the mental health and substance use disorder provisions of MHPAEA. These Benefits Advisors are available through an EBSA hotline, separate, regional office-specific phone numbers, and an online portal and through mail to the regional offices. They are required to respond to any call within one business day, to online inquiries within 2 business days, and to mail inquiries within 30 calendar days.

EBSA works diligently to ensure that Benefits Advisors are properly versed in the requirements and protections under the law. In fiscal years 2010 through 2015, EBSA received approximately 1,079 customer service inquiries related to MHPAEA (out of approximately 1.5 million total inquiries involving ERISA-covered employee benefit plans). While the majority of these MHPAEA contacts involve questions about the routine operation of the law, others involve credible allegations of MHPAEA violations by plan fiduciaries that may require referral for investigation. Often such inquiries involve numerous contacts, plan material reviews, and meetings with health plan representatives to ensure benefits are being provided as required by the law.

EBSA depends on these Benefits Advisors to seek voluntary, plan-wide correction from plans that may be in violation of the law. Issues initially fielded by EBSA benefits advisors often are also referred for further investigation. EBSA has 460 investigators, who review all types of ERISA plans including pension, health, and other employee benefit plans for compliance. In fiscal year 2015, EBSA created a new position, "Senior Advisor – Health Investigations" for each of its ten regional offices to assist in compliance activities. These individuals are responsible for developing investigative techniques, strategies, and best practices for large-format service provider investigations and large self-insured single employer investigations to ensure EBSA investigative resources are being used efficiently. EBSA devotes significant resources to the training and support of Benefits Advisors and investigators including new hire trainings, advanced training for experienced advisors and investigators, comprehensive quarterly trainings, monthly meetings and interim briefings as needed.

ii. Successful Investigations

EBSA's enforcement division has been aggressively pursuing compliance with MHPAEA. The following examples highlight some notable successes.

Inspired by a violation found in an EBSA plan investigation, one large, nationwide insurance company removed a requirement from all self-insured and fully-insured group health plan products it offered nationwide. Specifically, the provision had required that participants seeking mental health treatment obtain a written treatment plan for a specific program of therapy from their medical provider before benefits were covered by the plan. This broad-based requirement was not imposed on any medical or surgical benefits the plans offered and violated the MHPAEA parity rules relating to nonquantitative treatment limitations.

Another violation initially found in an EBSA health plan investigation included a broad preauthorization requirement which barred immediate access to mental health benefits. As corrective action, the Florida issuer providing coverage for the plan removed the provision from all of its fully-insured and self-insured products sold in the state. As a result, participants no longer had to delay medical treatment or risk the claim being unpaid.

A large union plan provided benefits for in-network and out-of-network, inpatient medical/surgical benefits and mental health benefits. However, it imposed a 20% coinsurance for in-network medical/surgical benefits and 40% coinsurance for in-network mental health benefits. It also imposed a 40% coinsurance for out-of-network medical/surgical benefits and 50% coinsurance for mental health benefits. As a result of the investigation, the plan re-adjudicated affected claims and paid over \$25,000 on behalf of affected participants.

In one instance, a Benefits Advisor at EBSA's Atlanta Regional Office assisted a participant whose plan imposed different copayments amounts and coverage levels on mental health benefits

than imposed on medical/surgical benefits. EBSA's Benefit Advisor contacted the plan, determined the plan was not in compliance with the law and explained the relevant provisions of the law to plan officials. As a result, the plan amended the plan, reprocessed claims and paid out \$59,000 in previously denied benefits to several plan participants.

A Benefit Advisor in the New York Regional Office assisted participants in a plan that had failed to count mental health payments towards the annual out-of-pocket maximum. As a result of EBSA's work, plan officials amended the rules of the plan to reflect compliance with the law, reprocessed claims and paid more than \$35,000 in wrongfully denied benefits to five plan participants.

In a Chicago Regional Office case, prior to EBSA's involvement, the plan limited outpatient visits for mental health services to 100 per year and capped the coverage of those visits to no more than \$40/day. This created an impermissible constructive annual dollar limit of \$4,000 per year for mental health benefits. An EBSA Benefits Advisor worked with the plan to ensure the necessary changes were made in order for the plan to comply with

Common MHPAEA Violations

Insufficient Benefits

- Not offering out-of-network providers or inpatient benefits to treat mental health or substance use disorders even though these benefits are available for medical/surgical benefits.

Higher Financial Requirements

- Charging higher copays to see mental health providers than those charged for medical/surgical providers.

More Restrictive Quantitative Treatment Limitations (QTLs)

- Imposing visit limits on mental health benefits that are more restrictive than those applied to medical/surgical visits.

More Restrictive Nonquantitative Treatment Limitations (NQTLs)

- Imposing broad preauthorization requirements on all mental health and substance use disorder treatments, even though these same plans only required pre-authorization on a select few medical/surgical treatments.
- Requiring written treatment plans for mental health services while not requiring similar plans to receive medical/surgical treatment.

Lower Annual Dollar Limits on Benefits

- Imposing annual dollar limits to treat autism spectrum disorders when such limitations are not imposed on medical/surgical benefits.

Inadequate Disclosures

- Not disclosing the criteria used for determining medical necessity and/or reasons for benefit denials

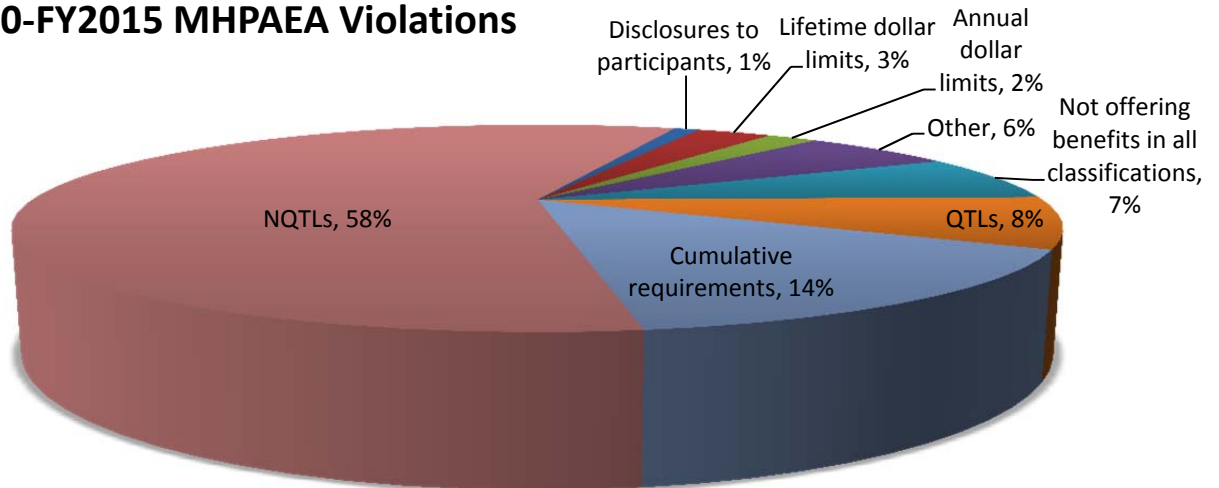
MHPAEA. In addition to impacting all the participants and beneficiaries enrolled in the plan, EBSA’s work also resulted in more than \$1,000 in wrongfully denied benefits being paid to affected plan participants.

Where Benefits Advisors have been unable to achieve voluntary compliance, they have played a valuable role in identifying complaints attributable to plan-wide fiduciary violations and referring such matters for formal investigation. EBSA anticipates MHPAEA inquiries will continue to rise since the law became fully applicable in recent years and increasingly individuals will learn about its protections.

iii. Enforcement Results and Remediating Violations

EBSA conducts the Health Benefits Security Project (HBSP) which is a comprehensive national project to conduct investigations on health plans and services providers to detect violations. Investigations under HBSP include, among other things, a review to determine if the subject is in compliance with MHPAEA. In fiscal years 2010³² through 2015, EBSA closed 3,118 civil investigations of health plans. Of those, 1,515 were subject to MHPAEA. Approximately 171 MHPAEA violations were cited. These violations included impermissible nonquantitative treatment limitations, impermissible quantitative treatment limitations, lifetime or annual dollar limits on mental health benefits, higher copayments with respect to mental health benefits than with respect to medical/surgical benefits and inadequate disclosures to participants related to medical necessity determinations and reasons for benefit denial. The chart below provides a breakdown of the type of violations cited.

FY2010-FY2015 MHPAEA Violations



Even though the governing plan documents contain ERISA- and ACA-compliant language and procedures, plans can fail to provide the promised health benefits or to adhere to the requirements of the law or the plan document. Accordingly, EBSA focuses on plans’ and claims administrators’ actual conduct, not just the words on the formal plan instruments. Through its investigations, EBSA is able to identify systemic violations and is then able to work with plans insurance providers and third party administrators to have the violation corrected across all products provided by those entities. EBSA has directed health investigative resources to focus on global correction of noncompliant plan provisions affecting multiple plans by approaching common service providers that operate under standard terms applied to multiple plan clients. This helps maximize the impact of

³² MHPAEA data collection results are reflective of data collection beginning in fiscal year 2010 (October 2009) which corresponds with the first fiscal year in which MHPAEA’s statutory provisions become applicable (plan years beginning on or after October 3, 2009).

enforcement. As the Secretary of Labor is statutorily barred by ERISA section 502(b)(3) from bringing enforcement actions against state-licensed health insurance issuers for violations of certain health rules such as MHPAEA, EBSA frequently works directly with issuers and states to voluntarily amend coverage terms that affect thousands of ERISA plans and, through widespread corrections, bring them into compliance.

Approximately 171 MHPAEA violations have been cited since October 2010. EBSA has encountered violations related to dollar limits, higher copays, quantitative treatment limitations and NQTLs, with the latter comprising the majority of the violations that EBSA has cited. The types of MHPAEA violations EBSA commonly finds in investigations include:

- Imposing broad preauthorization requirements only on mental health or substance use disorder benefits
- Imposing more restrictive visit limits on mental health/substance use disorder benefits
- Requiring written treatment plans to access care (only) for mental health services and
- Conditioning treatment on whether the mental health or substance use disorder treatment has a likelihood of success when a comparable limitation is not applied to medical/surgical treatment.

Since October 2010, EBSA has conducted over 1500 investigations related to MHPAEA and cited 171 violations for noncompliance with these rules.

EBSA has also encountered plans that refused to cover out-of-network benefits for mental health benefits, or have imposed more restrictive visit limits on mental health benefits. EBSA has succeeded in bringing these plans into compliance with the law and providing participants with benefits to which they are entitled. EBSA has also worked with several large insurance companies to remove impermissible barriers to mental health benefits, ensuring that hundreds of thousands of plans are no longer imposing these requirements.

The Department compliance review process to date is not without challenge. First, under ERISA section 502(b)(3), the Department is barred from directly enforcing the provisions of ERISA with respect to an issuer. Second, the Departments have found that analyzing NQTL compliance often necessitates a complex comparison of utilization review methods applicable to mental health/substance use disorder and medical/surgical benefits. The Departments recognize that such analyses may require the support of expert input. EBSA has been coordinating with experts related to open health plan investigations and will continue to evaluate the staffing and expertise needed to identify and establish violations and, if necessary, litigate instances of noncompliance.

iv. Supporting State and Private Action

The Department is also committed to supporting access to mental health and substance use disorder benefits in other contexts. The Department has worked with states to support their efforts to strengthen their health care systems, with an eye towards ensuring better integration of mental health and substance use disorder services with medical care. The Department has also submitted several amicus briefs supporting participants seeking mental health benefits coverage. A notable example includes *New York State Psychiatric Association v. United Health Group UHC*, a case in which the Department supported and the court affirmed the position that a third party administrator of a self-funded health plan may be sued under ERISA section 502(a)(1)(B) for denial of benefits under MHPAEA and may be subject to equitable relief in the form of surcharge and injunctive relief under ERISA section 502(a)(3) to enforce the parity act.³³ Recently, the Department of Labor collaborated with the

³³ Amicus curiae brief of the Secretary of Labor, *New York State Psychiatric Association v. UnitedHealth Group UHC*, 798 F.3d 125 (2nd Cir.

Department of Justice (DOJ) in preparing an amicus brief in support of Vermont’s healthcare reporting law, Vt. Stat. Ann. Tit. 18 § 9401 (2012), defending the ability of states to act within their traditional state spheres of health and safety. The statute, which was passed in part to “support efforts to integrate mental health and substance abuse services with overall medical care,” was challenged by an insurer as being preempted by ERISA and is currently before the Supreme Court.³⁴ In *Harrison v. Wells Fargo*, the court affirmed the position advanced by the Department in an amicus brief that a fiduciary claims administrator has a duty to obtain readily-available medical information if the information would be relevant to the claim and that fiduciary decision-makers violate ERISA claims provisions by failing to provide a denial letter that specifically informs the participant concerning the medical information missing in the case file, which in this case involved a plan’s failure to contact a psychiatrist in denying a disability claim.³⁵

v. Initiatives Aimed to Improve Future Enforcement Efforts

HHS is conducting a research project (set to run from Sept. 2014 to Sept. 2016) to examine changes in insurance coverage for mental health and substance use disorders prior to and subsequent to the ACA. Researchers are examining changes in behavioral health coverage between 2013 and 2014 in a sample of 192 insurance products in the individual and small group markets. The study will examine the scope of insurance coverage for screening and treatment, the levels of coverage, and the breadth of health provider networks for mental health and substance use disorder benefits in the individual and small group insurance markets. The Department and HHS will work together to apply information gained from the study to further advance parity compliance. Furthermore, EBSA is working to amend its enforcement database to collect and report in greater detail the types of MHPAEA violations it finds in health plan investigations.

2015), available at [http://www.dol.gov/sol/media/briefs/nyspa\(A\)-04-28-2014.pdf](http://www.dol.gov/sol/media/briefs/nyspa(A)-04-28-2014.pdf).

³⁴ Amicus Curiae Brief for the United States as Amicus Curiae Supporting Petitioner, *Gobeille v. Liberty Mutual Insurance Co.*, 135 S. Ct. 885 (2014), available at http://www.dol.gov/sol/media/briefs/gobeille_2015-09-04.pdf and See *Harrison v. Wells Fargo Bank, N.A.*, 773 F.3d 15 (4th Cir. 2014).

³⁵ See *Harrison v. Wells Fargo Bank, N.A.*, 773 F.3d 15 (4th Cir. 2014).

V. Customer Service, Outreach and Education

i. Outreach Events

The Department engaged in a rigorous outreach campaign to educate plans, issuers, medical providers, plan participants and beneficiaries, and States about their rights and responsibilities under MHPAEA and the other consumer protection laws EBSA administers, including the Affordable Care Act. This campaign includes webinars, conference calls and seminars provided for audiences including plan representatives, participants, beneficiaries, insurance representatives, third-party administrators, lawyers, consultants, and consumer organizations. EBSA sponsors and provides presentations on MHPAEA at ongoing HBEC seminars which are held in locations across the country. During fiscal years 2010-2015, the Department presented at 42 HBEC seminars. During fiscal year 2015 the Department gave presentations on MHPAEA at HBEC seminars in Austin, Texas; Hartford, Connecticut; Indianapolis, Indiana; Anchorage, Alaska; Omaha, Nebraska; West Columbia, South Carolina; and Philadelphia, Pennsylvania. In fiscal year 2014, EBSA, in conjunction with the IRS, HHS's Substance Abuse and Mental Health Services Administration (SAMHSA), and the Vice President's office, presented on MHPAEA to stakeholders. EBSA also conducted another well-received consumer webcast in the spring of 2015, which is now available online.³⁶ EBSA plans to conduct another MHPAEA-focused webcast in fiscal year 2016. The Department participates in three National Association of Insurance Commissioners (NAIC) meetings each year and participates in interim meetings throughout the year in order to facilitate ongoing coordination between the Departments and the States regarding a wide range of issues related to consistent State and Federal MHPAEA implementation.

ii. Publications and Resources

EBSA has developed a combination of consumer publications, online tools, and compliance assistance materials designed to promote better understanding of the MHPAEA requirements. All MHPAEA-related guidance and resources are available on the Department's MHPAEA-dedicated webpage, which was launched in May of 2012. The Department has developed MHPAEA-focused publications to explain the law and has updated its current publications to include information on MHPAEA.

EBSA's consumer publications on MHPAEA include:

- Frequently Asked Questions For Employees about the Mental Health Parity and Addiction Equity Act
- Questions and Answers on the Mental Health Parity Provisions
- Top Ten Ways to Make Your Health Benefits Work for You
- Your Health Plan and You: Know Your Health Coverage Protections
- ELaws Health Benefits Advisor
- Parity of Mental Health and Substance Use Benefits with Other Benefits: Using Your Employer Sponsored Health Plan to Cover Services

Compliance Assistance Resources:

- Fact Sheet: The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Compliance Assistance Guide; Health Benefits Under Federal Law
- Health Benefits Laws Self Compliance Guides including Mental Health Parity Compliance Tool
- Understanding Your Fiduciary Responsibilities Under a Group Health Plan
- Reporting and Disclosure Guide for Employee Benefit Plans
- FAQs on Understanding Implementation of the Mental Health Parity and Addiction Equity Act of 2008
- ELaws Health Benefits Advisor

³⁶ Mental Health Parity - Important Information About Your Health Coverage Webcast (May 28, 2015), available at <http://mp163422.cdn.mediaplatform.com/163422/wc/mp/4000/15208/30195/47810/Lobby/default.htm?ref=ProductionTeamEmail>.

EBSA recognizes the importance of transparency regarding compliance as a key means to preventing MHPAEA violations before they occur. EBSA has been working to issue compliance assistance materials to underscore requirements and best practices relating to health plan disclosures. EBSA has included highlights and tips in its updated version of the MHPAEA compliance tool, the same tool EBSA investigators use as an initial starting point for conducting compliance reviews. The updated tool includes step-by-step instructions on how to apply the parity requirements for quantitative treatment limitations, explanations of the terms used in the statute and regulations, examples of what the plan may or may not do and a list of suggested questions to be considered when analyzing a plan for MHPAEA compliance. In addition, in late 2014, the Department published its updated Self Compliance Guide, which includes a section dedicated to MHPAEA. Contemporaneous with issuance of this report, EBSA is publishing a MHPAEA Enforcement Fact Sheet highlighting investigative results³⁷. EBSA is seeking to publish additional highlights and tips in an updated MHPAEA compliance tool to be published in FY 2016.

EBSA also coordinated with HHS in its development of a MHPAEA compliance tool. HHS's compliance tool was released to state regulators in 2015 and will be used by HHS in 2016 in states in which HHS provides direct enforcement.

iii. Upcoming Outreach and New Tools in Development

EBSA plans to participate with HHS in a mental health and substance use disorder parity session, as part of the HHS/SAMHSA hosted All States block grant meeting being held during fiscal year 2016. This session is expected to bring together a broad range of State mental health agencies and provide an opportunity for both public education and information gathering. EBSA's partnership with SAMHSA enables the Department to reach an even broader audience. EBSA has seven HBEC conferences, which include mental health and substance use disorder parity outreach, scheduled during fiscal year 2016.

Recently, the Departments of Labor and HHS issued Parity of Mental Health and Substance Use Benefits with Other Benefits: Using Your Employer-Sponsored Health Plan to Cover Services in cooperation with HHS and SAMHSA. The resource was developed in response to calls with stakeholders, where the need for a consumer-friendly publication on submitting claims and appealing denial for mental health benefits was expressed. This resource assists individuals in evaluating what mental health and substance use disorder benefits are available under their group health plan; explains how to look for parity in those benefits in a consumer-friendly manner; and explains what to expect when submitting a claim and how best to address a denial of benefits, including information on how to appeal a claim and resources that may be available to assist consumers. In addition, in response to stakeholder feedback regarding Federal and State coordination, EBSA and HHS are coordinating with the NAIC to develop a compliance review resource on compliance with MHPAEA.

EBSA is also coordinating with HHS and SAMHSA to develop a MHPAEA Facts card to be distributed to mental health and substance use disorder treatment providers offices throughout the country.

EBSA anticipates that these comprehensive outreach and education initiatives will enable more individuals to understand their rights and responsibilities under the mental health and substance use disorder parity laws.

³⁷ See Appendix B.

iv. Stakeholder Outreach

EBSA partnered with SAMHSA to host a series of interactive stakeholder discussions. These outreach activities were intended to gather reactions from consumers, providers and others regarding successes and hurdles realized in the initial stages of implementation under the final rules. Call participants included a broad range of stakeholders including consumer representatives, insurers and providers. We spoke to over 85 individuals representing over 20 organizations,³⁸ with participants including stakeholder groups such as the Parity Implementation Coalition, Mental Health America, The Association for Behavioral Health and Wellness, Blue Cross Blue Shield Association, America's Health Insurance Plans (AHIP), The National Association of Psychiatric Health Systems, and the American Psychological Association. In addition, EBSA conducted stakeholder calls with the NAIC, the Massachusetts Department of Insurance (DOI), and CalNet. A summary of these calls was compiled by Truven on behalf of SAMHSA and is attached as an appendix to this report.

During each stakeholder call, in addition to inviting an open dialogue, the Departments posed a number of questions as a starting point to facilitate discussion. Questions asked by the Departments included:

1. Can you suggest a specific list of documents you would recommend that we request from group health plans to check for compliance with MHPAEA?
2. Can you suggest specific search terms on which we should focus when reviewing large volumes of plan procedural materials? For example, are there terms or phrases related to scope of services that we could search when reviewing plan utilization review processes to help us hone in on related plan practices that need to be reviewed for MHPAEA compliance?
3. Are there examples of best practices among group health plans that you can point to, especially in terms of disclosure related to NQTLs?
4. Are there certain guidelines or evidentiary standards that you would recommend as reliable or unreliable with respect to mental health benefits?
5. Are there guidelines that you would recommend as reliable with respect to medical/surgical benefits or organizations whose recommendations regarding guidelines you find to be reliable?
6. What might we be able to learn from organizations such as the Utilization Review and Accreditation Commission (URAC), The Agency for Healthcare Research and Quality (AHRQ), National Committee for Quality Assurance (NCQA) and any other organizations you might raise to our attention? and
7. With respect to analyzing for parity of specific NQTLs, what types of experts would you expect the departments would need to enlist and what issues would you expect the particular expert would be best able to address?

³⁸ DOL conducted a series of four calls with stakeholders. The first call, with the Parity Implementation Coalition, involved representatives from the American Psychiatric Association; Capitol Decisions; Watershed Addiction Treatment Programs; and the National Association of Psychiatric Health Systems. The second call, with the Association for Behavioral Health and Wellness, involved representatives from the Association for Behavioral Health and Wellness; Aetna; Beacon Health Options; Cenpatco; Cigna; New Directions Behavioral Health; Optum; Association for Behavioral Health and Wellness; Blue Cross Blue Shield; America's Health Insurance Plans; Managed Health Network; and Meridian Mutual Insurance. The third call, with providers and provider representatives, involved representatives from National Association of Psychiatric Health Systems; New Mexico Human Services Department; Tennessee Department of Mental Health and Substance Abuse Services; New York State Office of Mental Health and the American Psychological Association. The fourth call, with consumer representatives, involved representatives from Mental Health America; Legal Action Center; and the National Alliance of Mental Illness.

During this series of productive calls, stakeholders identified concerns related to the disclosure rights of participants, compliance with the parity requirements for NQTLs and information they suggest that the Department could provide to be helpful to compliance efforts. This feedback has helped EBSA identify areas for future guidance, consumer assistance and compliance efforts.

VI. CONCLUSION

Participants rely on their health benefits, including their mental health and substance use disorder benefits, at some of the most vulnerable times in their lives. Mental health and living without a substance use disorder are essential to leading a healthy productive life and to the development and realization of a person's full potential. The Departments regard MHPAEA as an essential tool to assist participants in obtaining the mental health and substance use disorder coverage they need to successfully manage or overcome their conditions and live long and fruitful lives.

In all of our efforts, we have endeavored to keep the needs of participants and beneficiaries foremost in our actions. The Department stands committed to standing at the forefront in the effort to improve access to quality mental health and substance use disorder benefits.

First, EBSA has issued comprehensive regulations and subregulatory guidance to implement the law and address interpretive issues as they arise. Second, EBSA maintains a vigorous enforcement effort. EBSA has focused on continuous national and regional staff training related to MHPAEA, facilitating investigations into those plans who fail in their obligation to provide coverage in compliance with the parity requirements. Our enforcement efforts have resulted in corrections of plans' noncompliant actions, advancing higher rates of compliance and ensuring that individuals receive the benefits they are entitled to under the law. Beyond these investigations, EBSA has and will continue to work to provide outreach and education to both the regulated community and consumers.

Finally, consumer outreach will remain a key component of EBSA's implementation strategy. EBSA will continue to rely on its Benefits Advisors to conduct outreach and consumer education efforts, and will continue to inform the public of the protections of MHPAEA, both through updating their current publications and through the development of exciting new efforts that focus exclusively on MHPAEA. EBSA will continue to meet and work with stakeholders in the coming years to better inform the guidance, resource development, and enforcement processes.

VII. APPENDICES

(See below)

APPENDIX A
MHPAEA Final Rules



FEDERAL REGISTER

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Part III

Department of the Treasury

Internal Revenue Service

26 CFR Part 54

Department of Labor

Employee Benefits Security Administration

29 CFR Part 2590

Department of Health and Human Services

45 CFR Parts 146 and 147

Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program; Final Rule

DEPARTMENT OF THE TREASURY**Internal Revenue Service****26 CFR Part 54**

[TD 9640]

RIN 1545-B170

DEPARTMENT OF LABOR**Employee Benefits Security Administration****29 CFR Part 2590**

RIN 1210-AB30

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[CMS-4140-F]

45 CFR Parts 146 and 147

RIN 0938-AP65

Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: This document contains final rules implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and group and individual health insurance coverage. This document also contains a technical amendment relating to external review with respect to the multi-state plan program administered by the Office of Personnel Management.

DATES: *Effective date.* These final regulations are effective on January 13, 2014, except that the technical amendments to 29 CFR 2590.715-2719 and 45 CFR 147.136 are effective on December 13, 2013.

Applicability date. The mental health parity provisions of these final regulations apply to group health plans and health insurance issuers for plan years (or, in the individual market, policy years) beginning on or after July

1, 2014. Until the final rules become applicable, plans and issuers must continue to comply with the mental health parity provisions of the interim final regulations.

FOR FURTHER INFORMATION CONTACT:

Amy Turner or Amber Rivers, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622-6080 or (202) 317-5500; Jacob Ackerman, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (410) 786-1565.

Customer service information:

Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws, including the mental health parity provisions, may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's Web site (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers (such as mental health and substance use disorder parity) can be found on the Centers for Medicare & Medicaid Services (CMS) Web site (www.cms.gov/ccio) and information on health reform can be found at www.HealthCare.gov. In addition, information about mental health is available at www.mentalhealth.gov.

SUPPLEMENTARY INFORMATION:**I. Background**

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on October 3, 2008 as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Pub. L. 110-343).¹ MHPAEA amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code). In 1996, Congress enacted the Mental Health Parity Act of 1996 (MHPA 1996), which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. Those mental health parity provisions were codified in section 712 of ERISA, section 2705 of the PHS Act, and section 9812 of the Code, and applied to employment-related group health plans and health insurance coverage offered in connection with a group health plan.

¹ A technical correction to the effective date for collectively bargained plans was made by Public Law 110-460, enacted on December 23, 2008.

The changes made by MHPAEA were codified in these same sections and consist of new requirements, including parity for substance use disorder benefits, as well as amendments to the existing mental health parity provisions. The changes made by MHPAEA are generally effective for plan years beginning after October 3, 2009.

The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, was enacted on March 30, 2010 (collectively, the "Affordable Care Act"). The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The Affordable Care Act adds section 715(a)(1) to ERISA and section 9815(a)(1) to the Code to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

The Affordable Care Act extended MHPAEA to apply to the individual health insurance market and redesignated MHPAEA in the PHS Act as section 2726.² Additionally, section 1311(j) of the Affordable Care Act applies section 2726 of the PHS Act to qualified health plans (QHPs) in the same manner and to the same extent as such section applies to health insurance issuers and group health plans. Furthermore, the Department of Health and Human Services (HHS) final regulation regarding essential health benefits (EHB) requires health insurance issuers offering non-grandfathered health insurance coverage in the individual and small group markets, through an Affordable Insurance Exchange (Exchange, also called a Health Insurance Marketplace or Marketplace) or outside of an Exchange, to comply with the requirements of the

² These final regulations apply to both grandfathered and non-grandfathered health plans. See section 1251 of the Affordable Care Act and its implementing regulations at 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140. Under section 1251 of the Affordable Care Act, grandfathered health plans are exempted only from certain Affordable Care Act requirements enacted in Subtitles A and C of Title I of the Affordable Care Act. The provisions extending MHPAEA requirements to the individual market and requiring that qualified health plans comply with MHPAEA were not part of these sections.

MHPAEA regulations in order to satisfy the requirement to cover EHB.³

On April 28, 2009, the Departments of the Treasury, Labor, and HHS published in the **Federal Register** (74 FR 19155) a request for information (RFI) soliciting comments on the requirements of MHPAEA. (Subsequent references to the “Departments” include all three Departments, unless the headings or context indicate otherwise.) On February 2, 2010, after consideration of the comments received in response to the RFI, the Departments published in the **Federal Register** (75 FR 5410) comprehensive interim final regulations implementing MHPAEA (interim final regulations). The interim final regulations generally became applicable to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010.

The interim final regulations established six classifications of benefits⁴ and provided that the parity requirements be applied on a classification-by-classification basis. The general parity requirement set forth in paragraph (c)(2) of the interim final regulations prohibited plans and issuers from imposing a financial requirement or quantitative treatment limitation on mental health and substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification. For this purpose, the interim final regulations incorporated the two-thirds “substantially all” numerical standard from the regulations implementing MHPA 1996, and quantified “predominant” to mean that more than one-half of medical/surgical benefits in the classification are subject to the financial requirement or quantitative treatment limitation in the relevant classification. Using these numerical standards, the Departments established a mathematical test by which plans and issuers could determine what level of a financial requirement or quantitative treatment limitation, if any, is the most restrictive level that could be imposed on mental health or substance use disorder benefits within a classification. (This mathematical test is referred to in this preamble as the quantitative parity analysis.)

³ See 45 CFR 147.150 and 156.115 (78 FR 12834, February 25, 2013).

⁴ The six classifications of benefits are inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs.

The interim final regulations also prohibited plans and issuers from applying cumulative financial requirements (such as deductibles or out-of-pocket maximums) or cumulative quantitative treatment limitations (such as annual or lifetime day or visit limits) to mental health or substance use disorder benefits in a classification that accumulate separately from any such cumulative financial requirements or cumulative quantitative treatment limitations established for medical/surgical benefits in the same classification.

Additionally, the interim final regulations set forth parity protections with respect to nonquantitative treatment limitations (NQTLs), which are limits on the scope or duration of treatment that are not expressed numerically (such as medical management techniques like prior authorization). The interim final regulations stated that a plan or issuer may not impose an NQTL with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification 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 same classification, except to the extent that recognized clinically appropriate standards of care may permit a difference. The Departments also set forth a special rule for evaluating parity of multi-tiered prescription drug benefits. The interim final regulations included several examples to illustrate each of these parity standards.

The interim final regulations also implemented MHPAEA’s disclosure provisions requiring that the criteria for medical necessity determinations and the reason for any denial of reimbursement or payment under a group health plan (or health insurance coverage) with respect to mental health or substance use disorder benefits be made available upon request in certain circumstances.

The interim final regulations also specifically requested comments in several areas, including whether additional examples would be helpful to illustrate the application of the NQTL rule to other features of medical management or general plan design; 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; what additional clarifications might be helpful to facilitate compliance with the disclosure requirement for medical necessity criteria or denials of mental health or substance use disorder benefits; and implementing the new statutory requirements for the increased cost exemption under MHPAEA, as well as information on how many plans expect to use the exemption.

In light of the comments and other feedback received in response to the interim final regulations, the Departments issued clarifications in several rounds of Frequently Asked Questions (FAQs). In the first FAQ about MHPAEA, the Departments set forth an enforcement safe harbor under which the Departments would not take enforcement action against plans and issuers that divide benefits furnished on an outpatient basis into two sub-classifications—(1) office visits, and (2) all other outpatient items and services—for purposes of applying the financial requirement and treatment limitation rules under MHPAEA.⁵

The Departments issued additional FAQs providing further clarifications.⁶ The FAQs issued in December 2010 addressed the changes made to the definition of “small employer” after the enactment of the Affordable Care Act, made clear how the disclosure requirements under MHPAEA interact with other ERISA disclosure requirements (and that health care providers are entitled to request such information on behalf of participants), and provided temporary information on how to claim the increased cost exemption.⁷ Additional FAQs issued in November 2011 addressed specific NQTLs, such as prior authorization and concurrent review.⁸ The Departments

⁵ See FAQ About Mental Health Parity and Addiction Equity Act, available at <http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>.

⁶ See FAQs about Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html, and FAQs about Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation, available at <http://www.dol.gov/ebsa/faqs/faq-aca7.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html#MentalHealthParityandAddictionEquityActof2008.

⁷ See FAQs about Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation, questions 8–11, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

⁸ See FAQs about Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation, questions 2–6, available at <http://www.dol.gov/ebsa/faqs/faq-aca7.html>.

also clarified that plans and issuers may charge the specialist copayment for mental health and substance use disorder benefits only if it is determined that this level of copayment is the predominant level that applies to substantially all medical/surgical benefits within a classification.⁹

After consideration of the comments and other feedback received from stakeholders, the Departments are publishing these final regulations.

II. Overview of the Regulations

In general, these final regulations incorporate clarifications issued by the Departments through FAQs since the issuance of the interim final regulations, and provide new clarifications on issues such as NQTLs and the increased cost exemption. The HHS final regulation also implements the provisions of MHPAEA for the individual health insurance market.

A. Meaning of Terms

Under MHPAEA and the interim final regulations, the term “medical/surgical benefits” means benefits for medical or surgical services, as defined under the terms of the plan or health insurance coverage. This term does not include mental health or substance use disorder benefits. The terms “mental health benefits” and “substance use disorder benefits” mean benefits with respect to services for mental health conditions or substance use disorders, respectively, as defined under the terms of the plan and in accordance with applicable Federal and State law. The interim final regulations further provided that the plan terms defining whether the benefits are medical/surgical benefits or mental health or substance use disorder benefits must be consistent with generally recognized 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 International Classification of Diseases (ICD), or State guidelines).

These final regulations make minor, technical changes to the meaning of these terms for consistency and clarity. Specifically, the final regulations clarify that the definitions of “medical/surgical

benefits,” “mental health benefits,” and “substance use disorder benefits” include benefits for items as well as services. The final regulations also clarify that medical conditions and surgical procedures, and mental health conditions and substance use disorders, are defined under the terms of the plan or coverage and in accordance with applicable Federal and State law.

One commenter suggested that the definitions of mental health benefits and substance use disorder benefits should be revised to refer only to the terms of the plan and applicable State law. The Departments decline to adopt this suggestion. The statutory definitions provided in MHPAEA specifically refer to applicable Federal law. Moreover, the reference to Federal law is appropriate because State law does not apply to all group health plans, and Federal law also identifies EHB categories, including the category of mental health and substance use disorder services, that non-grandfathered health plans in the individual and small group markets are required to cover beginning in 2014.

B. Clarifications—Parity Requirements

1. Classification of Benefits

As described earlier in this preamble, the interim final regulations set forth that the parity analysis be conducted on a classification-by-classification basis in six specific classifications of benefits. Subsequent to the issuance of the interim final regulations, several plans and issuers brought to the Departments’ attention that, with respect to outpatient benefits, many plans and issuers require a copayment for office visits (such as physician or psychologist visits) and coinsurance for all other outpatient services (such as outpatient surgery). In response to this information, the Departments published an FAQ establishing an enforcement safe harbor under which the Departments would not take enforcement action against plans and issuers that divide benefits furnished on an outpatient basis into two sub-classifications ((1) office visits and (2) all other outpatient items and services) for purposes of applying the financial requirement and treatment limitation rules under MHPAEA.¹⁰

The Departments have incorporated the terms of the FAQ in paragraph (c)(3)(iii)(C) of these final regulations, permitting sub-classifications for office visits, separate from other outpatient services. Other sub-classifications not specifically permitted in these final regulations, such as separate sub-

classifications for generalists and specialists, must not be used for purposes of determining parity. After the sub-classifications are established, a plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification (*i.e.*, office visits or non-office visits) that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph (c)(3)(i) of these final regulations. Example 6 under paragraph (c)(3)(iv) of these final regulations illustrates the approach that plans and issuers may employ when dividing outpatient benefits into sub-classifications in accordance with these final regulations.

Additionally, commenters requested that the final regulations permit plans and issuers to create sub-classifications to address plan designs that have two or more network tiers of providers. Commenters asserted that utilizing tiered networks helps plans manage the costs and quality of care and requested that the final regulations allow plans to conduct the parity analysis separately with respect to these various network tiers.

The Departments have considered these comments and recognize that tiered networks have become an important tool for health plan efforts to manage care and control costs. Therefore, for purposes of applying the financial requirement and treatment limitation rules under MHPAEA, these final regulations provide that if a plan (or health insurance coverage) provides in-network benefits through multiple tiers of in-network providers (such as an in-network tier of preferred providers with more generous cost sharing to participants than a separate in-network tier of participating providers), the plan may divide its benefits furnished on an in-network basis into sub-classifications that reflect those network tiers, if the tiering is based on reasonable factors and without regard to whether a provider is a mental health or substance use disorder provider or a medical/surgical provider.¹¹ After the sub-

www.dol.gov/ebsa/faqs/faq-aca7.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html#MentalHealthParityandAddictionEquityActof2008.

⁹ See FAQs about Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation, question 7, available at <http://www.dol.gov/ebsa/faqs/faq-aca7.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html#MentalHealthParityandAddictionEquityActof2008.

¹⁰ See FAQ About Mental Health Parity and Addiction Equity Act, available at <http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>.

¹¹ Under PHS Act section 2719A (incorporated into ERISA and the Code) and its implementing regulations, non-grandfathered group health plans and non-grandfathered group or individual health insurance coverage are prohibited from imposing any cost-sharing requirement expressed as a copayment amount or coinsurance rate with respect to a participant or beneficiary for out-of-network emergency services that exceeds the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-

classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph (c)(3)(i) of these final regulations.

The Departments are aware that some plans may have an uneven number of tiers between medical/surgical providers and mental health or substance use disorder providers (e.g., 3 tiers for medical/surgical providers and 2 tiers for mental health or substance use disorder providers). The Departments may provide additional guidance if questions persist with respect to plans with an uneven number of tiers or if the Departments become aware of tier structures that may be inconsistent with the parity analysis required under these final regulations. Until the issuance of further guidance, the Departments will consider a plan or issuer to comply with the financial requirement and quantitative treatment limitation rules under MHPAEA if a plan or issuer treats the least restrictive level of the financial requirement or quantitative treatment limitation that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to mental health or substance use disorder benefits in the same classification.

Some commenters requested clarification that all medical/surgical benefits and mental health or substance use disorder benefits offered by a plan or coverage must be contained within the six classifications of benefits and that plans and issuers could not classify certain benefits outside of the six classifications in order to avoid the parity requirements. Other commenters suggested that specific mental health or substance use disorder benefits be cross-walked or paired with specific medical/surgical benefits (e.g., physical rehabilitation with substance use disorder rehabilitation) for purposes of the parity analysis.

The final regulations retain the six classifications enumerated in the interim final regulations, specify the permissible sub-classifications, and provide that the parity analysis be performed within each classification and sub-classification. The

classifications and sub-classifications are intended to be comprehensive and cover the complete range of medical/surgical benefits and mental health or substance use disorder benefits offered by health plans and issuers. Medical/surgical benefits and mental health or substance use disorder benefits cannot be categorized as being offered outside of these classifications and therefore not subject to the parity analysis.

Cross-walking or pairing specific mental health or substance use disorder benefits with specific medical/surgical benefits is a static approach that the Departments do not believe is feasible, given the difficulty in determining “equivalency” between specific medical/surgical benefits and specific mental health and substance use disorder benefits and because of the differences in the types of benefits that may be offered by any particular plan.

2. Measuring Plan Benefits

Some commenters supported the “substantially all” and “predominant” tests as formulated in the interim final regulations, while other commenters were concerned that they were too restrictive and may create an administrative burden on plans. A few commenters requested clarification that the parity analysis would not need to be performed annually absent changes in plan design or indications that assumptions or data were inaccurate.

The interim final regulations incorporated the two-thirds “substantially all” numerical standard from the regulations implementing MHPA 1996, and quantified “predominant” to mean more than one-half of medical/surgical benefits in the classification are subject to the financial requirement or quantitative treatment limitation. The Departments believe group health plans and issuers have developed the familiarity and expertise to implement these parity requirements and therefore retain the numerical standards as set forth in the interim final regulations. The Departments clarify that a plan or issuer is not required to perform the parity analysis each plan year unless there is a change in plan benefit design, cost-sharing structure, or utilization that would affect a financial requirement or treatment limitation within a classification (or sub-classification).

These final regulations, like the interim final regulations, provide that the determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or

quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year. 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 quantitative treatment limitation. One commenter asked whether plan benefits are measured based on allowed plan costs, for purposes of the “substantially all” and “predominant” tests. 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.

3. Cumulative Financial Requirements and Cumulative Quantitative Treatment Limitations

The interim final regulations provide that a plan or issuer may not apply cumulative financial requirements (such as deductibles and out-of-pocket maximums) or cumulative quantitative treatment limitations (such as annual or lifetime day or visit limits) for mental health or substance use disorder benefits in a classification that accumulate separately from any cumulative requirement or limitation established for medical/surgical benefits in the same classification. These final regulations retain this standard and continue to provide that cumulative requirements and limitations must also satisfy the quantitative parity analysis. Accordingly, these final regulations continue to prohibit plans and issuers from applying separate cumulative financial requirements and cumulative quantitative treatment limitations to medical/surgical and mental health and substance use disorder benefits in a classification, and continue to provide that such cumulative requirements or limitations are only permitted to be applied for mental health and substance use disorder benefits in a classification to the extent that such unified cumulative requirements or limitations also apply to substantially all medical/surgical benefits in the classification.

Several commenters argued that the requirement in the interim final regulations to use a single, combined deductible in a classification was burdensome and would require significant resources to implement, especially for Managed Behavioral Health Organizations (MBHOs) that often work with multiple plans. One commenter asserted that this

requirement could impact the willingness of plan sponsors to offer mental health or substance use disorder benefits. A study sponsored by HHS, however, found that nearly all plans had eliminated the use of separate deductibles for mental health and substance use disorder benefits by 2011.¹² According to this study, even in 2010, only a very small percentage of plans were using separate deductibles. This study and other research¹³ have shown that the overwhelming majority of plans have retained mental health and substance use disorder coverage after issuance of the interim final regulations and, for the very small percent of plans that have dropped mental health or substance use disorder coverage, there is no clear evidence they did so because of MHPAEA. Accordingly, these final regulations retain the requirement that plans and issuers use a single, combined deductible in a classification.

4. Interaction With PHS Act Section 2711 (No Lifetime or Annual Limits)

MHPA 1996 and paragraph (b) of the interim final regulations set forth the parity requirements with respect to aggregate lifetime and annual dollar limits on mental health benefits or substance use disorder benefits where a group health plan or health insurance coverage provides both medical/surgical benefits and mental health benefits or substance use disorder benefits.

PHS Act section 2711, as added by the Affordable Care Act, prohibits lifetime and annual limits on the dollar amount of EHB, as defined in section 1302(b) of the Affordable Care Act. The definition of EHB includes “mental health and substance use disorder services, including behavioral health treatment.”¹⁴ Thus, notwithstanding the provisions of MHPAEA that permit

aggregate lifetime and annual dollar limits with respect to mental health or substance use disorder benefits as long as those limits are in accordance with the parity requirements for such limits, such dollar limits are prohibited with respect to mental health or substance use disorder benefits that are covered as EHB. While these final regulations generally retain the provisions of the interim final regulations regarding the application of the parity requirements to aggregate lifetime and annual dollar limits on mental health or substance use disorder benefits, language has been added specifying that these final regulations do not address the requirements of PHS Act section 2711. That is, the parity requirements regarding annual and lifetime limits described in these final regulations only apply to the provision of mental health and substance use disorder benefits that are not EHB. Because this greatly reduces the instances in which annual or lifetime limits will be permissible, the examples from the interim final regulations that expressly demonstrated how a plan could apply lifetime or annual dollar limits have been deleted.¹⁵

5. Interaction With PHS Act Section 2713 (Coverage of Preventive Health Services)

The interim final regulations provide that if a plan or issuer provides mental health or substance use disorder benefits in any classification, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. Under PHS Act section 2713, as added by the Affordable Care Act, non-grandfathered group health plans and health insurance issuers offering non-grandfathered group and individual coverage are required to provide coverage for certain preventive services without cost

sharing.¹⁶ These preventive services presently include, among other things, alcohol misuse screening and counseling, depression counseling, and tobacco use screening as provided for in the guidelines issued by the United States Preventive Services Task Force.

The Departments received several comments asking whether or to what extent a non-grandfathered plan that provides mental health or substance use disorder benefits pursuant to PHS Act section 2713 is subject to the requirements of MHPAEA. Many commenters urged the Departments to clarify that the provision of mental health and substance use disorder benefits in this circumstance does not trigger a broader requirement to comply with MHPAEA for non-grandfathered plans that do not otherwise offer mental health or substance use disorder benefits.

The Departments agree that compliance with PHS Act section 2713 should not, for that reason alone, require that the full range of benefits for a mental health condition or substance user disorder be provided under MHPAEA. Accordingly, paragraph (e)(3)(ii) of these final regulations provides that nothing in these regulations requires a group health plan (or health insurance issuer offering coverage in connection with a group health plan) that provides mental health or substance use disorder benefits only to the extent required under PHS Act section 2713 to provide additional mental health or substance use disorder benefits in any classification.

C. Nonquantitative Treatment Limitations

1. Exceptions for Clinically Appropriate Standards of Care

The final regulations generally retain the provision in the interim final regulations setting forth the parity requirements with respect to NQTLs. Under both the interim final regulations and these final regulations, a plan or issuer may not impose an NQTL with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification 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

¹² Final Report: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. NORC at the University of Chicago for the Office of the Assistant Secretary for Planning and Evaluation. This study analyzed information on large group health plan benefit designs from 2009 through 2011 in several databases maintained by benefits consulting firms that advise plans on compliance with MHPAEA as well as other requirements.

¹³ The 2010 Kaiser Family Foundation/HRET and the 2010 Mercer survey found that fewer than 2% of firms with over 50 employees dropped coverage of mental health or substance use disorder benefits. Final Report: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. NORC at the University of Chicago for the Office of the Assistant Secretary for Planning and Evaluation, pp. 43–44.

¹⁴ See section 1302(b)(1)(E) of the Affordable Care Act.

¹⁵ For self-insured group health plans, large group market health plans, and grandfathered health plans, to determine which benefits are EHB for purposes of complying with PHS Act section 2711, the Departments have stated that they will consider the plan to have used a permissible definition of EHB under section 1302(b) of the Affordable Care Act if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories). Furthermore, the Departments intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB. See FAQ–10 of Frequently Asked Questions on Essential Health Benefits Bulletin (published February 17, 2012), available at: <http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>.

¹⁶ See 26 CFR 54.9815–2713T; 29 CFR 2590.715–2713; 45 CFR 147.130.

medical/surgical benefits in the same classification.

The interim final regulations also contained an exception to the NQTL requirements allowing for variation “to the extent that recognized clinically appropriate standards of care may permit a difference.” A few commenters expressed support for the exception, emphasizing inherent differences in treatment for medical/surgical conditions and mental health conditions and substance use disorders. Many other commenters raised concerns that this exception could be subject to abuse and recommended the Departments set clear standards for what constitutes a “recognized clinically appropriate standard of care.” For example, commenters suggested a recognized clinically appropriate standard of care must reflect input from multiple stakeholders and experts; be accepted by multiple nationally recognized provider, consumer, or accrediting organizations; be based on independent scientific evidence; and not be developed solely by a plan or issuer. Additionally, since publication of the interim final regulations, some plans and issuers may have attempted to invoke the exception to justify applying an NQTL to all mental health or substance use disorder benefits in a classification, while only applying the NQTL to a limited number of medical/surgical benefits in the same classification. These plans and issuers generally argue that fundamental differences in treatment of mental health and substance use disorders and medical/surgical conditions, justify applying stricter NQTLs to mental health or substance use disorder benefits than to medical/surgical benefits under the exception in the interim final regulations.

In consideration of these comments, the Departments are removing the specific exception for “recognized clinically appropriate standards of care.”¹⁷ Plans and issuers will continue to have the flexibility contained in the NQTL requirements to take into account clinically appropriate standards of care when determining whether and to what extent medical management techniques and other NQTLs apply to medical/surgical benefits and mental health and

substance use disorder benefits, as long as the processes, strategies, evidentiary standards, and other factors used in applying an NQTL to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those with respect to medical/surgical benefits. In particular, the regulations do not require plans and issuers to use the same NQTLs for both mental health and substance use disorder benefits and medical/surgical benefits, but rather that the processes, strategies, evidentiary standards, and other factors used by the plan or issuer to determine whether and to what extent a benefit is subject to an NQTL are comparable to and applied no more stringently for mental health or substance use disorder benefits than for medical/surgical benefits. Disparate results alone do not mean that the NQTLs in use do not comply with these requirements. The final regulations provide examples of how health plans and issuers can comply with the NQTL requirements absent the exception for a recognized clinically appropriate standard of care.

However, MHPAEA specifically prohibits separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. Moreover, as reflected in FAQs¹⁸ released in November 2011, it is unlikely that a reasonable application of the NQTL requirement would result in all mental health or substance use disorder benefits being subject to an NQTL in the same classification in which less than all medical/surgical benefits are subject to the NQTL.

2. Parity Standards for NQTLs Versus Quantitative Treatment Limitations

As mentioned earlier in this preamble, MHPAEA and the interim final regulations prohibit plans and issuers from imposing a financial requirement or quantitative treatment limitation on mental health and substance use disorder benefits that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification. The interim final regulations incorporated the two-thirds “substantially all” numerical standard from the rules implementing the requirements of MHPA 1996, and quantified “predominant” to mean more than one-

half. Using these numerical standards, the Departments established a mathematical test by which plans and issuers could determine what level of a financial requirement or quantitative treatment limitation, if any, is the most restrictive level that could be imposed on mental health or substance use disorder benefits within a classification.

The Departments recognized that plans and issuers impose a variety of NQTLs affecting the scope or duration of benefits that are not expressed numerically. Some commenters recommended that the Departments adopt the same quantitative parity analysis for NQTLs. While NQTLs are subject to the parity requirements, the Departments understood that such limitations cannot be evaluated mathematically. These final regulations continue to provide different parity standards with respect to quantitative treatment limitations and NQTLs, because although both kinds of limitations operate to limit the scope or duration of mental health and substance use disorder benefits, they apply to such benefits differently.¹⁹

3. Clarification Regarding the Application of Certain NQTLs

Under the interim final regulations, the Departments set forth the parity requirement with respect to NQTLs and provided an illustrative list of NQTLs that plans and issuers commonly use. These NQTLs included: medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; formulary design for prescription drugs; standards for provider admission to participate in a network, including reimbursement rates; plan methods for determining usual, customary, and reasonable charges; refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and exclusions based on failure to complete a course of treatment. The interim final regulations also included examples illustrating the operation of the requirements for NQTLs.

After the interim final regulations were issued, some stakeholders asked questions regarding the application of

¹⁷ HHS convened a technical expert panel on March 3, 2011 to provide input on the use of NQTLs for mental health and substance use disorder benefits. The panel was comprised of individuals with clinical expertise in mental health and substance use disorder treatment as well as general medical treatment. These experts were unable to identify situations for which the clinically appropriate standard of care exception was warranted—in part because of the flexibility inherent in the NQTL standard itself.

¹⁸ See FAQs About Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation, question 5, available at: <http://www.dol.gov/ebsa/faqs/faq-aca7.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html.

¹⁹ The Departments reiterated the different parity standards with respect to quantitative treatment limitations and nonquantitative treatment limitations in an FAQ. See FAQs on Understanding Implementation of the Mental Health Parity and Addiction Equity Act of 2008, question 6, available at <http://www.dol.gov/ebsa/faqs/faq-mhpaeaimplementation.html>.

the NQTL rule to other features of medical management or general plan design not specifically addressed in the interim final regulations. Many commenters requested that the Departments address additional NQTLs, such as prior authorization and concurrent review, service coding, provider network criteria, policy coverage conditions, and both in- and out-of-network limitations.

These final regulations make clear that, while an illustrative list is included in these final regulations, all NQTLs imposed on mental health and substance use disorder benefits by plans and issuers subject to MHPAEA are required to be applied in accordance with these requirements. To the extent that a plan standard operates to limit the scope or duration of treatment with respect to mental health or substance use disorder benefits, the processes, strategies, evidentiary standards, or other factors used to apply the standard must be comparable to, and applied no more stringently than, those imposed with respect to medical/surgical benefits. By being comparable, the processes, strategies, evidentiary standards and other factors cannot be specifically designed to restrict access to mental health or substance use disorder benefits. Specifically, plan standards, such as in- and out-of-network geographic limitations, limitations on inpatient services for situations where the participant is a threat to self or others, exclusions for court-ordered and involuntary holds, experimental treatment limitations, service coding, exclusions for services provided by clinical social workers, and network adequacy, while not specifically enumerated in the illustrative list of NQTLs, must be applied in a manner that complies with these final regulations. In response to the comments received, in paragraph (c)(4)(ii) of these final regulations, the Departments added two additional examples of NQTLs to the illustrative list: network tier design and restrictions based on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage. Furthermore, the Departments included additional and revised examples on how NQTLs, enumerated in these final regulations or otherwise, may be applied in accordance with the requirements of these final regulations.

The Departments are aware that some commenters have asked how the NQTL requirements apply to provider reimbursement rates. Plans and issuers may consider a wide array of factors in

determining provider reimbursement rates for both medical/surgical services and mental health and substance use disorder services, such as service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience and licensure of providers. The NQTL provisions require that these or other factors be applied comparably to and no more stringently than those applied with respect to medical/surgical services. Again, disparate results alone do not mean that the NQTLs in use fail to comply with these requirements. The Departments may provide additional guidance if questions persist with respect to provider reimbursement rates.

Some commenters requested that the Departments require plans and issuers to comply with certain guidelines, independent national or international standards, or State government guidelines. While plans and issuers are not required under these final regulations to comply with any such guidelines or standards with respect to the development of their NQTLs, these standards, such as the behavioral health accreditation standards set forth by the National Committee for Quality Assurance or the standards for implementing parity in managed care set forth by URAC, may be used as references and best practices in implementing NQTLs, if they are applied in a manner that complies with these final regulations.

D. Scope of Services

In response to the RFI and interim final regulations, the Departments received many comments addressing an issue characterized as “scope of services” or “continuum of care.” Scope of services generally refers to the types of treatment and treatment settings that are covered by a group health plan or health insurance coverage. Some commenters requested that, with respect to a mental health condition or substance use disorder that is otherwise covered, the regulations clarify that a plan or issuer is not required to provide benefits for any particular treatment or treatment setting (such as counseling or non-hospital residential treatment) if benefits for the treatment or treatment setting are not provided for medical/surgical conditions. Other commenters requested that the regulations require plans and issuers to provide benefits for the full scope of medically appropriate services to treat a mental health condition or substance use disorder if the plan or issuer covers the full scope of medically appropriate services to treat medical/surgical conditions, even

if some treatments or treatment settings are not otherwise covered by the plan or coverage. Other commenters requested that MHPAEA be interpreted to require that group health plans and issuers provide benefits for any evidence-based treatment.

The interim final regulations established six broad classifications that in part define the scope of services under MHPAEA. The interim final regulations require that, if a plan or issuer provides coverage for mental health or substance use disorder benefits in any classification, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. The interim final regulations did not, however, address the scope of services that must be covered within those classifications. The Departments invited comments on whether and to what extent the final regulations should address the scope of services or continuum of care provided by a group health plan or health insurance coverage.

Many commenters requested that the Departments clarify how MHPAEA affects the scope of coverage for intermediate services (such as residential treatment, partial hospitalization, and intensive outpatient treatment) and how these services fit within the six classifications set forth by the interim final regulations. Some commenters suggested that the final regulations establish what intermediate mental health and substance use disorder services would be analogous to various intermediate medical/surgical services for purposes of the MHPAEA parity analysis. Other commenters suggested that the Departments not address scope of services in the final regulations.

The Departments did not intend that plans and issuers could exclude intermediate levels of care covered under the plan from MHPAEA’s parity requirements. At the same time, the Departments did not intend to impose a benefit mandate through the parity requirement that could require greater benefits for mental health conditions and substance use disorders than for medical/surgical conditions. In addition, the Departments’ approach defers to States to define the package of insurance benefits that must be provided in a State through EHB.²⁰

Although the interim final regulations did not define the scope of the six classifications of benefits, they directed that plans and issuers assign mental

²⁰ See 45 CFR 147.150 and 156.115 (78 FR 12834, February 25, 2013).

health and substance use disorder benefits and medical/surgical benefits to these classifications in a consistent manner. This general rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must assign covered intermediate mental health and substance use disorder benefits to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.

These final regulations also include additional examples illustrating the application of the NQTL rules to plan exclusions affecting the scope of services provided under the plan. The new examples clarify that plan or coverage restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services must comply with the NQTL parity standard under these final regulations.

E. Disclosure of Underlying Processes and Standards

MHPAEA requires that the criteria for plan medical necessity determinations with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request in accordance with regulations. MHPAEA also requires that the reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available on request or as otherwise required by the plan administrator (or health insurance issuer) to the participant or beneficiary in accordance with regulations.

Several commenters expressed concern about the lack of health plan transparency, or made

recommendations to improve transparency, including a request that plans and issuers be required to provide sufficient information to determine whether a plan is applying medical necessity criteria and other factors comparably to medical/surgical benefits and mental health and substance use disorder benefits. In addition, since the issuance of the interim final regulations, stakeholders have expressed concern that it is difficult to understand whether a plan complies with the NQTL provisions without information showing that the processes, strategies, evidentiary standards, and other factors used in applying an NQTL to mental health or substance use disorder benefits and medical/surgical benefits are comparable, impairing plan participants' means of ensuring compliance with MHPAEA.

In response to these concerns, the Departments published several FAQs clarifying the breadth of disclosure requirements applicable to group health plans and health insurance issuers under both MHPAEA and other applicable law, including ERISA and the Affordable Care Act.²¹ The substance of these FAQs is included in new paragraph (d)(3) of the final regulations, which reminds plans, issuers, and individuals that compliance with MHPAEA's disclosure requirements is not determinative of compliance with any other provision of applicable Federal or State law. In particular, in addition to MHPAEA's disclosure requirements, provisions of other applicable law require disclosure of information relevant to medical/surgical, mental health, and substance use disorder benefits. For example, ERISA section 104 and the Department of Labor's implementing regulations²² provide that, for plans subject to ERISA, instruments under which the plan is established or operated must generally be furnished by the plan administrator to plan participants²³ within 30 days of

²¹ See FAQs for Employees about the Mental Health Parity and Addiction Equity Act, available at <http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html>; FAQs about Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

²² 29 CFR 2520.104b 1.

²³ ERISA section 3(7) defines the term "participant" to include any employee or former employee who is or may become eligible to receive a benefit of any type from an employee benefit plan or whose beneficiaries may become eligible to receive any such benefit. Accordingly, employees who are not enrolled but are, for example, in a waiting period for coverage, or who are otherwise shopping amongst benefit package options at open season, generally are considered plan participants for this purpose.

request. Instruments under which the plan is established or operated include documents with 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 an NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

In addition, the Department of Labor's claims procedure regulations (applicable to ERISA plans), as well as the Departments' claims and appeals regulations under the Affordable Care Act (applicable to all non-grandfathered group health plans and health insurance issuers in the group and individual markets),²⁴ set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided by the plan or issuer, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits.²⁵ In addition, the plan or issuer must provide the claimant with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with a claim. If the plan or issuer is issuing an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. Such evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on

²⁴ 29 CFR 2560.503-1. See also 26 CFR 54.9815-2719T(b)(2)(i), 29 CFR 2590.715-2719(b)(2)(i), and 45 CFR 147.136(b)(2)(i), requiring non-grandfathered plans and issuers to incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503-1.

²⁵ See 29 CFR 2560.503-1. The Department of Labor's claim procedure regulation stipulates specific timeframes in which a plan administrator must notify a claimant of the plan's benefit determination, which includes, in the case of an adverse benefit determination, the reason for the denial. Accordingly, a plan administrator must notify a claimant of the plan's benefit determination with respect to a pre-service claim within a reasonable time period appropriate to the medical circumstances, but not later than 15 days after the receipt of the claim. With respect to post-service claims, a plan administrator must notify the claimant within a reasonable time period, but not later than 30 days after the receipt of the claim. In the case of an urgent care claim, a plan administrator must notify the claimant of the plan's benefit determination, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claimant's request.

review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.²⁶ The information required to be provided under these provisions includes documents of a comparable nature with 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 an NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

Even with these important disclosure requirements under existing law,²⁷ the Departments remain focused on transparency and whether individuals have the necessary information to compare NQTLs of medical/surgical benefits and mental health or substance use disorder benefits under the plan to effectively ensure compliance with MHPAEA. Accordingly, contemporaneous with the publication of these final regulations, the Departments of Labor and HHS are also publishing another set of MHPAEA FAQs, which, among other things, solicit comments on whether and how to ensure greater transparency and compliance.²⁸

F. Small Employer Exemption

Paragraph (f) of these final regulations implements the exemption for a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. Prior to the Affordable Care Act, MHPAEA defined a small employer, in connection with a group health plan with respect to a calendar year and a plan year, as an employer who employed an average of not more than 50 employees on business days during the preceding calendar year.

Section 2791 of the PHS Act was amended by the Affordable Care Act to

define a small employer as one that has 100 or fewer employees, while also providing States the option to use 50 employees rather than 100 for 2014 and 2015.²⁹ This definition is incorporated by reference in the MHPAEA provisions contained in section 2726 of the PHS Act. However, the MHPAEA provisions codified in ERISA section 712 and Code section 9812, together with section 732(a) of ERISA and section 8931(a) of the Code, continue to define an exempt small employer as one that has 50 or fewer employees. The Departments issued an FAQ³⁰ in December 2010 stating that, “for group health plans and health insurance issuers subject to ERISA and the Code, the Departments will continue to treat group health plans of employers with 50 or fewer employees as exempt from the MHPAEA requirements under the small employer exemption, regardless of any State insurance law definition of small employer.” The FAQ also acknowledged that, for non-Federal governmental plans, which are not subject to ERISA or the Code, the PHS Act was amended to define a small employer as one that has 100 or fewer employees. Consistent with the FAQs, the Department of Labor and the Department of the Treasury final regulations continue to exempt group health plans and group health insurance coverage of employers with 50 or fewer employees from MHPAEA. The HHS final regulations, which generally apply to non-Federal governmental plans, exempt group health plans and group health insurance coverage of employers with 100 or fewer employees (subject to State law flexibility for 2014 and 2015). Despite this difference, and certain other differences, in the applicability of the provisions of the Code, ERISA, and the PHS Act, the Departments do not find there to be a conflict in that no entity will be put in a position in which compliance with all of the provisions applicable to that entity is impossible.

At the same time, plans and issuers providing coverage in connection with group health plans sponsored by small employers should be aware that, on February 25, 2013, HHS published a final regulation on EHB³¹ that requires issuers of non-grandfathered plans in the individual and small group markets to ensure that such plans provide all EHB, including mental health and

substance use disorder benefits. The extent of the coverage of EHB is determined based on benchmark plans that are selected by the States. Furthermore, the EHB final regulation at 45 CFR 156.115(a)(3) requires issuers providing EHB to provide mental health and substance use disorder benefits in compliance with the requirements of the MHPAEA regulations, even where those requirements would not otherwise apply directly. Thus, all insured, non-grandfathered, small group plans must cover EHB in compliance with the MHPAEA regulations, regardless of MHPAEA’s small employer exemption. (Also, as discussed in section H.1. below, MHPAEA was amended to include individual health insurance coverage. Accordingly, both grandfathered and non-grandfathered coverage in the individual market must comply with MHPAEA.)

G. Increased Cost Exemption

MHPAEA contains an increased cost exemption that is available for plans and health insurance issuers that make changes to comply with the law and incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan or coverage or at least one percent in any subsequent plan or policy year. Under MHPAEA, plans or coverage that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan or policy year, and the exemption lasts for one plan or policy year. Thus, the increased cost exemption may only be claimed for alternating plan or policy years.³²

The interim final regulations reserved paragraph (g) regarding the increased cost exemption and solicited comments. The Departments issued guidance establishing an interim enforcement safe harbor under which a plan that has incurred an increased cost of two percent during its first year of compliance can obtain an exemption for the second plan year by following the exemption procedures described in the Departments’ 1997 regulations implementing MHPA 1996,³³ except that, as required under MHPAEA, for

²⁶ See 26 CFR 54.9815–2719T(b)(2)(ii)(C), 29 CFR 2590.715–2719(b)(2)(ii)(C), and 45 CFR 147.136(b)(2)(ii)(C).

²⁷ For other disclosure requirements that may be applicable to plans and issuers under existing Federal law, including disclosure requirements regarding prescription drug formulary coverage, see the summary plan description requirements for ERISA plans under 29 CFR 2520.102–3(j)(2) and (j)(3) and the preamble discussion at 65 FR 70226, 70237 (Nov. 11, 2000), as well as Department of Labor Advisory Opinion 96–14A (available at <http://www.dol.gov/ebsa/programs/ori/advisory/96/96-14a.htm>). See also the summary of benefits and coverage requirements under 26 CFR 54.9815–2715(a)(2)(i)(K), 29 CFR 2590.715–2715(a)(2)(i)(K), and 45 CFR 147.200(a)(2)(i)(K).

²⁸ Available at <http://www.dol.gov/ebsa/healthreform/> and <http://www.cms.gov/ccio/Resources/Fact-Sheets-and-FAQs/index.html>.

²⁹ See section 1304(b)(3) of the Affordable Care Act.

³⁰ See FAQs about Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation, question 8, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

³¹ 78 FR 12834.

³² An employer or issuer may elect to continue to provide mental health and substance use disorder benefits in compliance with this section with respect to the plan or coverage involved regardless of any increase in total costs. That is, mere eligibility for the exemption does not require an employer or issuer to use it. An exempt plan or coverage can continue to provide mental health and substance use disorder benefits during the exemption period in compliance with some, all, or none of the parity provisions.

³³ 62 FR 66932, December 22, 1997.

the first year of compliance the applicable percentage of increased cost is two percent and the exemption lasts only one year.³⁴

The Departments received several comments on the interim final regulations that requested guidance on attribution of cost increases to MHPAEA. Some commenters emphasized that the cost exemption must be based on actual total plan costs measured at the end of the plan year. Other commenters stated that plans should be permitted to estimate claims that have not yet been reported for purposes of calculating incurred expenditures. Additionally, some commenters stated that a plan's costs for purposes of the increased cost exemption should include not only claims costs, but also administrative expenses associated with complying with the parity requirements.

Paragraph (g) of these final regulations generally applies standards and procedures for claiming an increased cost exemption under MHPAEA consistent with MHPAEA's statutory standards and procedures as well as prior procedures set forth in the Departments' regulations implementing MHPA 1996. The test for an exemption must be based on the estimated increase in actual costs incurred by the plan or issuer that is directly attributable to expansion of coverage due to the requirements of this section and not otherwise due to occurring trends in utilization and prices, a random change in claims experience that is unlikely to persist, or seasonal variation commonly experienced in claims submission and payment patterns.

Under the final regulations, the increase in actual total costs attributable to MHPAEA is described by the formula $[(E_1 - E_0)/T_0] - D > k$, where E represents the level of health plan spending with respect to mental health and substance use disorder benefits over the measurement period, T is a measure of total actual costs incurred by a plan or coverage on all benefits (medical/surgical benefits and mental health and substance use disorder benefits under the plan), D is the average change in spending over the prior five years, and k is the applicable percentage of increased cost for qualifying for the cost exemption (i.e., one percent or two percent depending on the year). k will be expressed as a fraction for the purposes of this formula. The subscripts

1 and 0 refer to a base period and the most recent benefit period preceding the base period, respectively. Costs incurred under E include paid claims by the plan or coverage for services to treat mental health conditions and substance use disorders, and administrative costs associated with providing mental health or substance use disorder benefits (amortized over time).

In estimating the costs attributable to MHPAEA, a plan or issuer must rely on actual claims or encounter data incurred in the benefit period reported within 90 days of the end of the benefit period. Although MHPAEA specifies that determinations with regard to the cost exemption shall be made after a plan has complied with the law for six months of the plan year involved, the provision does not require that the benefit period used to make this calculation be limited to six months. Data from a six month period will not typically reflect seasonal variation in claims experience. To estimate $E_1 - E_0$, a plan or coverage must first calculate secular trends over five years in the volume of services and the prices paid for services for the major classifications of services by applying the formula $(E_1 - E_0)/T_0$ to mental health and substance use disorder spending to each of the five prior years and then calculating the average change in spending. The components of spending are estimated because secular trends can occur in prices and volume. After the average change in spending across the five years is calculated for each service type, the change in mental health and substance use disorder benefits spending attributable to MHPAEA is calculated net of the average annual spending growth that is due to a secular trend. This change in calculation is the main difference from the previous methodology used under prior guidance. It is recognized that for some smaller employers covered by MHPAEA, year to year spending may be somewhat unstable. In this case, an employer or issuer may propose an alternative estimation method. It is important to note that the language of the statute indicates that the base period against which the impact of MHPAEA is assessed moves up each year to the year prior to the current benefit year.

Administrative costs attributable to the implementation of MHPAEA must be reasonable and supported with detailed documentation from accounting records. Software and computing expenses associated with implementation of the prohibition on separate cumulative financial requirements or other provisions of the regulation should be based on a straight-

line depreciation over the estimated useful life of the asset (computer hardware five years; software three years, according to the American Hospital Association's Estimated Useful Life of depreciable Hospital Assets). Any other fixed administrative costs should also be amortized.

Some commenters suggested additional clarifications regarding the statutory provision that determinations as to increases in actual costs must be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. Some commenters suggested that the actuary must be qualified to perform such work based on meeting the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States. Other commenters suggested that the actuary must be independent and not employed by the group health plan or health insurance issuer claiming the exemption. The Departments believe the statutory language is sufficient to ensure reliable cost increase determinations. Moreover, this approach is consistent with the approach applicable to EHB in that the only qualification required for actuaries is that they be a member in good standing of the American Academy of Actuaries.³⁵ Accordingly, the Departments decline to adopt these suggestions. Determinations as to increases in actual costs attributable to implementation of the requirements of MHPAEA must be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations must be based on the formula specified in these final regulations in a written report prepared by the actuary. Additionally, the written report, along with all supporting documentation relied upon by the actuary, must be maintained by the group health plan or health insurance issuer for a period of six years.

Several commenters expressed concern regarding the administrative burden that would result from qualifying for the increased cost exemption for one year and then having to comply with the law the following year. MHPAEA's statutory language specifies that plans and issuers may qualify for the increased cost exemption for only one year at a time, stating that if the application of MHPAEA "results in an increase for the plan year involved of the actual total costs of coverage . . . by an amount that exceeds the applicable percentage . . . the

³⁴ See FAQs about Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation, question 11, available at: <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

³⁵ See 45 CFR 156.135(b).

provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year.”³⁶

Before a group health plan or health insurance issuer may claim the increased cost exemption, it must furnish a notice of the plan’s exemption from the parity requirements to participants and beneficiaries covered under the plan, the Departments (as described below), and appropriate State agencies. The notification requirements for the increased cost exemption under these final regulations are consistent with the requirements under the Departments’ 1997 regulations implementing MHPA 1996.

With respect to participants and beneficiaries, a group health plan subject to ERISA may satisfy this requirement by providing a summary of material reductions in covered services or benefits under 29 CFR 2520.104b–3(d), if it includes all the information required by these final regulations.

With respect to notification to the Departments, a plan or issuer must furnish a notice that satisfies the requirements of these final regulations. A group health plan that is a church plan (as defined in section 414(e) of the Code) must notify the Department of the Treasury. A group health plan subject to Part 7 of Subtitle B of Title I of ERISA must notify the Department of Labor. A group health plan that is a non-Federal governmental plan or a health insurance issuer must notify HHS. In all cases, the exemption is not effective until 30 days after notice has been sent to both participants and beneficiaries and to the appropriate Federal agency. The Departments will designate addresses for delivery of these notices in future guidance.

Finally, a plan or issuer must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. For purposes of this paragraph (g), an individual who is not a participant or beneficiary and who presents a notice described in paragraph (g)(6) of the final regulations is considered to be a representative. Such a representative may request the summary of information by providing the plan a copy of the notice provided to the participant or beneficiary with any personally identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of

claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with parity, and the administrative expenses attributable to complying with the parity requirements. In no event should a summary of information include individually identifiable information.

The increased cost exemption provision in paragraph (g) of these final regulations is effective for plan or policy years beginning on or after July 1, 2014 (see paragraph (i) of these final regulations), which for calendar year plans means the provisions apply on January 1, 2015. Accordingly, plans and issuers must use the formula specified in paragraph (g) of these final regulations to determine whether they qualify for the increased cost exemption in plan or policy years beginning on or after July 1, 2014. For claiming the increased cost exemption in plan or policy years beginning before July 1, 2014, plans and issuers should follow the interim enforcement safe harbor outlined in previously issued FAQs.³⁷

H. General Applicability Provisions and Application to Certain Types of Plans and Coverage

The interim final regulations combined in paragraph (e)(1) what had been separate rules under MHPA 1996 for (1) determining if a plan provides both medical/surgical and mental health or substance use disorder benefits; (2) applying the parity requirements on a benefit-package-by-benefit-package basis; and (3) counting the number of plans that an employer or employee organization maintains. The combined rule provides that (1) the parity requirements apply to a group health plan offering both medical/surgical benefits and mental health or substance use disorder benefits, (2) the parity requirements apply separately with respect to each combination of medical/surgical coverage and mental health or substance use disorder coverage that any participant (or beneficiary) can simultaneously receive from an employer’s or employee organization’s arrangement or arrangements to provide medical care benefits, and (3) all such combinations constitute a single group health plan for purposes of the parity requirements. Some comments expressed concern that the new combined rule would disrupt benefit programs that employers have

maintained as separate plans for important reasons having nothing to do with a desire to escape the parity requirements and that the rule should be rescinded or issued only in proposed form. Other comments welcomed the rule as an important protection to prevent evasion of the parity requirements. The final regulations do not change the combined rule from the interim final regulations. In the Departments’ view, the combined rule is necessary to prevent potential evasion of the parity requirements by allocating mental health or substance use disorder benefits to a plan or benefit package without medical/surgical benefits (when medical/surgical benefits are also otherwise available).

The preamble to the interim final regulations illustrated how the parity requirements would apply to various benefit package configurations, including multiple medical/surgical benefit packages combined with a single mental health and substance use disorder benefit package. One commenter asked for clarification in the case of a plan with an HMO option and a PPO option in which mental health and substance use disorder benefits are an integral part of each option. In such a case, the parity requirements apply separately to the HMO option and the PPO option.

The Departments are aware that employers and health insurance issuers sometimes contract with MBHOs or similar entities to provide or administer mental health or substance use disorder benefits in group health plans or in health insurance coverage. The fact that an employer or issuer contracts with one or more entities to provide or administer mental health or substance use disorder benefits does not, however, relieve the employer, issuer, or both of their obligations under MHPAEA. The coverage as a whole must still comply with the applicable provisions of MHPAEA, and the responsibility for compliance rests on the group health plan and/or the health insurance issuer, depending on whether the coverage is insured or self-insured. This means that the plan or issuer will need to provide sufficient information in terms of plan structure and benefits to the MBHO 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. Liability for any violation of MHPAEA rests with the group health plan and/or health insurance issuer.

Several commenters requested clarification about whether a plan or issuer may exclude coverage for specific

³⁶ Code section 9812(c)(2), ERISA 712(c)(2), PHS Act section 2726(c)(2).

³⁷ See FAQs about Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation, question 11, available at: <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

diagnoses or conditions under MHPAEA. These final regulations continue to provide that nothing in these regulations requires a plan or issuer to provide any mental health benefits or substance use disorder benefits. Moreover, the provision of benefits for one or more mental health conditions or substance use disorders does not require the provision of benefits for any other condition or disorder. Other Federal and State laws may prohibit the exclusion of particular disorders from coverage where applicable, such as the Americans with Disabilities Act. Other Federal and State laws may also require coverage of mental health or substance use disorder benefits, including the EHB requirements under section 2707 of the PHS Act and section 1302(a) of the Affordable Care Act.

1. Individual Health Insurance Market

Section 1563(c)(4) of the Affordable Care Act³⁸ amended section 2726 of the PHS Act to apply MHPAEA to health insurance issuers in the individual health insurance market. These changes are effective for policy years beginning on or after January 1, 2014. The HHS final regulation implements these requirements in new section 147.160 of title 45 of the Code of Federal Regulations. Under these provisions, unless otherwise specified, the parity requirements outlined in 45 CFR 146.136 of these final regulations apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner and to the same extent as such provisions apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the large group market. These provisions apply to both grandfathered and non-grandfathered individual health insurance coverage for policy years beginning on or after the applicability dates set forth in paragraph (i) of these final regulations.

2. Non-Federal Governmental Plans

Prior to enactment of the Affordable Care Act, sponsors of self-funded, non-Federal governmental plans were permitted to elect to exempt those plans from (“opt out of”) certain provisions of title XXVII of the PHS Act. This election was authorized under section 2721(b)(2) of the PHS Act (renumbered as section 2722(a)(2) by the Affordable Care Act). The Affordable Care Act made a number

of changes, with the result that sponsors of self-funded, non-Federal governmental plans can no longer opt out of as many requirements of title XXVII of the PHS Act. However, under the PHS Act, sponsors of self-funded, non-Federal governmental plans may continue to opt out of the requirements of MHPAEA.³⁹ If the sponsor of a self-funded, non-Federal governmental plan wishes to exempt its plan from the requirements of MHPAEA, it must follow the procedures and requirements outlined in section 2722 and corresponding Centers for Medicare & Medicaid Services (CMS) guidance, which includes notifying CMS to that effect in writing.⁴⁰

3. Retiree-Only Plans

Some commenters requested clarification regarding the applicability of these final regulations to retiree-only plans. ERISA section 732(a) generally provides that part 7 of ERISA—and Code section 9831(a) generally provides that chapter 100 of the Code—does not apply to group health plans with less than two participants who are current employees (including retiree-only plans that, by definition, cover less than two participants who are current employees).⁴¹ The Departments previously clarified in FAQs that the exceptions of ERISA section 732 and Code section 9831, including the exception for retiree-only health plans, remain in effect.⁴² Since the provisions of MHPAEA contained in ERISA section 712 and Code section 9812 are contained in part 7 of ERISA and chapter 100 of the Code, respectively, group health plans that do not cover at least two employees who are current employees (such as plans in which only retirees participate) are exempt from the

requirements of MHPAEA and these final regulations.⁴³

4. Employee Assistance Programs

Several comments also requested clarification regarding the applicability of the parity requirements to employee assistance programs (EAPs). An example in the interim final regulations clarified that a plan or issuer that limits eligibility for mental health and substance use disorder benefits until after benefits under an EAP are exhausted has established an NQTL subject to the parity requirements, and stated that if no comparable requirement applies to medical/surgical benefits, such a requirement could not be applied to mental health or substance use disorder benefits.⁴⁴ The final regulations retain this example and approach.⁴⁵

The Departments have also received questions regarding whether benefits under an EAP are considered to be excepted benefits. The Departments recently published guidance announcing their intentions to amend the excepted benefits regulations⁴⁶ to provide that benefits under an EAP are considered to be excepted benefits, but only if the program does not provide significant benefits in the nature of medical care or treatment.⁴⁷ Under this approach, EAPs that qualify as excepted benefits will not be subject to MHPAEA or these final regulations.

The guidance provides that until rulemaking regarding EAPs is finalized, through at least 2014, the Departments will consider an EAP to constitute excepted benefits only if the EAP does not provide significant benefits in the nature of medical care or treatment. For

³⁹ See Memo on Amendments to the HIPAA Opt-Out Provision Made by the Affordable Care Act (September 21, 2010). Available at: http://www.cms.gov/CCIIO/Resources/Files/Downloads/opt_out_memo.pdf.

⁴⁰ See Self-Funded Non-Federal Governmental Plans: Procedures and Requirements for HIPAA Exemption Election. Available at: http://www.cms.gov/CCIIO/Resources/Files/hipaa_exemption_election_instructions_04072011.html.

⁴¹ Prior to the enactment of the Affordable Care Act, the PHS Act had a parallel provision at section 2721(a); however, after the Affordable Care Act amended, reorganized, and renumbered title XXVII of the PHS Act, that exception no longer exists. See 75 FR 34538–34539.

⁴² See FAQs About the Affordable Care Act Implementation Part III, question 1, available at <http://www.dol.gov/ebsa/faqs/faq-aca3.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs3.html, which states that “statutory provisions in effect since 1997 exempting group health plans with ‘less than two participants who are current employees’ from HIPAA also exempt such plans from the group market reform requirements of the Affordable Care Act.”

⁴³ Additionally, as provided in the interim final regulations regarding grandfathered health plans, HHS does not intend to use its resources to enforce the requirements of title XXVII of the PHS Act, including the requirements of MHPAEA and these final regulations, with respect to non-Federal governmental retiree-only plans and encourages States not to apply those provisions to issuers of retiree-only plans. HHS will not cite a State for failing to substantially enforce the provisions of part A of title XXVII of the PHS Act in these situations. See 75 FR at 34538, 34540 (June 17, 2010).

⁴⁴ See Example 5 in paragraph (c)(4)(iii) of the interim final regulations.

⁴⁵ See Example 6 in paragraph (c)(4)(iii) of the final regulations.

⁴⁶ 26 CFR 54.9831–1(c), 29 CFR 2590.732(c), 45 CFR 146.145(c).

⁴⁷ See IRS Notice 2013–54 (available at <http://www.irs.gov/pub/irs-drop/n-13-54.pdf>) and DOL Technical Release 2013–03 (available at <http://www.dol.gov/ebsa/newsroom/tr13-03.html>), Q&A 9. See also CMS Insurance Standards Bulletin—Application of Affordable Care Act Provisions to Certain Healthcare Arrangements (available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cms-hra-notice-9-16-2013.pdf>).

³⁸ There are two sections numbered 1563 in the Affordable Care Act. The section 1563 that is the basis for this rulemaking is the section titled “Conforming amendments.”

this purpose, employers may use a reasonable, good faith interpretation of whether an EAP provides significant benefits in the nature of medical care or treatment.

5. Medicaid and CHIP Managed Care Plans

These final regulations apply to group health plans and health insurance issuers. These final regulations do not apply to Medicaid managed care organizations (MCOs), alternative benefit plans (ABPs), or the Children's Health Insurance Program (CHIP). However, MHPAEA requirements are incorporated by reference into statutory provisions that do apply to those entities. On January 16, 2013, CMS released a State Health Official Letter regarding the application of the MHPAEA requirements to Medicaid MCOs, ABPs, and CHIP.⁴⁸ In this guidance, CMS adopted the basic framework of MHPAEA and applied the statutory principles as appropriate across these Medicaid and CHIP authorities. The letter also stated that CMS intends to issue additional guidance that will assist States in their efforts to implement the MHPAEA requirements in their Medicaid programs.

I. Interaction With State Insurance Laws

Several commenters requested that the final regulations clearly describe how MHPAEA interacts with State insurance laws. Commenters sought clarification as to how MHPAEA may or may not preempt State laws that require parity for mental health or substance use disorder benefits, mandate coverage of mental health or substance use disorder benefits, or require a minimum level of coverage (such as a minimum dollar, day, or visit level) for mental health conditions or substance use disorders. These commenters expressed a desire that the final regulations articulate that existing State laws on mental health or substance use disorder benefits would remain in effect to the extent they did not prevent the application of MHPAEA.

The preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implemented in 29 CFR 2590.731 and 45 CFR 146.143(a)) apply so that the MHPAEA requirements are not to be "construed to supersede any provision of State law

which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of MHPAEA and other applicable provisions.⁴⁹ The HIPAA conference report indicates that this is intended to be the "narrowest" preemption of State laws.⁵⁰

For example, a State law may mandate that an issuer offer coverage for a particular condition or require that an issuer offer a minimum dollar amount of mental health or substance use disorder benefits. (While MHPAEA does not require plans or issuers to offer any mental health benefits, once benefits are offered, for whatever reason (except as previously described related to PHS Act section 2713), MHPAEA applies to the benefits.) These State law provisions do not prevent the application of MHPAEA, and therefore would not be preempted. To the extent the State law mandates that an issuer provide some coverage for any mental health condition or substance use disorder, benefits for that condition or disorder must be provided in parity with medical/surgical benefits under MHPAEA. This means that an issuer subject to MHPAEA may be required to provide mental health or substance use disorder benefits beyond the State law minimum in order to comply with MHPAEA.

J. Enforcement

Comments received in response to the interim final regulations suggested some confusion and concern regarding the Departments' authority to impose penalties and ensure compliance with the requirements under MHPAEA. The enforcement responsibilities of the Federal government and the States with respect to health insurance issuers are set forth in the PHS Act. Pursuant to PHS Act section 2723(a), States have primary enforcement authority over health insurance issuers regarding the provisions of part A of title XXVII of the PHS Act, including MHPAEA. HHS (through CMS) has enforcement authority over the issuers in a State if the State notifies CMS that it has not enacted legislation to enforce or is otherwise not enforcing, or if CMS determines that the State is not substantially enforcing, a provision (or

provisions) of part A of title XXVII of the PHS Act. Currently, CMS believes that most States have the authority to enforce MHPAEA and are acting in the areas of their responsibility. In States that lack the authority to enforce MHPAEA, CMS is either directly enforcing MHPAEA or collaborating with State departments of insurance to ensure enforcement.

The Departments of Labor and the Treasury generally have primary enforcement authority over private sector employment-based group health plans, while HHS has primary enforcement authority over non-Federal governmental plans, such as those sponsored by State and local government employers.

Some commenters suggested that States need a stronger understanding of MHPAEA and its implementing regulations to better inform the public about the protections of the law and to ensure proper compliance by issuers. These commenters believed that States would benefit from additional and continued guidance from CMS regarding the requirements of MHPAEA and its impact upon State law. The Departments encourage State regulators to familiarize themselves with the MHPAEA requirements, in particular the rules governing NQTLs, and any guidance issued by the Departments, so that the States can instruct issuers in their jurisdictions on the correct implementation of the statute and regulations, and appropriately enforce the provisions. The Departments will continue to provide technical assistance to State regulators either individually or through the National Association of Insurance Commissioners to ensure that the States have the tools they need to implement and enforce MHPAEA.

K. Applicability Dates

MHPAEA's statutory provisions were self-implementing and generally became effective for plan years beginning after October 3, 2009.⁵¹ The requirements of the interim final regulations generally became effective on the first day of the first plan year beginning on or after July

⁵¹ There is a special effective date for group health plans maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, which states that the requirements of the interim final regulations do not apply to the plan (or health insurance coverage offered in connection with the plan) for plan years beginning before the later of either the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008), or July 1, 2010. MHPAEA also provides that any plan amendment made pursuant to a collective bargaining agreement solely to conform to the requirements of MHPAEA will not be treated as a termination of the agreement.

⁴⁸ Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans, available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.

⁴⁹ The preemption provision of PHS Act section 2724 also applies to individual health insurance coverage.

⁵⁰ See House Conf. Rep. No. 104-736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2008.

1, 2010. These final regulations apply to group health plans and health insurance issuers offering group health insurance coverage on the first day of the first plan year beginning on or after July 1, 2014. Examples, cross-references, and other clarifications have been added in some places to facilitate compliance and address common questions, much of which has already been published by the Departments.⁵² Each plan or issuer subject to the interim final regulations must continue to comply with the applicable provisions of the interim final regulations until the corresponding provisions of these final regulations become applicable to that plan or issuer.

L. Technical Amendment Relating to OPM Multi-State Plan Program and External Review

This document also contains a technical amendment relating to external review with respect to the Multi-State Plan Program (MSPP) administered by the Office of Personnel Management (OPM). Section 2719 of the PHS Act and its implementing regulations provide that group health plans and health insurance issuers must comply with either a State external review process or the Federal external review process. Generally, if a State has an external review process that meets, at a minimum, the consumer protections set forth in the interim final regulations on internal claims and appeals and external review,⁵³ then an issuer (or a plan) subject to the State process must comply with the State process.⁵⁴ For

⁵² For additional examples and other clarifications published by the Departments to facilitate compliance under the interim final rules, see also <http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>; FAQs about Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation, available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html; FAQs about Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation, available at <http://www.dol.gov/ebsa/faqs/faq-aca7.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html; FAQs on Understanding Implementation of the Mental Health Parity and Addiction Equity Act of 2008, available at <http://www.dol.gov/ebsa/faqs/faq-mhpaeaimplementation.html>; and FAQs for Employees about the Mental Health Parity and Addiction Equity Act, available at <http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html>.

⁵³ The interim final regulations relating to internal claims and appeals and external review processes are codified at 26 CFR 54.9815–2719T, 29 CFR 2590.715–2719, and 45 CFR 147.136. These requirements do not apply to grandfathered health plans. The interim final regulations relating to status as a grandfathered health plan are codified at 26 CFR 54.9815–1251T, 29 CFR 2590.715–1251, and 45 CFR 147.140.

⁵⁴ More information on the regulatory requirements for State external review processes, including the regulations, Uniform Health Carrier

plans and issuers not subject to an existing State external review process (including self-insured plans), a Federal external review process applies.⁵⁵ The statute requires the Departments to establish standards, “through guidance,” governing a Federal external review process. Through guidance issued by the Departments, HHS has established a Federal external review process for self-insured non-Federal governmental health plans, as well as for plans and issuers in States that do not have an external review process that meets the minimum consumer protections in the regulations.

In proposed regulations published on March 21, 2013 (78 FR 17313), the Departments proposed to amend the interim final regulations implementing PHS Act section 2719 to specify that MSPs will be subject to the Federal external review process under PHS Act section 2719(b)(2) and paragraph (d) of the internal claims and appeals and external review regulations. This proposal reflects the Departments’ interpretation of section 2719(b)(2) as applicable to all plans not subject to a State’s external review process. OPM has interpreted section 1334(a)(4) of the Affordable Care Act to require OPM to maintain authority over external review because Congress directed that OPM implement the MSPP in a manner similar to the manner in which it implements the contracting provisions of the FEHBP, and in the FEHBP, OPM resolves all external appeals on a nationwide basis as a part of its contract administration responsibilities.⁵⁶ This assures consistency in benefit administration for those OPM plans that are offered on a nationwide basis. Accordingly, under OPM’s interpretation, it would be inconsistent with section 1334(a)(4) of the Affordable Care Act for MSPs and MSPP issuers to follow State-specific external review processes under section 2719(b)(1) of the PHS Act. OPM’s final rule on the establishment of the multi-State plan program nonetheless does require the MSPP external review process to meet the requirements of PHS Act section

External Review Model Act promulgated by the National Association of Insurance Commissioners, technical releases, and other guidance, is available at <http://www.dol.gov/ebsa> and <http://cciio.cms.gov>.

⁵⁵ More information on the regulatory requirements for the Federal external review process, including the regulations, technical releases, and other guidance, is available at <http://www.dol.gov/ebsa> and <http://cciio.cms.gov>.

⁵⁶ See the OPM proposed rule on establishment of the MSPP, 77 FR 72582, 72585 (Dec. 5, 2012); see also the final rule, 78 FR 15559, 15574 (Mar. 11, 2013) (“we believe our approach to external review is required by section 1334 of the Affordable Care Act[.]”).

2719 and its implementing regulations.⁵⁷

The Departments also proposed to amend the interim final regulations implementing PHS Act section 2719 to specify that the scope of the Federal external review process, as described in paragraph (d)(1)(ii), is the minimum required scope of claims eligible for external review for plans using a Federal external review process, and that Federal external review processes developed in accordance with paragraph (d) may have a scope that exceeds the minimum requirements.

The Departments did not receive any comments relating to these proposed amendments and therefore retain the amendments in this final rule without change, except for one minor correction.⁵⁸ The Departments made a typographical error in the March 21, 2013 proposed rule, inadvertently omitting the word “internal” from paragraph (d)(1)(i). That provision should have stated that the Federal external review process “applies, at a minimum, to any adverse benefit determination or final *internal* adverse benefit determination. . . .” (emphasis added). The Departments did not intend to remove the word “internal” from the interim final rule through the proposed amendment, and we are correcting the final amendment to include the word.

III. Economic Impact and Paperwork Burden

Executive Orders 12866 (Regulatory Planning and Review, September 30, 1993) and 13563 (Improving Regulation and Regulatory Review, February 2, 2011) direct agencies to propose or adopt a regulation only upon a reasoned determination that its benefits justify its costs, to assess the costs and benefits of regulatory alternatives, and to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity).

Agencies must determine whether a regulatory action is “significant” which is defined in Executive Order 12866 as an action that is likely to result in a rule (1) having an annual effect on the

⁵⁷ See 45 CFR 800.115(k) and 45 CFR part 800; see also 78 FR at 15574 (“the level playing field provisions of section 1324 of the Affordable Care Act would not be triggered because MSPs and MSPP issuers would comply with the external review requirements in section 2719(b) of the PHS Act, just as other health insurance issuers in the group and individual markets are required to do.”).

⁵⁸ Treasury is not adopting amendments to the external review regulations in 26 CFR at this time. Any changes to the Treasury external review regulations will be made when the entire section of those regulations is adopted as final regulations.

economy of \$100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A. Summary—Department of Labor and Department of Health and Human Services

The Departments have determined that this regulatory action is economically significant within the meaning of section 3(f)(1) of the Executive Order, because it is likely to have an effect on the economy of \$100 million or more in at least one year. Accordingly, the Departments provide the following assessment of the potential costs and benefits of these final regulations. As elaborated below, the Departments believe that the benefits of the rule justify its costs.

As described earlier in this preamble, these final regulations expand on the protections and parity requirements set forth in the interim final regulations, incorporate clarifications issued by the Departments through sub-regulatory guidance since the issuance of the interim final regulations, and provide clarifications related to NQTLs and disclosure requirements. These final regulations also include additional clarifications and examples illustrating the parity requirements and their applicability, as well as provisions to implement the increased cost exemption with respect to financial requirements and treatment limitations. The HHS final regulation also implements the parity requirements for individual health insurance coverage.

A recent study on plan responses to MHPAEA indicates that by 2011, most plans had removed most financial requirements and treatment limitations that did not meet the requirements of MHPAEA and the interim final regulations.⁵⁹ The use of higher copays

and coinsurance for inpatient mental health and substance use disorder services declined rapidly in large employer plans following implementation of MHPAEA.⁶⁰ In addition, nearly all plans had eliminated the use of separate deductibles for mental health or substance use disorder out-of-pocket costs by 2011.⁶¹ (Even by 2010, only 3.2 percent of plans had used separate deductibles.) The HHS study also found that the number of plans that applied unequal inpatient day limits, outpatient visit limits or other quantitative treatment limitations for mental health or substance use disorder benefits had dropped significantly by 2011.

Since this study found that the implementation of the requirements of MHPAEA has progressed consistent with the interim final rules, this impact analysis includes estimates of any additional costs and benefits resulting from changes made to the provisions in the interim final regulations by these final regulations. As background, in section III.D of this preamble, the Departments summarize the cost estimates included in the interim final regulations.

B. Need for Regulatory Action

Congress directed the Departments to issue regulations implementing the MHPAEA provisions. In response to this Congressional directive, these final regulations clarify and interpret the MHPAEA provisions under section 712 of ERISA, section 2726 of the PHS Act, and section 9812 of the Code. Historically, plans have offered coverage for mental health conditions and substance use disorders at lower levels than coverage for other conditions. Plans limited coverage through restrictive benefit designs that discouraged enrollment by individuals perceived to be high-cost due to their behavioral health conditions and by imposing special limits on mental health and substance use disorder benefits out of concern that otherwise utilization and costs would be unsustainable. Parity advocates argued that these approaches were unfair and limited access to needed treatment for vulnerable populations. In addition, research demonstrated that restrictive benefit designs were not the only way

to address costs.⁶² Initially, MHPA 1996 was designed to eliminate more restrictive annual and lifetime dollar limits on mental health benefits. However, as illustrated in a General Accountability Office report on implementation of MHPA 1996, the statute had an unintended consequence: most plans coming into compliance instead turned to more restrictive financial requirements and treatment limitations.⁶³

These final regulations provide the specificity and clarity needed to effectively implement the provisions of MHPAEA and prevent the use of prohibited limits on coverage, including nonquantitative treatment limitations that disproportionately limit coverage of treatment for mental health conditions or substance use disorders. The requirements in these final regulations are needed to address questions and concerns that have been raised regarding the implications of the interim final regulations with regard to intermediate level services, NQTLs, and the increasing use of multi-tiered provider networks. The Departments’ assessment of the expected economic effects of these regulations is discussed in detail below.

C. Response to Comments on the Economic Impact Analysis for the Interim Final Regulations—Department of Labor and Department of Health and Human Services

The Departments received the following public comments regarding the economic impact analysis in the interim final regulations.

One commenter urged that the discussion on cost implications for increased utilization of mental health and substance use disorder services must take into account the cost savings that will result from the elimination of the costs associated with “unique and discriminatory medical management controls” (or NQTLs). Although the Departments concur that the nature and rigor of utilization management affects

⁶² See discussion in the preamble to the interim final rule on the effect of managed care in controlling health plan spending on mental health and substance use disorder treatment under state parity laws and in the Federal Employee Health Benefit Program, Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410, 5424–5425 (see e.g., footnote 46) (February 2, 2010).

⁶³ General Accountability Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, May 2000, (GAO/HEHS-00-95), p. 5. In this report, GAO found that 87 percent of compliant plans contained at least one more restrictive provision for mental health benefits with the most prevalent being limits on the number of outpatient office visits and hospital day limits.

⁵⁹ Final Report: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. NORC at the University of Chicago for the Office of the Assistant Secretary for Planning and Evaluation.

This study analyzed information on large group health plan benefit designs from 2009 through 2011 in several databases maintained by benefits consulting firms that advise plans on compliance with MHPAEA as well as other requirements.

⁶⁰ Ibid.

⁶¹ Ibid.

the cost of care and the administrative expenses associated with care management, there is scant evidence at this time on the way that utilization management will evolve under MHPAEA. Existing evidence suggests that plans and issuers can apply a range of tools to manage care and that even when management of care is consistent with the principles of parity, care management continues. (See the discussion of Oregon state parity law later in this preamble).

Several commenters asserted that the Departments had underestimated the cost and burden of complying with the interim final regulations. However, a study sponsored by HHS found that by 2011 most plans had removed most financial requirements that did not meet the requirements of MHPAEA and the interim final regulations.⁶⁴ In addition, the number of plans that applied unequal inpatient day limits, outpatient visit limits, or other quantitative treatment limitations for mental health or substance use disorder benefits had dropped significantly by 2011. Yet, there is no evidence that plans' costs and burdens have been significantly impacted by the requirements of the statute and its implementing interim final regulations. Research has shown that only a very small percentage of plans have dropped mental health or substance use disorder benefits after implementation of MHPAEA and even for those plans that did so, there is no clear evidence that they dropped mental health or substance use disorder benefits because of MHPAEA. Moreover, no plans have applied for the increased cost exemption under MHPAEA. Finally, in spending reports that have been reported in the aggregate, there is no evidence that spending growth for behavioral health saw a significant upturn in 2011, the first full year in which the interim final regulations generally were in effect.

One commenter asserted that plans are not set up to conduct a parity analysis within the six classifications and as a result the interim final regulations impose a substantial burden, especially on employers that offer multiple plans. In response, the Departments note that the alternative to using the six classifications would

require conducting a parity analysis across all types of benefits grouped together that would have resulted in incongruous and unintended consequences with, for example, day limits for inpatient care being the standard for outpatient benefits. Moreover, there is no evidence that plans or issuers have found these requirements to be overly burdensome.

One commenter stated that the Federal Employees' Health Benefits Program (FEHBP) parity requirements and State parity laws are not comparable to the standards in the interim final regulations and therefore are not predictive of the possible cost impacts of the interim final regulations, especially regarding NQTLs. In response, the Departments note that, like MHPAEA, the parity requirements for FEHBP apply to financial requirements and treatment limitations for both mental health conditions and substance use disorders. Furthermore, the FEHBP requirements are more expansive in that "plans must cover all categories of mental health or substance use disorders to the extent that the services are included in authorized treatment plans . . . developed in accordance with evidence-based clinical guidelines, and meet[ing] medical necessity criteria."⁶⁵ Under the MHPAEA statute, plans and issuers have discretion as to which diagnoses and conditions are covered under the plan.

Several State parity laws are very similar to MHPAEA. For example, Vermont's parity law applies to both mental health and substance use disorder benefits.⁶⁶ The Vermont parity law also requires that management of care for these conditions be in accordance with rules adopted by the State Department of Insurance to assure that timely and appropriate access to care is available; that the quantity, location and specialty distribution of health care providers is adequate and that administrative or clinical protocols do not serve to reduce access to medically necessary treatment.⁶⁷ These requirements are very similar to the NQTL requirements under MHPAEA which likewise seek to ensure plans and issuers do not inequitably limit access to mental health or substance use disorder treatment. In addition, the NQTLs requirements likewise require comparable approaches to utilization management through protocols and other strategies in determining coverage

of mental health and substance use disorder treatment compared to medical/surgical treatment. A study of this State parity law also did not find significant increases in cost.⁶⁸

The Oregon State parity law is also very similar to MHPAEA in that it applies to mental health and substance use disorder financial requirements and treatment limitations and also applies to NQTLs. According to the Oregon Insurance Division, utilization management tools such as "selectively contracted panels of providers, health policy benefit differential designs, preadmission screening, prior authorization, case management, utilization review, or other mechanisms designed to limit eligible expenses to treatment that is medically necessary" may not be used for management of mental health or substance use disorder benefits unless they were used in the same manner that such methods were used for other medical conditions.⁶⁹ A study of the Oregon parity law found that plans removed coverage limits as required and used management techniques to the same degree or less under this law and the impact on mental health and substance use disorder spending was minimal.⁷⁰ Together, the similarities between the FEHBP, Vermont, and Oregon parity requirements lead the Departments to conclude that any differences in terms of the impacts on cost would be small.

Several commenters argued that the requirement in the interim final regulations to use a single or shared deductible in a classification is overly burdensome and would require significant resources to implement, particularly by MBHOs since they often work with multiple plans. One commenter asserted that this requirement could impact the willingness of sponsors to offer mental health or substance use disorder benefits. In response, the Departments note that a study sponsored by HHS found that nearly all plans had eliminated the use of separate deductibles for mental health and substance use disorder benefits by

⁶⁴ Final Report: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. NORC at the University of Chicago for the Office of the Assistant Secretary for Planning and Evaluation. This study analyzed information on large group health plan benefit designs from 2009 through 2011 in several databases maintained by benefits consulting firms that advise plans on compliance with MHPAEA as well as other requirements.

⁶⁵ FEHB Program Carrier Letter, No. 2009-08, April 20, 2009.

⁶⁶ Vt. Stat. Ann. tit. 8, § 4089b (1998).

⁶⁷ Ibid.

⁶⁸ Rosenbach M, Lake T, Young C, et al. Effects of the Vermont Mental Health and Substance Abuse Parity Law. DHHS Pub. No. SMA 03-3822, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2003.

⁶⁹ Q&A Oregon Mental Health Parity Law for Providers. Oregon Insurance Division Web site. http://www.cbs.state.or.us/ins/FAQs/mental-health-parity_provider-faqs.pdf.

⁷⁰ McConnell JK, Gast SH, Ridgely SM. Behavioral health insurance parity: Does Oregon's experience presage the national experience with the Mental Health Parity and Addiction Equity Act? *American Journal of Psychiatry* 2012; 169(1): 31-38.

2011.⁷¹ According to this study, even in 2010, only a very small percentage of plans were using separate deductibles. This study and other research have shown that only a very small percent of plans have dropped mental health or substance use disorder benefits after implementation of MHPAEA and there is no clear evidence they did so because of MHPAEA.

One commenter urged that the regulations be revised to be less burdensome for plans that are part of a more comprehensive network of benefits within Medicaid healthcare delivery systems. These final regulations apply to group health plans and health insurance issuers but do not, by their own terms, apply to Medicaid. In response, the Departments note that CMS oversees implementation of federal requirements for the Medicaid program. CMS issued a state health official letter on the application of MHPAEA to Medicaid managed care organizations, the Children's Health Insurance Program, and Alternative Benefit (Benchmark) plans on January 16, 2013.⁷²

Two commenters raised concerns about the burden imposed on plans by the requirement that provider reimbursement rates be based on comparable criteria particularly for MBHOs that may as a result have to use multiple rate schedules. The Departments believe that the process of establishing rate schedules is already complex, that MBHOs that contract with other multiple plans are likely to already have multiple rate schedules, and that adding a parity requirement to ensure that rates for behavioral health providers are based on comparable criteria to those used for medical/surgical providers does not add much to this complexity.

One commenter argued that the costs for outpatient mental health and

substance use disorder benefits will be higher than estimated because the NQTL parity standard would hamper plans' ability to manage care and control costs. In response, the Departments note that, as discussed above, the Oregon State parity law also applies to NQTLs and a study of this law found that plans in that State removed coverage limits as required and used management techniques to the same degree or less under the Oregon law and the impact on mental health and substance use disorder spending was minimal.⁷³

D. Summary of the Regulatory Impact Analysis for the Interim Final Regulations—Department of Labor and Department of Health and Human Services

In the regulatory impact analysis for the interim final regulations, the Departments quantified the costs associated with three aspects of that rulemaking: The cost of implementing a unified deductible, compliance review costs, and costs associated with information disclosure requirements in MHPAEA. The Departments estimated the cost of developing the interface necessary to implement a single deductible as \$35,000 per affected interface between a managed behavioral health company and a group health plan with a total estimated cost at \$39.2 million (amounting to \$0.60 per health plan enrollee) in the first year. The interim final regulations' impact analysis estimated the cost to health plans and insurance issuers of reviewing coverage for compliance with MHPAEA and the interim final regulations at \$27.8 million total. This estimate was based on findings that there were about 460 issuers and at least 120 MBHOs and assumed that per-plan compliance costs would be low because third party administrators for self-insured plans would spread the cost across multiple client plans.

Regarding the requirement to disclose medical necessity criteria, the Departments assumed that each plan would receive one such request on

average, that it would take a trained staff person about five minutes to respond, and with an average hourly rate of \$27, the total annual cost would be about \$1 million. The Departments assumed only 38 percent of requests would be delivered electronically with de minimis cost and that the materials, printing and postage costs of responding to about 290,000 requests by paper would be an additional \$192,000 for a total of about \$1.2 million per year. These costs totaled \$114.6 million undiscounted over ten years (2010–2019). The Departments did not include a cost for the requirement in MHPAEA to disclose the reasons for any claims denials because the Department of Labor's claims procedure regulation (at 29 CFR 2560.503–1) already required such disclosures and the same third-party administrators and insurers are hired by ERISA and non-ERISA covered plans so both types of plans were likely to already be in compliance with these rules.

In terms of transfers, in the interim final regulations impact analysis, the Departments estimated premiums would rise 0.4 percent due to MHPAEA, reflecting a transfer from individuals not using mental health and substance use disorder benefits to those that do. This estimated increase in premiums amounted to a transfer of \$2.36 billion in 2010 gradually increasing each year over a ten year period to \$2.81 billion in 2019. This estimate was based on findings in the literature. For a more complete discussion, see section III.I later in this preamble.

E. Summary of the Impacts of the Final Rule—Department of Labor and Department of Health and Human Services

Table 1, below, summarizes the costs associated with the final regulations above the costs estimated for the interim final regulations. Over a five-year period of 2014 to 2018, the total undiscounted cost of the rule is estimated to be \$1.16 billion in 2012 dollars. Columns D and E display the costs discounted at 3 percent and 7 percent, respectively. Column F shows a transfer of \$3.5 billion over the five-year period. All other numbers included in the text are not discounted, except where noted.

⁷¹ Final Report: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. NORC at the University of Chicago for the Office of the Assistant Secretary for Planning and Evaluation.

⁷² Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans, available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.

⁷³ McConnell JK, Gast SH, Ridgely SM. Behavioral health insurance parity: does Oregon's experience presage the national experience with the Mental Health Parity and Addiction Equity Act? *American Journal of Psychiatry* 2012; 169(1): 31–38.

TABLE 1—TOTAL COSTS OF FINAL REGULATIONS
[In millions of 2012 dollars]

Year	Incremental change in individual market plan spending (A)	Disclosure requirements (B)	Total undiscounted costs A+B	Total 3% discounted costs (D)	Total 7% discounted costs (E)	Transfers (undiscounted) (F)
2014	\$189.9	\$4.3	\$194.2	\$194.2	\$194.2	\$699.2
2015	208.4	4.3	212.7	206.5	198.8	732.0
2016	226.8	4.3	231.1	217.9	201.9	764.8
2017	245.3	4.3	249.6	228.4	203.7	797.6
2018	263.8	4.3	268.1	238.2	204.5	830.4
Total	1,134.2	21.5	1,155.6	1085.1	1,003.1	3,824.0

1. Estimated Number of Affected Entities

MHPAEA has already brought about coverage changes for approximately 103 million participants in 420,700 ERISA-covered employment-based group health plans with more than 50 participants, and an estimated 29.5 million participants in the approximately 23,000 public, non-Federal employer group health plans with more than 50 participants sponsored by State and local governments. Plans with 50 or fewer participants were previously exempt from MHPAEA.⁷⁴ In addition, approximately 510 health insurance issuers providing mental health or substance use disorder benefits in the group and individual health insurance markets and at least 120 MBHOs providing mental health or substance use disorder benefits to group health plans are also affected by these final regulations.⁷⁵

As discussed earlier, the Affordable Care Act extended MHPAEA to apply to a health insurance issuer offering individual health insurance coverage and the HHS final regulation regarding EHB requires QHPs and non-grandfathered health insurance plans in the individual and small group markets

⁷⁴ The Departments' estimates of the numbers of affected participants are based on DOL estimates using the 2012 CPS, ERISA plan counts are based on DOL estimates using the 2011 MEP-IC and Census Bureau statistics. The number of State and local government employer-sponsored plans was estimated using 2012 Census data and DOL estimates. Please note that the estimates are based on survey data that is not broken down by the employer size covered by MHPAEA making it difficult to exclude from estimates those participants employed by employers who employed an average of at least 2 but no more than 50 employees on the first day of the plan year.

⁷⁵ The Departments' estimate of the number of insurers is based on medical loss ratio reports submitted by issuers for 2012 reporting year and industry trade association membership. Please note that these estimates could undercount small State-regulated insurers.

to provide covered mental health and substance use disorder services in a manner that complies with the parity requirements of the MHPAEA implementing regulations in order to satisfy the requirement to cover EHB. According to the 2012 Medical Loss Ratio filings, about 11 million people are covered in the individual market; another 7 million are expected to gain coverage in 2014 under the Affordable Care Act.⁷⁶ There are an estimated 12.3 million participants in about 837,000 non-grandfathered ERISA-covered employment-based group plans with 50 or fewer participants, and an estimated 800,000 participants in approximately 59,000 non-grandfathered public, non-Federal employer group health plans with 50 or fewer participants sponsored by State and local governments which were previously exempt from MHPAEA.

About one-third of those who are currently covered in the individual market have no coverage for substance use disorder services and nearly 20 percent have no coverage for mental health services, including outpatient therapy visits and inpatient crisis intervention and stabilization.⁷⁷ In addition, even when individual market plans provide these benefits, the federal parity law previously did not apply to these plans to ensure that coverage for mental health and substance use disorder services is generally comparable to coverage for medical and surgical care.

In the small group market, coverage of mental health and substance use disorder treatment is more common than in the individual market. We estimate that about 95 percent of those

⁷⁶ "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline," Congressional Budget Office, May 14, 2013.

⁷⁷ ASPE Issue Brief, "Essential Health Benefits: Individual Market Coverage," ed. U.S. Department of Health & Human Services (2011).

with small group market coverage have substance abuse and mental health benefits.⁷⁸ Again, the federal parity law previously did not apply to small group plans. In many States, State parity laws offer those covered in this market some parity protection, but most State parity laws are narrower than the federal parity requirement.

2. Anticipated Benefits

a. Benefits Attributable to the Statute or Interim Final Regulations

In enacting MHPAEA, one of Congress' primary objectives was to improve access to mental health and substance use disorder benefits by eliminating more restrictive visit limits and inpatient days covered as well as higher cost-sharing for mental health and substance use disorder benefits that were prevalent in private insurance plans after implementation of MHPA 1996.⁷⁹

A recent study funded by HHS found that large group health plans and insurance issuers have made significant changes to financial requirements and treatment limitations for mental health and substance use disorder benefits in the first few years following enactment of MHPAEA.⁸⁰ The statute went into effect for plan years beginning after October 3, 2009 (calendar year 2010 for

⁷⁸ ASPE Issue Brief, "Essential Health Benefits: Comparing Benefits in Small Group Products and State and Federal Employee Plans," ed. U.S. Department of Health & Human Services (2011).

⁷⁹ See the interim final regulations for a fuller discussion of the legislative history.

⁸⁰ Final Report: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 at pages vii–ix. NORC at the University of Chicago for the Office of the Assistant Secretary for Planning and Evaluation. This study analyzed information on large group health plan benefit designs from 2009 through 2011 in several databases maintained by benefits consulting firms that advise plans on compliance with MHPAEA as well as other requirements.

many plans) and the interim final regulations went into effect for plans years beginning on or after July 10, 2010 (calendar year 2011 for many plans). This HHS study found that by 2011, most plans had removed most financial requirements and treatment limitations that did not meet the requirements of MHPAEA and its implementing interim final regulations.

According to this HHS study, in 2010, ten percent of a nationally representative sample of large employers' behavioral health benefits had *inpatient* financial requirements (e.g., deductibles, co-pays, or co-insurance) that needed modification to comply with MHPAEA. Analysis of a separate set of large employer-based plans for 2011 found virtually all 230 large employer-based plans included had inpatient benefits that conformed to MHPAEA standards. A third database of plan designs from 2009 through 2011 confirmed that the use of higher copayments and coinsurance for inpatient mental health and substance use disorder services declined rapidly in large employer plans following implementation of MHPAEA.⁸¹

Among the representative sample of plans for 2010 included in this study, more than 30 percent had copayments or coinsurance rates for *outpatient* mental health and substance use disorder benefits that were inconsistent with MHPAEA. In a separate sample of large employer-based plans for 2011, the use of higher coinsurance for mental health and substance use disorder benefits dropped dramatically. However, the study found that about 20 percent of the 140 plans tested continued to utilize outpatient in-network co-pays that failed to meet MHPAEA standards. A third database of plan designs for 2009 through 2011 confirmed a dramatic decline in the use of more restrictive cost-sharing for outpatient mental health and substance use disorder benefits although a minority continued to use high copays.

Nearly all plans had eliminated the use of separate deductibles for mental health or substance use disorder out-of-pocket costs by 2011. (Even by 2010, only 3.2 percent of plans had used separate deductibles.)⁸²

The HHS study also found that the number of plans that applied unequal inpatient day limits, outpatient visit limits or other quantitative treatment limitations for mental health or substance use disorder benefits had dropped significantly by 2011. In 2010, it found that most large employer-based

plans used day limits on mental health *inpatient* benefits that generally conformed to MHPAEA standards.

While almost 20 percent of these plans imposed more restrictive day limits on in-network, inpatient benefits for substance use disorders than applied to medical/surgical benefits, the separate sample of 2011 large employer-based plans indicated a significant decline with only eight percent of plans using stricter day limits for inpatient benefits for substance use disorders. These findings were corroborated by analysis of an additional database of plan designs from 2009 through 2011, which also indicated a dramatic decline in the proportion of plans using more restrictive inpatient day limits on mental health and substance use disorder benefits (from 50 percent in 2009 to ten percent in 2010).

In 2010, more than 50 percent of large employer-based plans in the study's representative sample used more restrictive visit limits for outpatient mental health and substance use disorder services that did not conform to MHPAEA standards. But, in the 2011 sample of large employer-based health plans, less than seven percent were using unequal visit limits. This trend was also evident in the plan design database comparing plans across 2009, 2010, and 2011. There too, substantial reductions in quantitative treatment limitations for mental health and substance use disorder benefits in large employer-based plans were seen after enactment of MHPAEA.

b. Potential Benefits of the Final Regulations

The Departments expect that MHPAEA and these final regulations will have their greatest impact on people needing the most intensive treatment and financial protection. The Departments cannot estimate how large this impact will be, but the numbers of beneficiaries who have a medical necessity for substantial amount of care are likely to be relatively small.

Improving coverage in the small group and individual markets will also expand financial protection for a significant segment of those covered and soon to be covered by private health insurance. One indicator of the consequences of unprotected financial risk is bankruptcies. The literature on bankruptcies identifies mental health care as a source of high spending that is less protected than other areas of health care.⁸³ One estimate is that about

17 percent of bankruptcies are due to health care bills.⁸⁴ Another estimate using the same data is that about ten percent of medical bankruptcies are attributable to high mental health care costs, and an additional two to three percent of bankruptcies are attributable to drug and alcohol abuse.⁸⁵

Improvements in coverage of mental health and substance use disorder services expected to result from implementation of MHPAEA can be expected to reduce some of the financial risk and also yield successful treatment for people with mental health or substance use disorder problems.

Earlier entry into treatment may have a salutary impact on entry into disability programs. Of the 8.6 million disabled workers receiving Social Security Disability Insurance benefits, 28 percent are identified as having a disability related to mental disorders, not including intellectual disability. Mental disorders are the second largest diagnostic category among awards to disabled workers, after conditions associated with the musculoskeletal system and connective tissue (29 percent) but ahead of those related to the circulatory system (8.5 percent).⁸⁶

Improving coverage of mental health and substance use disorder treatment could also more generally improve productivity and improve earnings among those with these conditions. Studies have shown that the high prevalence of depression causes \$31 billion to \$51 billion annually in lost productivity in the United States.⁸⁷ More days of work loss and work impairment are caused by mental illness than by various other chronic conditions, including diabetes and lower back pain.⁸⁸ A recent meta-analysis of randomized studies that

⁸⁴ Dranove D and ML Millenson, Medical Bankruptcy: Myth Versus Fact, Health Affairs 25, w74-w83 February 28, 2006.

⁸⁵ Dranove D and ML Millenson, Medical Bankruptcy: Myth Versus Fact, Health Affairs 25, w74-w83 February 28, 2006.

⁸⁶ Social Security Administration (SSA). (2012). Annual Statistical Report on the Social Security Disability Insurance Program, 2011. SSA Publication No. 13-11826.

⁸⁷ Stewart, W.F., Ricci, J.A., Chee, E., Hahn, S.R. & Morgenstein, D. (2003, June 18). "Cost of lost productive work time among US workers with depression." *JAMA: Journal of the American Medical Association*. 289, 23, 3135-3144; Kessler, R.C., Akiskal, H.S., Ames, M., Birnbaum, H., Greenberg, P., Hirschfeld, H.M.A. et al. (2006). "Prevalence and effects of mood disorders on work performance in a nationally representative sample of U.S. workers." *American Journal of Psychiatry*, 163, 1561-1568.

⁸⁸ Stewart, W.F., Ricci, J.A., Chee, E., Hahn, S.R. & Morgenstein, D. (2003, June 18). "Cost of lost productive work time among US workers with depression." *JAMA: Journal of the American Medical Association*. 289, 23, 3135-3144.

⁸¹ Ibid at page xii.

⁸² Ibid at page xi.

⁸³ Robertson CT, R Egelhof, M Hoke, Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures, Health Matrix 18:65-105, 2008.

examined the impact of treating depression on labor market outcomes showed that while the labor supply effects were smaller than the impact on clinical symptoms, there were consistently significant and positive effects of treatment on labor supply.^{89 90} Although the expected impact of MHPAEA on labor supply is likely modest for large employers, it is probably considerably larger for small group and individual plans where pre-MHPAEA coverage was more limited than in the large group market.

As stated earlier, these final regulations clarify that the general rule regarding consistency in classification of benefits applies to intermediate services provided under the plan or coverage. These final regulations are expected to maintain or perhaps slightly improve coverage for intermediate levels of care. These services that fall between inpatient care for acute conditions and regular outpatient care can be effective at improving outcomes for people with mental health conditions or substance use disorders.^{91 92 93}

This final rule allows for policies such as multi-tiered provider networks. Multi-tiered networks are spreading rapidly among large group policies. There is some early evidence that such approaches can successfully attenuate costs and improve quality of care.

3. Anticipated Costs

a. Illustrative Results From Past Policy Interventions

Existing evidence on implementation of parity in States and FEHBP suggests there will not be significant increases in plan expenditures and premiums as a result of the increased access to mental health and substance use disorder services that are expected to result from these final regulations. Since the

effective date of the interim final regulations, no employer has applied for a cost exemption. A recent research study funded by HHS shows that in general, large employer-sponsored plans eliminated higher financial requirements and more limited inpatient day limits, outpatient visit limits and other quantitative treatment limitations for mental health or substance use disorder benefits fairly quickly in the first few years following the enactment of MHPAEA. Differences in cost sharing for prescription medications and emergency care also declined, and by 2011 almost all large employer-based plans studied appeared to comply with MHPAEA for those benefits.⁹⁴ Over that same period, a very small percent of employers dropped mental health or substance use disorder coverage. Moreover, there is no clear evidence that the small number of plans that did drop mental health and substance use disorder coverage did so because of MHPAEA.

Furthermore, evidence suggests that plans did not exclude more mental health or substance use disorder diagnoses from coverage in response to MHPAEA and there is no evidence that plans or employers reduced medical/surgical benefits to comply with parity requirements.⁹⁵ All of these findings indicate that any increases in the costs of covering mental health and substance use disorder benefits following implementation of MHPAEA did not have a substantial impact on overall plan spending.

Other recent analyses of claims data from self-insured employer-sponsored group health plans have suggested that an overwhelming majority of privately insured individuals who used mental health or substance use disorder services prior to MHPAEA did so at a rate far below pre-parity limits on benefits.⁹⁶ Using econometric models to estimate the effect of MHPAEA on high-utilization beneficiaries who are most likely to use expanded coverage, researchers have estimated that MHPAEA may at most increase total health care costs by 0.6 percent.⁹⁷ Furthermore, a recent study of

substance use disorder spending from 2001 to 2009 by large employer-sponsored health plans shows that substance use disorder spending remained a relatively constant share of all health spending, comprising about 0.4 percent of all health spending in 2009. This low share of overall spending means that even large increases in utilization of substance use disorder treatment are unlikely to have a significant impact on premiums.⁹⁸

Although most State parity laws are more limited than MHPAEA, some are comparable, and studies on the impact of these more comparable laws provide a fair indication of the effect of MHPAEA. For example, Oregon's State parity law enacted in 2007 is quite comparable in that it applies to treatment limits (including NQTLs) and financial requirements for mental health and substance use disorder benefits. A study of the Oregon parity law found that plans removed coverage limits and used management techniques more consistently but did not significantly increase spending on mental health and substance use disorder care.⁹⁹ Vermont's parity law also applies to both mental health and substance use disorder services. A study of this State parity law also did not find significant increases in spending.¹⁰⁰

b. Costs (and Transfers) Attributable to the Final Regulations

The Departments do not expect the clarification that plans should classify intermediate services consistently for mental health and substance use disorders and medical/surgical benefits will result in a significant increase in costs. Nor do the Departments expect the clarification that the NQTL rules apply to these types of services to cause a substantial increase in plan spending. Analyses of claims data for large group health plans conducted by two different contractors for HHS indicate that most plans cover intermediate behavioral health services, particularly partial hospitalization and intensive outpatient services, but intermediate services account for less than one percent of total health plan spending.¹⁰¹ Internal

⁸⁹ Timbie JW, M Horvitz-Lennon, RG Frank and SLT Normand. A Meta-Analysis of Labor Supply Interventions for Major Depressive Disorder, *Psychiatric Services* 57(2) 212–219, 2006.

⁹⁰ Wang PS, GE Simon, J Avorn et al, Telephone Screening, Outreach, and Care Management for Depressed Workers and Impact on Clinical and Work Productivity Outcomes, *JAMA* 298(12) 1401–1411, 2007.

⁹¹ Bateman A, Fonagy P: Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up. *Am J Psychiatry* 2001; 158:36–42.

⁹² Horvitz-Lennon M, Normand SL, Gaccione P and Frank RG. "Partial vs. Full Hospitalization for Adults in Psychiatric Distress: A Systematic Review of the Published Literature." *American Journal of Psychiatry*, 158(5), 2001.

⁹³ Drake, Robert E., Erica L. O'Neal, and Michael A. Wallach. "A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders." *Journal of substance abuse treatment* 34.1 (2008): 123–138.

⁹⁴ Final Report for ASPE: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 at page x. NORC at the University of Chicago for the Office of the Assistant Secretary for Planning and Evaluation.

⁹⁵ Ibid at page xi.

⁹⁶ Mark, TL, Vandivort-Warren, R, Miller, K, Mental health spending by private insurance: Implications for the Mental Health Parity and Addiction Equity Act, *Psych Services*, 2012; 63(4): 313–318.

⁹⁷ Ibid.

⁹⁸ Ibid.

⁹⁹ Ibid.

¹⁰⁰ Mark, TL, Vandivort-Warren, R, Spending trends on substance abuse treatment under private employer-sponsored insurance, 2001–2009, *Drug and Alcohol Dependence*, 2012; 125:203–207.

¹⁰¹ Short-Term Analysis to Support Mental Health and Substance Use Disorder Parity Implementation. RAND Corporation for the Office of the Assistant Secretary for Planning and Evaluation. February 8, 2012 (<http://aspe.hhs.gov/daltcp/reports/2012/mhsud.shtml>); internal analysis of claims data for large self-insured employers and health plans.

research and analysis by HHS indicates that the number of enrollees who use intermediate services for mental health and substance use disorders is very small. Furthermore, those who used intermediate services did so at modest rates. In addition, the number of enrollees who used intermediate services for medical/surgical benefits was similarly small. Available data suggest that intermediate behavioral health services account for between eight percent and eleven percent of total behavioral health spending in private insurance. This means that since behavioral health care accounts for about 5.5 percent of health plan spending, intermediate behavioral health spending amounts to between 0.4 and 0.6 percent of total health plan spending. In light of the small number of enrollees that utilize this intermediate level of care and the small percentage of total costs that intermediate mental health and substance use disorder services comprise, the Departments expect that any increase in coverage would be very unlikely to have any significant effect on total health plan spending.

Moreover, the Departments investigated the patterns of classification of intermediate services and found that they are generally covered in the six classifications set out in the interim final regulations. Behavioral health intermediate services are generally categorized in a similar fashion as analogous medical services; for example, residential treatment tends to be categorized in the same way as skilled nursing facility care in the inpatient classification. Thus, the Departments do not expect much change in how most plans consider intermediate behavioral health care in terms of the six existing benefit classifications.

Tiered provider networks are expanding in private health insurance. The interim final regulations made no allowance for such insurance innovations. The final regulations clarify how the parity requirements apply to multi-tiered provider networks. The evidence on the impact of these networks is beginning to emerge.¹⁰² There is some evidence that points to small reductions in health spending associated with tiered provider networks. There are also studies showing little to no savings associated with these network designs. Some

¹⁰² Thomas JM, G Nalli AF Cockburn. What we know and don't know about tiered provider networks, *Journal of Health Care Finance* 33(4), 53–67, 2007; Sinaiko AD, Tiered provider Networks as a Strategy to Improve Health Care Quality and Efficiency, NICHM Foundation February 2012.

modest impact on quality has been observed in some cases and none in others.¹⁰³ The Departments are therefore assuming no cost impact of this provision.

There is limited data on spending for mental health and substance use disorder treatment under individual health insurance plans. The Departments therefore rely on some recent tabulations from the Medical Expenditure Panel Survey (MEPS) and a recent report on premiums and coverage in the individual health insurance market along with information from several other sources to make projections of the likely impact of applying MHPAEA to the individual market.¹⁰⁴ The Departments began by estimating baseline spending in the individual market. The Departments calculate the weighted average premium for the individual insurance market from the paper by Whitmore and colleagues that was reported in 2007 dollars and inflate it to 2012 dollars using the GDP deflator. Because premiums report more than just health care costs, the Departments convert the premium into plan payments for services by applying the medical loss ratio of 0.70 reported in the technical appendix to the Medical Loss Ratio interim final rule.¹⁰⁵ The resulting estimate is \$2437 in 2012 dollars. That figure represents total health spending by plans per member per year. The Departments obtain an estimate of the behavioral health costs by assuming that about four percent of those expenditures are for behavioral health. That figure is obtained by recognizing that coverage for behavioral health in the individual market is more limited than in the employer sponsored insurance market where mental health and substance use disorder care accounts for about 5.5 percent of spending overall.¹⁰⁶ Applying the four percent figure to the plan spending estimates results in an

¹⁰³ Ibid.

¹⁰⁴ Whitmore H, JR Gabel, J Pickreign R McDevitt, *The Individual Insurance Market Before Reform: Low Premiums and Low Benefits*, *Medical Care Research and Review* 68(5): 594–606, 2011.

¹⁰⁵ Technical Appendix to the Regulatory Impact Analysis for the Interim Final Rule for Health Insurance Issuers Implementing the Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, November 22, 2010, available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr_20101122_technical_appendix.pdf.

¹⁰⁶ Substance Abuse and Mental Health Services Administration. *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009*. HHS Publication No. SMA–13–4740. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

estimate of \$98 per member per year in plan spending for mental health and substance use disorder benefits. The Departments then calculate the share of spending paid out-of-pocket by using the MEPS data to obtain an estimate of outpatient mental health and substance use disorder out-of-pocket spending, because outpatient services generally carry higher cost sharing than inpatient care and because overall non-inpatient care accounts for about 65 to 70 percent of behavioral health care. The MEPS data indicate that out-of-pocket costs for mental health and substance use disorder care accounts for 47 percent of total spending. This contrasts with an estimate of 26 percent for medical/surgical care. The implication of this is a total (plan and out-of-pocket) spending estimate for mental health and substance use disorder benefits of \$185 per member per year in 2012. It is important to recognize that roughly 40 percent of total behavioral health spending in private insurance is accounted for by spending on psychotropic drugs and drug benefits will remain relatively unchanged, to the extent prescription drug tiers are based on neutral factors independent of whether a particular drug is prescribed to treat a medical/surgical condition, or a mental health condition or substance use disorder. This is because psychotropic drugs are typically under the same benefit design and formulary rules as all other drugs in private health insurance. Thus the baseline spending that would be affected by MHPAEA is estimated to be \$111 per member per year.

To obtain the impact of extending MHPAEA to the individual market, the Departments assume that a primary impact of MHPAEA is to equalize cost sharing arrangements between mental health and substance use disorder benefits and medical/surgical benefits. The Departments therefore assume that the out-of-pocket share for mental health and substance use disorder services covered in the individual insurance market will decline from 47 percent to 26 percent. The Departments apply an estimate of the price elasticity of demand to the total spending level for mental health and substance use disorder for people covered in the individual market. Two recent studies have shown that the price elasticity of demand for mental health and substance use disorder care has declined significantly in the era of managed care.¹⁰⁷ They show that the elasticity of

¹⁰⁷ Meyerhoefer CD and Zuvekas, S, “New Estimates of the Demand for Physical and Mental Health Treatment”, *Health Economics* 19(3): 297–

demand for ambulatory care fell between -0.16 and -0.26. This is relevant because the Whitmore paper reports that roughly 95 percent of individual policies are either under managed care arrangements of some form or are part of a Health Savings Account policy (17.5 percent). The Departments therefore apply an elasticity of -0.21 to the 45 percent reduction in out-of-pocket costs for people using mental health and substance use disorder care. That yields a projected 9.5 percent increase in total spending for mental health and substance use disorder care for people in the individual market. Applying the 9.5 percent estimate to the \$111 baseline subject to MHPAEA provisions results in an impact estimate of \$10.55 per covered person in 2012 or a 5.7 percent increase in total mental health and substance use disorder spending and a 0.04 percent change in total plan spending. The Departments apply the per insured person cost of mental health and substance use disorder care in the individual market estimate to an estimate of the population that would be covered under individual coverage after January of 2014. Based on the Congressional Budget Office estimates of the impact of the Affordable Care Act, the Departments expect enrollment in the individual market to be approximately 18 million people as of 2014.¹⁰⁸ Applying the \$10.55 estimate to the 18 million people¹⁰⁹ suggests a total spending increase of about \$189.9 million in 2012 dollars. The Departments project that, by 2018, the 25 million-enrollee estimate shown in CBO's report will capture all individual plan coverage. Assuming a constant rate of growth in enrollment, the five year cost will be \$1.13 billion. This estimate reflects increased spending on mental health and substance use disorder services resulting from coverage expansion that is attributable to MHPAEA above and beyond historical levels in the small group and individual markets and beyond the EHB coverage requirements for mental health and substance use disorder coverage.

MHPAEA can be expected to affect coverage in the small group market

through the provisions governing EHBs. The Departments estimate that there are currently approximately 27 million people insured under small group benefits. The Congressional Budget Office (CBO) and HHS projections are in agreement that there will be little change in the size of this market in the coming years. Thus for the purposes of this analysis the Departments assume that the market will remain stable at 27.3 million insured (including 26.1 million in ERISA plans and 1.2 million in public plans).¹¹⁰ In examining coverage in the small group market using data from 2012, the Departments find that plans used comparable levels of management to large group plans in that less than 1 percent of either small group or large group enrollees are covered by indemnity insurance arrangements. HMOs account for 15 percent of small group and 16 percent of large group enrollees. PPOs/POS plans account for 61 percent of small group and 67 percent of large group enrollees. High deductible plans make up 17 percent of small group and 24 percent of large group enrollees.¹¹¹ In addition, other recent analyses show that the actuarial value of health insurance benefits in large and small group plans are largely identical.¹¹² Data from recent studies of parity implementation in Oregon that focused in great part on small group coverage shows that parity had the effect of reducing out-of-pocket spending. Yet because it was done in the context of managed care arrangements (including regulations of management practices) there was no statistically significant impact on total spending on mental health and substance use disorder services attributable to parity.¹¹³ For this reason, the Departments assume that virtually all the impact of MHPAEA on the small group market involves a shift of final responsibility for payment from households to insurers. The Oregon parity results (McConnell et al.,

2012) are consistent with a shift of roughly 0.5 percent of spending. This shift in cost constitutes a transfer (see additional analysis in section III.D.4 below).

The final regulations retain the disclosure provisions for group health plans and health insurance coverage offered in connection with a group health plan. In addition, these disclosure provisions are extended to non-grandfathered insurance coverage in the small group market through the EHB requirements and to the individual market as a result of the amendments to the PHS Act under the Affordable Care Act as discussed in section II.F and II.H.1 of this preamble. The burden and cost related to these disclosure requirements are discussed in detail in the Paperwork Reduction Act section below and are estimated to be approximately \$4.3 million per year.

4. Transfers

The application of MHPAEA to the individual market will also shift responsibility for some existing payments from individuals to health plans by reducing cost sharing from 47 percent to 26 percent, or \$336 million in the first year increasing to \$467 million by 2018 reflecting increases in the number of individual enrollees. The Departments estimate that this shift in cost-sharing to plans combined with the increase in spending due to increased utilization discussed above could be expected to lead to an increase of 0.8% in premiums in the individual market. The small group plan average premium in 2012 was \$5588. Applying the 0.5 percent estimated shift in spending derived above in section III.E.3 to the average premium as a proxy for plan spending, the Departments obtain a figure of \$27.94. Multiplying that figure by 13 million enrollees in small group plans yields an estimated transfer amount of \$363 million per year. Likewise, premiums in the small group market may be expected to increase by 0.5%.

F. Regulatory Alternatives

In addition to the regulatory approach outlined in these final regulations, the Departments considered several alternatives when developing policy regarding NQTLs, disclosure requirements, multi-tier provider networks, and how parity applies to intermediate services.

Multiple stakeholders requested clarification regarding the application of the parity requirements to NQTLs. The Departments considered narrowing the clinically appropriate standard of care exception instead of eliminating it.

¹⁰⁸ 315 2010; Lu C, Frank, RG and McGuire TG. "Demand Response of Mental Health Services to Cost Sharing Under Managed Care." *Journal of Mental Health Policy and Economics* 11(3):113–126 2008.

¹⁰⁹ "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline," Congressional Budget Office, May 14, 2013.

¹¹⁰ The figure of 11 million enrollees based on the 2012 MLR filings data discussed earlier in this preamble is added to the CBO estimate of enrollees in the individual market in 2014.

¹¹¹ Congressional Budget Office, Letter to the Honorable Paul Ryan: Analysis of the Administration's Announced delay of certain Requirements Under the Affordable Care Act, July 30, 2013; and CBO's May 2013 Estimates of the Effects of the Affordable Care Act on Health Insurance Coverage, May 14, 2013.

¹¹² Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits—2012 Annual Survey.

¹¹³ McDevitt R, J Gabel, R Lore et al, Group Insurance: A Better Deal for Most People than Individual Plans, *Health Affairs* 29(1): 156–164, 2010.

¹¹⁴ McConnell KJ, SHN Gast, MS Ridgely et al. Behavioral Health Insurance Parity: Does Oregon's Experience Presage the National Experience with the Mental Health Parity and Addiction Equity Act?, *American Journal of Psychiatry* 2012; 169(1): 31–38.

However, this approach could result in even more confusion regarding how to apply the parity standard for NQTLs. Moreover, a technical expert panel comprised of individuals with clinical expertise in mental health and substance use disorder treatment as well as general medical treatment, and experience developing and using evidence-based practice guidelines, could not identify situations in which the exception allowing a clinically appropriate standard of care to justify a different use of NQTLs would be needed.¹¹⁴ Thus, the Departments believe that clarification in paragraph (c)(4) of the regulations will not reduce the flexibility afforded to plans and issuers by the underlying rule.

As stated earlier, concerns have also been raised regarding disclosure and transparency. The Departments considered whether participants and beneficiaries have adequate access to information regarding the processes, strategies, evidentiary standards, or other factors used to apply the NQTL and also comparable information regarding medical/surgical benefits to ensure compliance with MHPAEA. These final regulations make clear that plans and issuers are required to make this information available in accordance with MHPAEA and other applicable law, such as ERISA and the Affordable Care Act, more generally. The Departments also are publishing contemporaneously with publication of these final regulations, another set of FAQs.¹¹⁵ Among other things, these FAQs solicit comments on whether more should be done, and how, to ensure transparency and compliance.

The Departments are aware of the increasing use of multi-tier provider networks and commenters have asked how parity requirements should apply to those arrangements. The Departments considered as an alternative requiring plans to collapse their provider tiers in conducting an assessment of compliance with parity. However, this would have negated a primary reason to have provider tiers which is to offer incentives for providers to accept lower reimbursement in exchange for lower copays for their services and presumably greater patient volume. The Departments considered this alternative to be interfering unreasonably with

legitimate plan cost-management techniques. The approach in the final regulations strikes a reasonable balance between allowing plans to use provider tiers to effectively manage costs and the policy principles of MHPAEA.

As described earlier in this preamble, many commenters to the interim final regulations requested that the Departments clarify how MHPAEA affects the scope of coverage for intermediate services (such as residential treatment for substance use disorders or mental health conditions, partial hospitalization, and intensive outpatient treatment) and how these services fit within the six classifications set forth by the interim final regulations. Some stakeholders recommended establishing a separate classification for this intermediate level of care. The Departments considered this approach but determined that whereas the existing classifications—inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care, and prescription medications—are classifications commonly used by health plans and issuers, a separate classification for intermediate care is not commonly used by plans and issuers. The Departments believe that a clearer, more reasonable approach is to incorporate the principles of parity into existing benefit designs and care management strategies. Thus, the final regulations provide examples of intermediate services and clarify that plans and issuers must assign covered intermediate level mental health and substance use disorder benefits to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications.

G. Regulatory Flexibility Act— Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (RFA) requires agencies that issue a rule to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a “small entity” as—(1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000 (States and individuals are not included in the definition of “small entity”). A change in revenues of more than 3 percent to 5 percent is often used by the Departments of Labor and HHS as the measure of significant economic

impact on a substantial number of small entities.

As discussed in the Web Portal interim final rule with comment period published on May 5, 2010 (75 FR 24481), HHS examined the health insurance industry in depth in the Regulatory Impact Analysis for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis it was determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for “small” business (currently \$35.5 million in annual receipts for health insurance issuers).¹¹⁶ HHS also used the data from Medical Loss Ratio annual report submissions for the 2012 reporting year to develop an estimate of the number of small entities that offer comprehensive major medical coverage. These estimates may overstate the actual number of small health insurance issuers that would be affected by these regulations, since they do not include receipts from these companies’ other lines of business. It is estimated that there are 58 small entities with less than \$35.5 million each in earned premiums that offer individual or group health insurance coverage and would therefore be subject to the requirements of these regulations. Forty-three percent of these small issuers belong to larger holding groups, and many, if not all, of these small issuers are likely to have other lines of business that would result in their revenues exceeding \$35.5 million. For these reasons, the Departments expect that these final regulations will not significantly affect a substantial number of small issuers.

As noted previously, MHPAEA provisions are extended to non-grandfathered insurance coverage in the small group market through the EHB requirements. Group health plans and health insurance coverage offered by small employers will incur costs to comply with the provisions of these final regulations. There are an estimated 837,000 ERISA-covered non-grandfathered employer group health plans with 50 or fewer participants, and an estimated 59,000 non-grandfathered public, non-Federal employer group health plans with 50 or fewer participants sponsored by State and local governments which were

¹¹⁴ Short-Term Analysis to Support Mental Health and Substance Use Disorder Parity Implementation. RAND Corporation for the Office of the Assistant Secretary for Planning and Evaluation. February 8, 2012 (<http://aspe.hhs.gov/daltcp/reports/2012/mhsud.shtml>).

¹¹⁵ Available at: [http://www.dol.gov/ebsa/healthreform/and http://www.cms.gov/ccio/Resources/Fact-Sheets-and-FAQs/index.html](http://www.dol.gov/ebsa/healthreform/andhttp://www.cms.gov/ccio/Resources/Fact-Sheets-and-FAQs/index.html).

¹¹⁶ “Table of Small Business Size Standards Matched To North American Industry Classification System Codes,” effective July 23, 2013, U.S. Small Business Administration, available at <http://www.sba.gov>.

previously exempt from MHPAEA. Approximately 13 million participants of these plans will benefit from the provisions of these regulations. As explained earlier in this impact analysis, virtually all the impact of MHPAEA on the small group market will involve a shift of final responsibility for payment from households to insurers, resulting in an estimated increase of 0.5 percent in spending. The cost related to the disclosure requirements is estimated to be approximately \$2.4 million for non-grandfathered small group plans that were previously exempt from MHPAEA. The Departments expect the rules to reduce the compliance burden imposed on plans and insurers by the statute and the implementing interim final regulations by clarifying definitions and terms contained in the statute and providing examples of acceptable methods to comply with specific provisions.

H. Special Analyses—Department of the Treasury

For purposes of the Department of the Treasury, it has been determined that this Treasury decision is not a

significant regulatory action for purposes of Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. It is hereby certified that the collections of information contained in these final regulations will not have a significant impact on a substantial number of small entities. Accordingly, a regulatory flexibility analysis is not required.

The final regulations generally apply to employers who provide health coverage through group health plans to employees that include benefits for mental health or substance use disorder conditions. The IRS expects the final regulations to reduce the compliance burden imposed on plans and issuers by clarifying definitions and terms contained in the statute and providing examples of acceptable methods to comply with specific provisions. MHPAEA and the regulations under it do not apply to employers with 50 or fewer employees (although, separately, the EHB regulations adopt MHPAEA).

Moreover, small employers subject to the rule that have more than 50 employees will generally provide any health coverage through insurance or a third-party administrator. The issuers of insurance or other third-party administrators of the health plans, rather than the small employers, will as a practical matter, satisfy the requirements of the regulations in order to provide a marketable product. For this reason, the burden imposed by the reporting requirement of the statute and these final regulations on small entities is expected to be near zero. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding these final regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small businesses.

I. Paperwork Reduction Act

The table below summarizes the hour burden and costs related to the disclosure requirements in these regulations. For plans that use issuers or third party administrators, the costs are reported as cost burden while for plans that administer claims in-house, the burden is reported as hour burden.

Plan type	Number of respondents	Labor hours	Cost burden
ERISA-Covered Employer Group Health Plans	1,258,000	11,976	\$2,989,000
Public, Non-Federal Employer Group Health Plans	82,324	2,517	1,375,312
Individual Market Health Plans	418	25,465	51,066

1. Departments of Labor and the Treasury

In accordance with the requirements of the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)), the interim final regulations solicited comments on the information collections included therein. The Departments submitted an information collection request (ICR) to OMB in accordance with 44 U.S.C. 3507(d), contemporaneously with the publication of the interim final regulations for OMB's review. OMB approved the ICR on April 27, 2010, under OMB Control Numbers 1210-0138 (Department of Labor) and 1545-2165 (Department of the Treasury/IRS). The Departments also submitted an ICR to OMB in accordance with 44 U.S.C. 3507(d) for the ICR as revised by the final regulations. OMB approved the ICR under OMB control numbers 1210-0138 and 1545-2165, which will expire on November 30, 2016.

As discussed earlier in this preamble, the final regulations retain the disclosure provisions for group health plans and health insurance coverage

offered in connection with a group health plan. (In addition, these disclosure provisions are extended to non-grandfathered insurance coverage in the small group market through the EHB requirements and to the individual market as a result of the amendments to the PHS Act under the Affordable Care Act, as discussed in section II.F and II.H.1 of this preamble.)

The MHPAEA disclosures are information collection requests (ICRs) subject to the PRA. The final regulations (29 CFR 2590.712(d)(2)) require a Claims Denial Disclosure to be made available upon request or as otherwise required by the plan administrator (or the health insurance issuer offering such coverage) to a participant or beneficiary that provides the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits.

The Departments did not submit an IRC to OMB for the Claims Denial Disclosure, because the Department of Labor's ERISA claims procedure

regulation (29 CFR 2560.503-1) and disclosure regulation (29 CFR 2520.104b-1) already require such disclosure. The same third-party administrators and insurers are hired by ERISA and non-ERISA covered plans, so both types of plans were likely to already be in compliance with the Department of Labor rules. Therefore, the hour and cost burden associated with the claims denial notice already is accounted in the ICR for the ERISA claims procedure regulation that was approved under OMB Control Number 1210-0053.

The final regulations (29 CFR 2590.712(d)(1)) also require plan administrators to make the plan's medical necessity determination criteria available upon request to potential participants, beneficiaries, or contracting providers. The Departments are unable to estimate with certainty the number of requests for medical necessity criteria disclosures that will be received by plan administrators; however, the Departments have assumed that, on average, each plan affected by the rule will receive one

request. The Departments estimate that there are about 1,258,000 ERISA covered health plans affected by the regulations. The Departments estimate that approximately seven percent of large plans and all small plans administer claims using service providers; therefore, about 11 percent of the medical necessity criteria disclosures will be done in-house. For PRA purposes, plans using service providers will report the costs as a cost burden, while plans administering claims in-house will report the burden as an hour burden.

The Departments assume that it will take a medically trained clerical staff member five minutes to respond to each request at a wage rate of \$26.85¹¹⁷ per hour. This results in an annual hour burden of nearly 12,000 hours and an associated equivalent cost of nearly \$322,000 for the approximately 144,000 requests done in-house by plans. The remaining 1,114,000 medical necessity criteria disclosures will be provided through service providers resulting in a cost burden of approximately \$2,493,000.

The Departments also calculated the cost to deliver the requested medical necessity criteria disclosures. Many insurers and plans already may have the information prepared in electronic form, and the Departments assume that 38 percent of requests will be delivered electronically resulting in a de minimis cost. The Departments estimate that the cost burden associated with distributing the approximately 780,000 medical necessity criteria disclosures sent by paper will be approximately \$496,000.¹¹⁸ The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.¹¹⁹ The Departments will provide notice of OMB approval via a **Federal Register** notice.

These paperwork burden estimates are summarized as follows:

Type of Review: Ongoing.

Agencies: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of the Treasury,

Title: Notice of Medical Necessity Criteria under the Mental Health Parity and Addition Equity Act of 2008.

¹¹⁷ EBSA estimates based on the National Occupational Employment Survey (June 2012, Bureau of Labor Statistics) and the Employment Cost Index (September 2012, Bureau of Labor Statistics).

¹¹⁸ This estimate is based on an average document size of four pages, \$.05 cents per page material and printing costs, \$.44 cent postage costs.

¹¹⁹ 5 CFR 1320.1 through 1320.18.

OMB Number: 1210–0138; 1545–2165.

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents: 1,258,000.

Total Responses: 1,258,000.

Frequency of Response: Occasionally.

Estimated Total Annual Burden

Hours: 5,988 hours (Employee Benefits Security Administration); 5,988 hours (Internal Revenue Service).

Estimated Total Annual Burden Cost: \$1,494,000 (Employee Benefits Security Administration); \$1,494,000 (Internal Revenue Service).

2. Department of Health and Human Services

As discussed earlier in this preamble, the final regulations retain the disclosure provisions for group health plans and health insurance coverage offered in connection with a group health plan. (In addition, these disclosure provisions are extended to non-grandfathered insurance coverage in the small group market through the EHB requirements and to the individual market as a result of the amendments to the PHS Act under the Affordable Care Act, as discussed in section II.F and II.H.1 of this preamble.) The burden estimates below have been updated to reflect these changes.

In addition, as described earlier in this preamble, the final regulations reiterate that, in addition to MHPAEA's disclosure requirements, provisions of other applicable law require disclosure of information relevant to medical/surgical, mental health, and substance use disorder benefits. For example, the Departments' claims and appeals regulations under the Affordable Care Act (applicable to non-grandfathered group health plans (including non-ERISA plans) and non-grandfathered health insurance issuers in the group and individual markets),¹²⁰ set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits.¹²¹

¹²⁰ 29 CFR 2560.503–1. See also 26 CFR 54.9815–2719T(b)(2)(i), 29 CFR 2590.715–2719(b)(2)(i), and 45 CFR 147.136(b)(2)(i), requiring non-grandfathered plans and issuers to incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503–1.

¹²¹ As described earlier in this preamble, this includes documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies,

The burden associated with this disclosure is accounted for in the ICR approved under OMB control number 0938–1099.

Medical Necessity Disclosure

HHS estimates that there are about 30.2 million participants covered by approximately 82,004 State and local public plans that are subject to the MHPAEA disclosure requirements.¹²² HHS is unable to estimate with certainty the number of requests for medical necessity criteria disclosures that will be received by plan administrators; however, HHS has assumed that, on average, each plan affected by the rule will receive one request. HHS estimates that approximately 93 percent of large plans administer claims using third party administrators. Furthermore the vast majority of all smaller employers usually are fully insured such that issuers will be administering their claims. Therefore 5.1 percent of claims are administered in-house. For plans that use issuers or third party administrators, the costs are reported as cost burden while for plans that administer claims in-house, the burden is reported as hour burden. For purposes of this estimate, HHS assumes that it will take a medically trained clerical staff member five minutes to respond to each request at a wage rate of \$26.85¹²³ per hour. This results in an annual hour burden of 350 hours and an associated equivalent cost of about \$9,000 for the approximately 4,200 requests handled by plans. The remaining 78,000 claims (94.9 percent) are provided through a third-party administrator or an issuer and results in a cost burden of approximately \$175,000.

In the individual market there will be an estimated 18 million enrollees¹²⁴ enrolled in plans offered by 418 issuers

evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

¹²² Non-Federal governmental plans may opt-out of MHPAEA and certain other requirements under section 2721 of the PHS Act. Since past experience has shown that the number of non-Federal governmental plans that opt-out is small, the impact of the opt-out election should be immaterial on the Department's estimates.

¹²³ EBSA estimates based on the National Occupational Employment Survey (June 2012, Bureau of Labor Statistics) and the Employment Cost Index (September 2012, Bureau of Labor Statistics).

¹²⁴ Estimate based on medical loss ratio reports submitted by issuers for 2012 reporting year and from the study "Effects on Health Insurance and the Federal Budget for the Insurance Coverage Provisions in the Affordable Care Act—May 2013 Baseline," by Congressional Budget Office, May 14, 2013.

offering coverage in multiple states. Assuming that, on average, each issuer will receive one request in each State that it offers coverage in, there will be a total of about 2,600 requests in each year. The annual burden to issuers for sending the medical necessity disclosures is estimated to be 220 hours with an associated equivalent cost of approximately \$6,000.

Claims Denial Disclosure

As described earlier in this preamble, the Department of Labor's ERISA claims procedure regulation (29 CFR 2560.503-1) already requires such disclosures. Although non-ERISA covered plans, such as plans sponsored by State and local governments and individual plans that are subject to the PHS Act, are not required to comply with the ERISA claims procedure regulation, the final regulations provide that these plans (and health insurance coverage offered in connection with such plans) will be deemed to satisfy the MHPAEA claims denial disclosure requirement if they comply with the ERISA claims procedure regulation.

Using assumptions similar to those used for the ERISA claims procedure regulation, HHS estimates that for State and local public plans, there will be approximately 30.9 million claims for mental health or substance use disorder benefits with approximately 4.6 million denials that could result in a request for the reason for denial. HHS has no data on the percent of denials that will result in a request for an explanation, but assumed that ten percent of denials will result in a request for an explanation (464,000 requests). HHS estimates that a medically trained clerical staff member may require five minutes to respond to each request at a labor rate of \$26.85 per hour. This results in an annual burden of nearly 2,000 hours and an associated equivalent cost of nearly \$53,000 for the approximately 24,000 requests completed by plans. The remaining 440,000 are provided through an issuer or a third-party administrator, which results in a cost burden of approximately \$984,000. In the individual market, under similar assumptions, HHS estimates that there will be approximately 18.4 million claims for mental health or substance use disorder benefits with approximately 2.75 million denials that could result in a request for explanation of denial. Assuming ten percent of denials result in such a request, it is estimated that there will be about 275,000 requests for an explanation of reason for denial, which will be completed with a burden of 23,000

hours and equivalent cost of approximately \$616,000.

In association with the explanation of denial, participants may request a copy of the medical necessity criteria. While HHS does not know how many notices of denial will result in a request for the criteria of medical necessity, HHS assumes that ten percent of those requesting an explanation of the reason for denial will also request the criteria of medical necessity, resulting in about 46,000 requests, 2,400 of which will be completed in-house with a burden of 200 hours and equivalent cost of approximately \$5,000 and about 44,000 requests handled by issuers or third-party providers with a cost burden of approximately \$98,000. In the individual market, under similar assumptions, HHS estimates that there will be about 27,500 requests for medical necessity criteria, which will be completed with a burden of 2,295 hours and equivalent cost of approximately \$62,000.

HHS also calculated the cost to deliver the requested information. Many insurers or plans may already have the information prepared in electronic format, and HHS assumes that requests will be delivered electronically resulting in a de minimis cost.¹²⁵ HHS estimates that the cost burden associated with distributing the approximately 256,000 disclosures sent by paper will be approximately \$169,000.¹²⁶

The ICRs associated with the medical necessity and claims denial disclosures are currently approved under OMB control number 0938-1080. The Department will seek OMB approval for revised ICRs that will include the burden to small group health plans and individual market plans related to the disclosure requirements in the final regulations. A **Federal Register** notice will be published, providing the public with an opportunity to comment on the ICRs.

J. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any final rule that includes a Federal mandate that could result in expenditure in any one year by State, local or tribal governments, in the

aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2013, that threshold level is approximately \$141 million. These regulations are not subject to the UMRA because they were not preceded by a notice of proposed rulemaking. However, consistent with policy embodied in the UMRA, these regulations have been designed to be a low-burden alternative for State, local and tribal governments, and the private sector while achieving the objectives of MHPAEA.

K. Federalism Statement—Department of Labor and Department of Health and Human Services

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

In the Departments' view, these regulations have Federalism implications, because they have direct effects on the States, the relationship between the Federal government and States, or on the distribution of power and responsibilities among various levels of government. However, in the Departments' view, the Federalism implications of these regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States have enacted or will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal MHPAEA standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the MHPAEA requirements are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of MHPAEA. The conference report accompanying HIPAA indicates that this is intended to be the "narrowest" preemption of State laws. (See House Conf. Rep. No. 104-736, at

¹²⁵ Following the assumption in the ERISA claims regulation, it was assumed 75 percent of the explanation of denials disclosures would be delivered electronically, while it was assumed that 38 percent of non-denial related requests for the medical necessity criteria would be delivered electronically.

¹²⁶ This estimate is based on an average document size of four pages, \$.05 cents per page material and printing costs, \$0.46 cent postage costs.

205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.)

States may continue to apply State law requirements except to the extent that such requirements prevent the application of the MHPAEA requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the Federal requirements are unlikely to “prevent the application of” MHPAEA, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, the Departments have engaged in numerous efforts to consult with and work cooperatively with affected State and local officials. For example, HHS has provided training on MHPAEA for state regulators through the National Association Insurance Commissioners (NAIC) and has been available to State regulators to address any issues that arise. HHS has also collaborated with regulators in a number of States on MHPAEA enforcement strategies with the goal of maintaining state regulator involvement in the implementation and enforcement of MHPAEA in their States. It is expected that the Departments will continue to act in a similar fashion in enforcing the MHPAEA requirements.

Throughout the process of developing these regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to MHPAEA, the Departments have attempted to balance the States’ interests in regulating health insurance issuers, and Congress’ intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments’ view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to these regulations, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached regulations in a meaningful and timely manner.

L. Congressional Review Act

These final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of

1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and have been transmitted to Congress and the Comptroller General for review.

IV. Statutory Authority

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law 104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110–343, 122 Stat. 3765; Public Law 110–460, 122 Stat. 5123; Secretary of Labor’s Order 1–2011, 77 FR 1088 (January 9, 2012).

The Department of Health and Human Services regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 USC 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Parts 146 and 147

Health care, Health insurance, Reporting and recordkeeping

requirements, and State regulation of health insurance.

John Dalrymple,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: November 6, 2013.

Mark J. Mazur,

Assistant Secretary of the Treasury (Tax Policy).

Signed this 6th day of November, 2013.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: October 25, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 5, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Chapter I

Accordingly, 26 CFR Part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for part 54 is amended by removing the entry for § 54.9812–1T and by adding an entry in numerical order to read as follows:

Authority: 26 U.S.C. 7805 * * *
Section 54.9812–1 also issued under 26 U.S.C. 9833. * * *

■ **Par. 2.** Section 54.9812–1T is removed.

■ **Par. 3.** Section 54.9812–1 is added to read as follows:

§ 54.9812–1 Parity in mental health and substance use disorder benefits.

(a) *Meaning of terms.* For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or health insurance coverage offered in connection with such a plan) for any coverage unit.

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.

Coverage unit means coverage unit as described in paragraph (c)(1)(iv) of this section.

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.)

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.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

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).

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).

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).

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, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

(b) *Parity requirements with respect to aggregate lifetime and annual dollar limits.* This paragraph (b) details the application of the parity requirements with respect to aggregate lifetime and annual dollar limits. This paragraph (b) does not address the provisions of PHS Act section 2711, as incorporated in ERISA section 715 and Code section 9815, which prohibit imposing lifetime and annual limits on the dollar value of essential health benefits.

(1) *General*—(i) *General parity requirement.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraph (b)(2), (b)(3), or (b)(5) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan (or health insurance coverage) satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or health insurance coverage) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan (or health insurance coverage) includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or

(ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. (For cumulative limits other than aggregate lifetime or annual dollar limits, see paragraph (c)(3)(v) of this section prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.)

(4) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits 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 aggregate lifetime or annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(5) *Plan not described in paragraph (b)(2) or (b)(3) of this section*—(i) *In general.* A group health plan (or health insurance coverage) that is not described in paragraph (b)(2) or (b)(3) of this section with respect to aggregate lifetime or annual dollar limits on medical/surgical benefits, must either—

(A) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or

(B) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the

weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(5)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated dollar limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(5), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(4) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(c) *Parity requirements with respect to financial requirements and treatment limitations—(1) Clarification of terms—*

(i) *Classification of benefits.* When reference is made in this paragraph (c) to a classification of benefits, the term “classification” means a classification as described in paragraph (c)(2)(ii) of this section.

(ii) *Type of financial requirement or treatment limitation.* When reference is made in this paragraph (c) to a type of financial requirement or treatment limitation, the reference to type means its nature. Different types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits. See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.

(iii) *Level of a type of financial requirement or treatment limitation.* When reference is made in this paragraph (c) to a level of a type of financial requirement or treatment limitation, level refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent; different levels of a copayment include \$15 and \$20; different levels of a deductible include \$250 and \$500; and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

(iv) *Coverage unit.* When reference is made in this paragraph (c) to a coverage unit, 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.

(2) *General parity requirement—(i) General rule.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The application of the rules of this paragraph (c)(2) to financial requirements and quantitative treatment limitations is addressed in paragraph (c)(3) of this section; the application of the rules of this paragraph (c)(2) to nonquantitative treatment limitations is addressed in paragraph (c)(4) of this section.

(ii) *Classifications of benefits used for applying rules—(A) In general.* If a plan (or health insurance coverage) provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits. To the extent that a plan (or health insurance coverage) provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, the rules of this paragraph (c) apply separately with respect to that classification for all financial requirements or treatment limitations (illustrated in examples in

paragraph (c)(2)(ii)(C) of this section). The following classifications of benefits are the only classifications used in applying the rules of this paragraph (c):

(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. See special rules for plans with multiple network tiers in paragraph (c)(3)(iii) of this section.

(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.

(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.

(4) *Outpatient, out-of-network.* Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers. See special rules for office visits in paragraph (c)(3)(iii) of this section.

(5) *Emergency care.* Benefits for emergency care.

(6) *Prescription drugs.* Benefits for prescription drugs. See special rules for multi-tiered prescription drug benefits in paragraph (c)(3)(iii) of this section.

(B) *Application to out-of-network providers.* See paragraph (c)(2)(ii)(A) of this section, under which a plan (or health insurance coverage) that provides mental health or substance use disorder benefits in any classification of benefits must provide mental health or substance use disorder benefits in every classification in which medical/surgical benefits are provided, including out-of-network classifications.

(C) *Examples.* The rules of this paragraph (c)(2)(ii) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. A group health plan offers inpatient and outpatient benefits and does not contract with a network of providers. The plan imposes a \$500

deductible on all benefits. For inpatient medical/surgical benefits, the plan imposes a coinsurance requirement. For outpatient medical/surgical benefits, the plan imposes copayments. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 1*, because the plan has no network of providers, all benefits provided are out-of-network. Because inpatient, out-of-network medical/surgical benefits are subject to separate financial requirements from outpatient, out-of-network medical/surgical benefits, the rules of this paragraph (c) apply separately with respect to any financial requirements and treatment limitations, including the deductible, in each classification.

Example 2. (i) *Facts.* A plan imposes a \$500 deductible on all benefits. The plan has no network of providers. The plan generally imposes a 20 percent coinsurance requirement with respect to all benefits, without distinguishing among inpatient, outpatient, emergency care, or prescription drug benefits. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 2*, because the plan does not impose separate financial requirements (or treatment limitations) based on classification, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance across all benefits.

Example 3. (i) *Facts.* Same facts as *Example 2*, except the plan exempts emergency care benefits from the 20 percent coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 3*, because the plan imposes separate financial requirements based on classifications, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance separately for—

(A) Benefits in the emergency care classification; and

(B) All other benefits.

Example 4. (i) *Facts.* Same facts as *Example 2*, except the plan also imposes a preauthorization requirement for all inpatient treatment in order for benefits to be paid. No such requirement applies to outpatient treatment.

(ii) *Conclusion.* In this *Example 4*, because the plan has no network of providers, all benefits provided are out-of-network. Because the plan imposes a separate treatment limitation based on classifications, the rules of this paragraph (c) apply with respect to the deductible and coinsurance separately for—

(A) Inpatient, out-of-network benefits; and

(B) All other benefits.

(3) *Financial requirements and quantitative treatment limitations—(i) Determining “substantially all” and “predominant”—(A) Substantially all.* For purposes of this paragraph (c), a type of financial requirement or quantitative treatment limitation 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. (For this purpose, benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation.) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

(B) *Predominant—(1)* If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation 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 or quantitative treatment limitation.

(2) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan (or health insurance issuer) may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(C) *Portion based on plan payments.* For purposes of this paragraph (c), the determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative

treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation).

(D) *Clarifications for certain threshold requirements.* For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied. For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Similar rules apply for any other thresholds at which the rate of plan payment changes. (See also PHS Act section 2707(b) and Affordable Care Act section 1302(c), which establish limitations on annual deductibles for non-grandfathered health plans in the small group market and annual limitations on out-of-pocket maximums for all non-grandfathered health plans.)

(E) *Determining the dollar amount of plan payments.* Subject to paragraph (c)(3)(i)(D) of this section, any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation).

(ii) *Application to different coverage units.* If a plan (or health insurance coverage) applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits, the predominant level that applies to substantially all medical/surgical benefits in the classification is determined separately for each coverage unit.

(iii) *Special rules—(A) Multi-tiered prescription drug benefits.* If a plan (or health insurance coverage) applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative

treatment limitations) and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the plan (or health insurance coverage) satisfies the parity requirements of this paragraph (c) with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

(B) *Multiple network tiers.* If a plan (or health insurance coverage) provides benefits through multiple tiers of in-network providers (such as an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers), the plan may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or mental health or substance use disorder benefits. After the sub-

classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder 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 using the methodology set forth in paragraph (c)(3)(i) of this section.

(C) *Sub-classifications permitted for office visits, separate from other outpatient services.* For purposes of applying the financial requirement and treatment limitation rules of this paragraph (c), a plan or issuer may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this paragraph (c)(3)(iii)(C). After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-

classification using the methodology set forth in paragraph (c)(3)(i) of this section. Sub-classifications other than these special rules, such as separate sub-classifications for generalists and specialists, are not permitted. The two sub-classifications permitted under this paragraph (c)(3)(iii)(C) are:

(1) Office visits (such as physician visits), and

(2) All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

(iv) *Examples.* The rules of paragraphs (c)(3)(i), (c)(3)(ii), and (c)(3)(iii) of this section are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. For inpatient, out-of-network medical/surgical benefits, a group health plan imposes five levels of coinsurance. Using a reasonable method, the plan projects its payments for the upcoming year as follows:

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

The plan projects plan costs of \$800x to be subject to coinsurance (\$100x + \$450x + \$100x + \$150x = \$800x). Thus, 80 percent (\$800x/\$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25 percent of the benefits subject to coinsurance are projected to be subject to the 15 percent coinsurance level.

(ii) *Conclusion.* In this *Example 1*, the two-thirds threshold of the substantially all

standard is met for coinsurance because 80 percent of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15 percent coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to

inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15 percent level of coinsurance.

Example 2. (i) Facts. For outpatient, in-network medical/surgical benefits, a plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

Copayment amount	\$0	\$10	\$15	\$20	\$50	Total.
Projected payments	\$200x	\$200x	\$200x	\$300x	\$100x	\$1,000x.
Percent of total plan costs	20%	20%	20%	30%	10%	
Percent subject to copayments	N/A	25%	25%	37.5%	12.5%	
		(200x/800x)	(200x/800x)	(300x/800x)	(100x/800x)	

The plan projects plan costs of \$800x to be subject to copayments (\$200x + \$200x + \$300x + \$100x = \$800x). Thus, 80 percent (\$800x/\$1,000x) of the benefits are projected to be subject to a copayment.

(ii) *Conclusion.* In this *Example 2*, the two-thirds threshold of the substantially all standard is met for copayments because 80 percent of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to a

copayment (for the \$10 copayment, 25%; for the \$15 copayment, 25%; for the \$20 copayment, 37.5%; and for the \$50 copayment, 12.5%). The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to mental health or substance use disorder benefits. If the plan combines the highest levels of copayment, the combined projected payments for the two highest copayment levels, the \$50 copayment and the \$20 copayment, are not more than one-half of the outpatient, in-network

medical/surgical benefits subject to a copayment because they are exactly one-half (\$300x + \$100x = \$400x; \$400x/\$800x = 50%). The combined projected payments for the three highest copayment levels—the \$50 copayment, the \$20 copayment, and the \$15 copayment—are more than one-half of the outpatient, in-network medical/surgical benefits subject to the copayments (\$100x + \$300x + \$200x = \$600x; \$600x/\$800x = 75%). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that

is more restrictive than the least restrictive copayment in the combination, the \$15 copayment.

Example 3. (i) Facts. A plan imposes a \$250 deductible on all medical/surgical benefits for self-only coverage and a \$500 deductible on all medical/surgical benefits for family coverage. The plan has no network of providers. For all medical/surgical benefits, the plan imposes a coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 3*, because the plan has no network of providers, all benefits are provided out-of-network. Because self-only and family coverage are subject to different deductibles, whether the deductible applies to substantially all medical/surgical benefits is determined separately for self-only medical/surgical benefits and family medical/surgical benefits. Because the coinsurance is applied without regard to coverage units, the predominant coinsurance that applies to substantially all medical/surgical benefits is determined without regard to coverage units.

Example 4. (i) Facts. A plan applies the following financial requirements for prescription drug benefits. The requirements are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits. Moreover, the process for certifying a particular drug as “generic”, “preferred brand name”, “non-preferred brand name”, or “specialty” complies with the rules of paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations).

	Tier 1	Tier 2	Tier 3	Tier 4
Tier description	Generic drugs	Preferred brand name drugs	Non-preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)	Specialty drugs
Percent paid by plan	90%	80%	60%	50%

(ii) *Conclusion.* In this *Example 4*, the financial requirements that apply to prescription drug benefits are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits; the process for certifying drugs in different tiers complies with paragraph (c)(4) of this section; and the bases for establishing different levels or types of financial requirements are reasonable. The financial requirements applied to prescription drug benefits do not violate the parity requirements of this paragraph (c)(3).

Example 5. (i) Facts. A plan has two-tiers of network of providers: a preferred provider tier and a participating provider tier. Providers are placed in either the preferred tier or participating tier based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section, such as accreditation, quality and performance measures (including customer feedback), and relative reimbursement rates. Furthermore, provider tier placement is determined without regard to whether a provider specializes in the treatment of mental health conditions or substance use disorders, or medical/surgical conditions. The plan divides the in-network classifications into two sub-classifications (in-network/preferred and in-network/participating). The plan does not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in either of these sub-classifications that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in each sub-classification.

(ii) *Conclusion.* In this *Example 5*, the division of in-network benefits into sub-classifications that reflect the preferred and participating provider tiers does not violate the parity requirements of this paragraph (c)(3).

Example 6. (i) Facts. With respect to outpatient, in-network benefits, a plan

imposes a \$25 copayment for office visits and a 20 percent coinsurance requirement for outpatient surgery. The plan divides the outpatient, in-network classification into two sub-classifications (in-network office visits and all other outpatient, in-network items and services). The plan or issuer does not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in either of these sub-classifications that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in each sub-classification.

(ii) *Conclusion.* In this *Example 6*, the division of outpatient, in-network benefits into sub-classifications for office visits and all other outpatient, in-network items and services does not violate the parity requirements of this paragraph (c)(3).

Example 7. (i) Facts. Same facts as *Example 6*, but for purposes of determining parity, the plan divides the outpatient, in-network classification into outpatient, in-network generalists and outpatient, in-network specialists.

(ii) *Conclusion.* In this *Example 7*, the division of outpatient, in-network benefits into any sub-classifications other than office visits and all other outpatient items and services violates the requirements of paragraph (c)(3)(iii)(C) of this section.

(v) *No separate cumulative financial requirements or cumulative quantitative treatment limitations—*(A) A group health plan (or health insurance coverage offered in connection with a group health plan) may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for

medical/surgical benefits in the same classification.

(B) The rules of this paragraph (c)(3)(v) are illustrated by the following examples:

Example 1. (i) Facts. A group health plan imposes a combined annual \$500 deductible on all medical/surgical, mental health, and substance use disorder benefits.

(ii) *Conclusion.* In this *Example 1*, the combined annual deductible complies with the requirements of this paragraph (c)(3)(v).

Example 2. (i) Facts. A plan imposes an annual \$250 deductible on all medical/surgical benefits and a separate annual \$250 deductible on all mental health and substance use disorder benefits.

(ii) *Conclusion.* In this *Example 2*, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

Example 3. (i) Facts. A plan imposes an annual \$300 deductible on all medical/surgical benefits and a separate annual \$100 deductible on all mental health or substance use disorder benefits.

(ii) *Conclusion.* In this *Example 3*, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

Example 4. (i) Facts. A plan generally imposes a combined annual \$500 deductible on all benefits (both medical/surgical benefits and mental health and substance use disorder benefits) except prescription drugs. Certain benefits, such as preventive care, are provided without regard to the deductible. The imposition of other types of financial requirements or treatment limitations varies with each classification. Using reasonable methods, the plan projects its payments for medical/surgical benefits in each classification for the upcoming year as follows:

Classification	Benefits subject to deductible	Total benefits	Percent subject to deductible
Inpatient, in-network	\$1,800x	\$2,000x	90
Inpatient, out-of-network	1,000x	1,000x	100
Outpatient, in-network	1,400x	2,000x	70
Outpatient, out-of-network	1,880x	2,000x	94
Emergency care	300x	500x	60

(ii) *Conclusion.* In this *Example 4*, the two-thirds threshold of the substantially all standard is met with respect to each classification except emergency care because in each of those other classifications at least two-thirds of medical/surgical benefits are subject to the \$500 deductible. Moreover, the \$500 deductible is the predominant level in each of those other classifications because it is the only level. However, emergency care mental health and substance use disorder benefits cannot be subject to the \$500 deductible because it does not apply to substantially all emergency care medical/surgical benefits.

(4) *Nonquantitative treatment limitations*—(i) *General rule.* A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification 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.

(ii) *Illustrative list of nonquantitative treatment limitations.* Nonquantitative treatment limitations include—

(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) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(D) Standards for provider admission to participate in a network, including reimbursement rates;

(E) Plan methods for determining usual, customary, and reasonable charges;

(F) Refusal to pay for higher-cost therapies until it can be shown that a

lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(G) Exclusions based on failure to complete a course of treatment; and

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

(iii) *Examples.* The rules of this paragraph (c)(4) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) *Facts.* A plan requires prior authorization from the plan’s utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient’s attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient’s attending provider and approved by the plan.

(ii) *Conclusion.* In this *Example 1*, the plan violates the rules of this paragraph (c)(4) because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits.

Example 2. (i) *Facts.* A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorders, but only 30 percent of medical/surgical conditions.

(ii) *Conclusion.* In this *Example 2*, the plan complies with the rules of this paragraph (c)(4) because the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.

Example 3. (i) *Facts.* A plan requires prior approval that a course of treatment is medically necessary for outpatient, in-network medical/surgical, mental health, and substance use disorder benefits and uses comparable criteria in determining whether a course of treatment is medically necessary. For mental health and substance use disorder treatments that do not have prior approval, no benefits will be paid; for medical/surgical treatments that do not have prior approval, there will only be a 25 percent reduction in the benefits the plan would otherwise pay.

(ii) *Conclusion.* In this *Example 3*, the plan violates the rules of this paragraph (c)(4).

Although the same nonquantitative treatment limitation—medical necessity—is applied both to mental health and substance use disorder benefits and to medical/surgical benefits for outpatient, in-network services, it is not applied in a comparable way. The penalty for failure to obtain prior approval for mental health and substance use disorder benefits is not comparable to the penalty for failure to obtain prior approval for medical/surgical benefits.

Example 4. (i) *Facts.* A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition.

(ii) *Conclusion.* In this *Example 4*, the plan complies with the rules of this paragraph (c)(4) because the processes for developing the evidentiary standards used to determine medical appropriateness and the application of these standards to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.

Example 5. (i) *Facts.* A plan generally covers medically appropriate treatments. In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For

other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) *Conclusion*. In this *Example 5*, the plan violates the rules of this paragraph (c)(4). Although the standard for applying a nonquantitative treatment limitation is the same for both mental health and substance use disorder benefits and medical/surgical benefits—whether a drug has a black box warning—it is not applied in a comparable manner. The plan's unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning.

Example 6. (i) Facts. An employer maintains both a major medical plan and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical plan only after exhausting the counseling sessions provided by the EAP. No similar exhaustion requirement applies with respect to medical/surgical benefits provided under the major medical plan.

(ii) *Conclusion*. In this *Example 6*, limiting eligibility for mental health and substance use disorder benefits only after EAP benefits are exhausted is a nonquantitative treatment limitation subject to the parity requirements of this paragraph (c). Because no comparable requirement applies to medical/surgical benefits, the requirement may not be applied to mental health or substance use disorder benefits.

Example 7. (i) Facts. Training and State licensing requirements often vary among types of providers. A plan applies a general standard that any provider must meet the highest licensing requirement related to supervised clinical experience under applicable State law in order to participate in the plan's provider network. Therefore, the plan requires master's-level mental health therapists to have post-degree, supervised clinical experience but does not impose this requirement on master's-level general medical providers because the scope of their licensure under applicable State law does require clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or Ph.D. level psychologists since their licensing already requires supervised training.

(ii) *Conclusion*. In this *Example 7*, the plan complies with the rules of this paragraph (c)(4). The requirement that master's-level mental health therapists must have supervised clinical experience to join the network is permissible, as long as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers.

Example 8. (i) Facts. A plan considers a wide array of factors in designing medical

management techniques for both mental health and substance use disorder benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these factors in a comparable fashion, prior authorization is required for some (but not all) mental health and substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. For example, the plan requires prior authorization for: outpatient surgery; speech, occupational, physical, cognitive and behavioral therapy extending for more than six months; durable medical equipment; diagnostic imaging; skilled nursing visits; home infusion therapy; coordinated home care; pain management; high-risk prenatal care; delivery by cesarean section; mastectomy; prostate cancer treatment; narcotics prescribed for more than seven days; and all inpatient services beyond 30 days. The evidence considered in developing its medical management techniques includes consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials). This evidence and how it was used to develop these medical management techniques is also well documented by the plan.

(ii) *Conclusion*. In this *Example 8*, the plan complies with the rules of this paragraph (c)(4). Under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its prior authorization requirement with respect to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those applied with respect to medical/surgical benefits.

Example 9. (i) Facts. A plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) *Conclusion*. In this *Example 9*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of substance use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

Example 10. (i) Facts. A plan generally provides coverage for medically appropriate

medical/surgical benefits as well as mental health and substance use disorder benefits. The plan excludes coverage for inpatient, out-of-network treatment of chemical dependency when obtained outside of the State where the policy is written. There is no similar exclusion for medical/surgical benefits within the same classification.

(ii) *Conclusion*. In this *Example 10*, the plan violates the rules of this paragraph (c)(4). The plan is imposing a nonquantitative treatment limitation that restricts benefits based on geographic location. Because there is no comparable exclusion that applies to medical/surgical benefits, this exclusion may not be applied to mental health or substance use disorder benefits.

Example 11. (i) Facts. A plan requires prior authorization for all outpatient mental health and substance use disorder services after the ninth visit and will only approve up to five additional visits per authorization. With respect to outpatient medical/surgical benefits, the plan allows an initial visit without prior authorization. After the initial visit, the plan pre-approves benefits based on the individual treatment plan recommended by the attending provider based on that individual's specific medical condition. There is no explicit, predetermined cap on the amount of additional visits approved per authorization.

(ii) *Conclusion*. In this *Example 11*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—prior authorization to determine medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits for outpatient services, it is not applied in a comparable way. While the plan is more generous with respect to the number of visits initially provided without pre-authorization for mental health benefits, treating all mental health conditions and substance use disorders in the same manner, while providing for individualized treatment of medical conditions, is not a comparable application of this nonquantitative treatment limitation.

(5) *Exemptions*. The rules of this paragraph (c) do not apply if a group health plan (or health insurance coverage) satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(d) *Availability of plan information—*
(1) *Criteria for medical necessity determinations*. The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

(2) *Reason for any denial*. The reason for any denial under a group health plan

(or health insurance coverage offered in connection with such plan) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with this paragraph (d)(2).

(i) *Plans subject to ERISA.* If a plan is subject to ERISA, it must provide the reason for the claim denial in a form and manner consistent with the requirements of 29 CFR 2560.503-1 for group health plans.

(ii) *Plans not subject to ERISA.* If a plan is not subject to ERISA, upon the request of a participant or beneficiary the reason for the claim denial must be provided within a reasonable time and in a reasonable manner. For this purpose, a plan that follows the requirements of 29 CFR 2560.503-1 for group health plans complies with the requirements of this paragraph (d)(2)(ii).

(3) *Provisions of other law.* Compliance with the disclosure requirements in paragraphs (d)(1) and (d)(2) of this section is not determinative of compliance with any other provision of applicable Federal or State law. In particular, in addition to those disclosure requirements, provisions of other applicable law require disclosure of information relevant to medical/surgical, mental health, and substance use disorder benefits. For example, ERISA section 104 and 29 CFR 2520.104b-1 provide that, for plans subject to ERISA, instruments under which the plan is established or operated must generally be furnished to plan participants within 30 days of request. Instruments under which the plan is established or operated include documents with 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 nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan. In addition, 29 CFR 2560.503-1 and 29 CFR 2590.715-2719 set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant

to the claimant's claim for benefits. This includes documents with 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 nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

(e) *Applicability—(1) Group health plans.* The requirements of this section apply to a group health plan offering medical/surgical benefits and mental health or substance use disorder benefits. If, under an arrangement or arrangements to provide medical care benefits by an employer or employee organization (including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans), any participant (or beneficiary) can simultaneously receive coverage for medical/surgical benefits and coverage for mental health or substance use disorder benefits, then the requirements of this section (including the exemption provisions in paragraph (g) of this section) apply separately with respect to each combination of medical/surgical benefits and of mental health or substance use disorder benefits that any participant (or beneficiary) can simultaneously receive from that employer's or employee organization's arrangement or arrangements to provide medical care benefits, and all such combinations are considered for purposes of this section to be a single group health plan.

(2) *Health insurance issuers.* The requirements of this section apply to a health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits in connection with a group health plan subject to paragraph (e)(1) of this section.

(3) *Scope.* This section does not—
(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a plan (or health insurance coverage) for one or more mental health conditions or substance use disorders does not require the plan or health insurance coverage under this section to provide benefits for any other mental health condition or substance use disorder;

(ii) Require a group health plan (or health insurance issuer offering coverage in connection with a group

health plan) that provides coverage for mental health or substance use disorder benefits only to the extent required under PHS Act section 2713 to provide additional mental health or substance use disorder benefits in any classification in accordance with this section; or

(iii) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan (or health insurance coverage) except as specifically provided in paragraphs (b) and (c) of this section.

(4) *Coordination with EHB requirements.* Nothing in paragraph (f) or (g) of this section changes the requirements of 45 CFR 147.150 and 45 CFR 156.115, providing that a health insurance issuer offering non-grandfathered health insurance coverage in the individual or small group market providing mental health and substance use disorder services, including behavioral health treatment services, as part of essential health benefits required under 45 CFR 156.110(a)(5) and 156.115(a), must comply with the provisions of 45 CFR 146.136 to satisfy the requirement to provide essential health benefits.

(f) *Small employer exemption—(1) In general.* The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (f), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (or one in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year. See section 9831(a) and § 54.9831-1(b), which provide that this section (and certain other sections) does not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (f)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ

on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(g) *Increased cost exemption*—(1) *In general.* If the application of this section to a group health plan (or health insurance coverage offered in connection with such plans) results in an increase for the plan year involved of the actual total cost of coverage with respect to medical/surgical benefits and mental health and substance use disorder benefits as determined and certified under paragraph (g)(3) of this section by an amount that exceeds the applicable percentage described in paragraph (g)(2) of this section of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for one plan year. An employer or issuer may elect to continue to provide mental health and substance use disorder benefits in compliance with this section with respect to the plan or coverage involved regardless of any increase in total costs.

(2) *Applicable percentage.* With respect to a plan or coverage, the applicable percentage described in this paragraph (g) is—

(i) 2 percent in the case of the first plan year in which this section is applied to the plan or coverage; and

(ii) 1 percent in the case of each subsequent plan year.

(3) *Determinations by actuaries*—(i) Determinations as to increases in actual costs under a plan or coverage that are attributable to implementation of the requirements of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations must be based on the formula specified in paragraph (g)(4) of this section and shall be in a written report prepared by the actuary.

(ii) The written report described in paragraph (g)(3)(i) of this section shall be maintained by the group health plan or health insurance issuer, along with all supporting documentation relied upon by the actuary, for a period of six years following the notification made under paragraph (g)(6) of this section.

(4) *Formula.* The formula to be used to make the determination under paragraph (g)(3)(i) of this section is expressed mathematically as follows:

$$[(E_1 - E_0)/T_0] - D > k$$

(i) E_1 is the actual total cost of coverage with respect to mental health

and substance use disorder benefits for the base period, including claims paid by the plan or issuer with respect to mental health and substance use disorder benefits and administrative costs (amortized over time) attributable to providing these benefits consistent with the requirements of this section.

(ii) E_0 is the actual total cost of coverage with respect to mental health and substance use disorder benefits for the length of time immediately before the base period (and that is equal in length to the base period), including claims paid by the plan or issuer with respect to mental health and substance use disorder benefits and administrative costs (amortized over time) attributable to providing these benefits.

(iii) T_0 is the actual total cost of coverage with respect to all benefits during the base period.

(iv) k is the applicable percentage of increased cost specified in paragraph (g)(2) of this section that will be expressed as a fraction for purposes of this formula.

(v) D is the average change in spending that is calculated by applying the formula $(E_1 - E_0)/T_0$ to mental health and substance use disorder spending in each of the five prior years and then calculating the average change in spending.

(5) *Six month determination.* If a group health plan or health insurance issuer seeks an exemption under this paragraph (g), determinations under paragraph (g)(3) of this section shall be made after such plan or coverage has complied with this section for at least the first 6 months of the plan year involved.

(6) *Notification.* A group health plan or health insurance issuer that, based on the certification described under paragraph (g)(3) of this section, qualifies for an exemption under this paragraph (g), and elects to implement the exemption, must notify participants and beneficiaries covered under the plan, the Secretary, and the appropriate State agencies of such election.

(i) *Participants and beneficiaries*—(A) *Content of notice.* The notice to participants and beneficiaries must include the following information:

(1) A statement that the plan or issuer is exempt from the requirements of this section and a description of the basis for the exemption.

(2) The name and telephone number of the individual to contact for further information.

(3) The plan or issuer name and plan number (PN).

(4) The plan administrator's name, address, and telephone number.

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (g)(6)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN).

(6) The effective date of such exemption.

(7) A statement regarding the ability of participants and beneficiaries to contact the plan administrator or health insurance issuer to see how benefits may be affected as a result of the plan's or issuer's election of the exemption.

(8) A statement regarding the availability, upon request and free of charge, of a summary of the information on which the exemption is based (as required under paragraph (g)(6)(i)(D) of this section).

(B) *Use of summary of material reductions in covered services or benefits.* A plan or issuer may satisfy the requirements of paragraph (g)(6)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (g)(6)(i)(C) of this section) with a summary of material reductions in covered services or benefits consistent with 29 CFR 2520.104b-3(d) that also includes the information specified in paragraph (g)(6)(i)(A) of this section. However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (g)(6)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (29 U.S.C. 1024(b)(1)) and its implementing regulations (for example, first-class mail). If the notice is provided to the participant and any beneficiaries at the participant's last known address, then the requirements of this paragraph (g)(6)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Availability of documentation.* The plan or issuer must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. (For purposes of this paragraph (g), an individual who is not a participant or beneficiary and who presents a notice described in paragraph (g)(6)(i) of this section is considered to be a representative. A representative may request the summary of information by

providing the plan a copy of the notice provided to the participant under paragraph (g)(6)(i) of this section with any personally identifiable information redacted.) The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan or coverage absent amendments required to comply with paragraphs (b) and (c) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any personally identifiable information.

(ii) *Federal agencies*—(A) *Content of notice*. The notice to the Secretary must include the following information:

(1) A description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost exemption under this paragraph (g) by such plan (or coverage);

(2) For both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical/surgical benefits and mental health and substance use disorder benefits; and

(3) For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(B) *Reporting with respect to church plans*. A church plan (as defined in section 414(e)) claiming the exemption of this paragraph (g) for any benefit package, must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (g)(6)(ii)(A) of this section identifying the benefit package to which the exemption applies.

(C) *Reporting with respect to ERISA plans*. See 29 CFR 2590.712(g)(6)(ii) for delivery with respect to ERISA plans.

(iii) *Confidentiality*. A notification to the Secretary under this paragraph (g)(6) shall be confidential. The Secretary shall make available, upon request and not more than on an annual basis, an anonymous itemization of each notification that includes—

(A) A breakdown of States by the size and type of employers submitting such notification; and

(B) A summary of the data received under paragraph (g)(6)(ii) of this section.

(iv) *Audits*. The Secretary may audit the books and records of a group health plan or a health insurance issuer relating to an exemption, including any actuarial reports, during the 6 year period following notification of such exemption under paragraph (g)(6) of this section. A State agency receiving a notification under paragraph (g)(6) of this section may also conduct such an audit with respect to an exemption covered by such notification.

(h) *Sale of nonparity health insurance coverage*. A health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with paragraph (b) or (c) of this section, except to a plan for a year for which the plan is exempt from the requirements of this section because the plan meets the requirements of paragraph (f) or (g) of this section.

(i) *Applicability dates*—(1) *In general*. Except as provided in paragraph (i)(2) of this section, this section applies to group health plans and health insurance issuers offering group health insurance coverage on the first day of the first plan year beginning on or after July 1, 2014.

(2) *Special effective date for certain collectively-bargained plans*. For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan (or health insurance coverage offered in connection with the plan) for plan years beginning before the date on which the last of the collective bargaining agreements terminates (determined without regard to any extension agreed to after October 3, 2008).

Employee Benefits Security Administration

29 CFR Chapter XXV

29 CFR Part 2590 is amended as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 1. The authority citation for Part 2590 is revised to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law 104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110–343, 122 Stat. 3765; Public Law 110–460, 122 Stat. 5123; Secretary of Labor's Order 1–2011, 77 FR 1088 (January 9, 2012).

■ 2. Section 2590.712 is revised to read as follows:

§ 2590.712 Parity in mental health and substance use disorder benefits.

(a) *Meaning of terms*. For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or health insurance coverage offered in connection with such a plan) for any coverage unit.

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.

Coverage unit means coverage unit as described in paragraph (c)(1)(iv) of this section.

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.)

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.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

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).

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).

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).

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, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

(b) *Parity requirements with respect to aggregate lifetime and annual dollar limits.* This paragraph (b) details the application of the parity requirements with respect to aggregate lifetime and annual dollar limits. This paragraph (b) does not address the provisions of PHS Act section 2711, as incorporated in ERISA section 715 and Code section 9815, which prohibit imposing lifetime and annual limits on the dollar value of essential health benefits. For more information, see 29 CFR 2590.715–2711.

(1) *General—(i) General parity requirement.* A group health plan (or health insurance coverage offered by an

issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraph (b)(2), (b)(3), or (b)(5) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan (or health insurance coverage) satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or health insurance coverage) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan (or health insurance coverage) includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or

(ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. (For cumulative limits other than aggregate lifetime or annual dollar limits, see paragraph (c)(3)(v) of this section prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.)

(4) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits 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 aggregate lifetime or

annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(5) *Plan not described in paragraph (b)(2) or (b)(3) of this section—(i) In general.* A group health plan (or health insurance coverage) that is not described in paragraph (b)(2) or (b)(3) of this section with respect to aggregate lifetime or annual dollar limits on medical/surgical benefits, must either—

(A) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or

(B) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(5)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated dollar limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(5), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(4) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(c) *Parity requirements with respect to financial requirements and treatment limitations—(1) Clarification of terms—*

(i) *Classification of benefits.* When reference is made in this paragraph (c) to a classification of benefits, the term “classification” means a classification as described in paragraph (c)(2)(ii) of this section.

(ii) *Type of financial requirement or treatment limitation.* When reference is made in this paragraph (c) to a type of financial requirement or treatment limitation, the reference to type means

its nature. Different types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits. See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.

(iii) *Level of a type of financial requirement or treatment limitation.* When reference is made in this paragraph (c) to a level of a type of financial requirement or treatment limitation, level refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent; different levels of a copayment include \$15 and \$20; different levels of a deductible include \$250 and \$500; and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

(iv) *Coverage unit.* When reference is made in this paragraph (c) to a coverage unit, 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.

(2) *General parity requirement—(i) General rule.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The application of the rules of this paragraph (c)(2) to financial requirements and quantitative treatment limitations is addressed in paragraph (c)(3) of this section; the application of the rules of this paragraph (c)(2) to nonquantitative treatment limitations is addressed in paragraph (c)(4) of this section.

(ii) *Classifications of benefits used for applying rules—(A) In general.* If a plan (or health insurance coverage) provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits. To the extent that a plan (or health insurance coverage) provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, the rules of this paragraph (c) apply separately with respect to that classification for all financial requirements or treatment limitations (illustrated in examples in paragraph (c)(2)(ii)(C) of this section). The following classifications of benefits are the only classifications used in applying the rules of this paragraph (c):

(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. See special rules for plans with multiple network tiers in paragraph (c)(3)(iii) of this section.

(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.

(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.

(4) *Outpatient, out-of-network.* Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers. See special rules for office visits in paragraph (c)(3)(iii) of this section.

(5) *Emergency care.* Benefits for emergency care.

(6) *Prescription drugs.* Benefits for prescription drugs. See special rules for multi-tiered prescription drug benefits in paragraph (c)(3)(iii) of this section.

(B) *Application to out-of-network providers.* See paragraph (c)(2)(ii)(A) of this section, under which a plan (or health insurance coverage) that provides mental health or substance use disorder benefits in any classification of benefits must provide mental health or substance use disorder benefits in every classification in which medical/surgical benefits are provided, including out-of-network classifications.

(C) *Examples.* The rules of this paragraph (c)(2)(ii) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. A group health plan offers inpatient and outpatient benefits and does not contract with a network of providers. The plan imposes a \$500 deductible on all benefits. For inpatient medical/surgical benefits, the plan imposes a coinsurance requirement. For outpatient medical/surgical benefits, the plan imposes copayments. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 1*, because the plan has no network of providers, all benefits provided are out-of-network. Because inpatient, out-of-network medical/surgical benefits are subject to separate financial requirements from outpatient, out-of-network medical/surgical benefits, the rules of this paragraph (c) apply separately with respect to any financial requirements and treatment limitations, including the deductible, in each classification.

Example 2. (i) Facts. A plan imposes a \$500 deductible on all benefits. The plan has no network of providers. The plan generally imposes a 20 percent coinsurance requirement with respect to all benefits, without distinguishing among inpatient, outpatient, emergency care, or prescription drug benefits. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 2*, because the plan does not impose separate financial requirements (or treatment limitations) based on classification, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance across all benefits.

Example 3. (i) Facts. Same facts as *Example 2*, except the plan exempts emergency care benefits from the 20 percent coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 3*, because the plan imposes separate financial requirements based on classifications, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance separately for—

(A) Benefits in the emergency care classification; and

(B) All other benefits.

Example 4. (i) *Facts.* Same facts as *Example 2*, except the plan also imposes a preauthorization requirement for all inpatient treatment in order for benefits to be paid. No such requirement applies to outpatient treatment.

(ii) *Conclusion.* In this *Example 4*, because the plan has no network of providers, all benefits provided are out-of-network. Because the plan imposes a separate treatment limitation based on classifications, the rules of this paragraph (c) apply with respect to the deductible and coinsurance separately for—

(A) Inpatient, out-of-network benefits; and

(B) All other benefits.

(3) *Financial requirements and quantitative treatment limitations—(i) Determining “substantially all” and “predominant”*—(A) *Substantially all.* For purposes of this paragraph (c), a type of financial requirement or quantitative treatment limitation 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. (For this purpose, benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation.) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

(B) *Predominant*—(1) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation 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 or quantitative treatment limitation.

(2) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than

one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan (or health insurance issuer) may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(C) *Portion based on plan payments.* For purposes of this paragraph (c), the determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation).

(D) *Clarifications for certain threshold requirements.* For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied. For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Similar rules apply for any other thresholds at which the rate of plan payment changes. (See also PHS Act section 2707(b) and Affordable Care Act section 1302(c), which establish limitations on annual deductibles for non-grandfathered health plans in the small group market and annual limitations on out-of-pocket maximums for all non-grandfathered health plans.)

(E) *Determining the dollar amount of plan payments.* Subject to paragraph (c)(3)(i)(D) of this section, any reasonable method may be used to determine the dollar amount expected

to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation).

(ii) *Application to different coverage units.* If a plan (or health insurance coverage) applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits, the predominant level that applies to substantially all medical/surgical benefits in the classification is determined separately for each coverage unit.

(iii) *Special rules—(A) Multi-tiered prescription drug benefits.* If a plan (or health insurance coverage) applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations) and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the plan (or health insurance coverage) satisfies the parity requirements of this paragraph (c) with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

(B) *Multiple network tiers.* If a plan (or health insurance coverage) provides benefits through multiple tiers of in-network providers (such as an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers), the plan may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or mental health or substance use disorder benefits. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder 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 using the methodology set forth in paragraph (c)(3)(i) of this section.

(C) *Sub-classifications permitted for office visits, separate from other outpatient services.* For purposes of applying the financial requirement and treatment limitation rules of this paragraph (c), a plan or issuer may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this paragraph (c)(3)(iii)(C). After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-

classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph (c)(3)(i) of this section. Sub-classifications other than these special rules, such as separate sub-classifications for generalists and specialists, are not permitted. The two sub-classifications permitted under this paragraph (c)(3)(iii)(C) are:

- (1) Office visits (such as physician visits), and
- (2) All other outpatient items and services (such as outpatient surgery, facility charges for day treatment

centers, laboratory charges, or other medical items).

(iv) *Examples.* The rules of paragraphs (c)(3)(i), (c)(3)(ii), and (c)(3)(iii) of this section are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. For inpatient, out-of-network medical/surgical benefits, a group health plan imposes five levels of coinsurance. Using a reasonable method, the plan projects its payments for the upcoming year as follows:

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

The plan projects plan costs of \$800x to be subject to coinsurance (\$100x + \$450x + \$100x + \$150x = \$800x). Thus, 80 percent (\$800x/\$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25 percent of the benefits subject to coinsurance are projected to be subject to the 15 percent coinsurance level.

(ii) *Conclusion.* In this *Example 1*, the two-thirds threshold of the substantially all

standard is met for coinsurance because 80 percent of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15 percent coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to

inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15 percent level of coinsurance.

Example 2. (i) Facts. For outpatient, in-network medical/surgical benefits, a plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

Copayment amount	\$0	\$10	\$15	\$20	\$50	Total.
Projected payments	\$200x	\$200x	\$200x	\$300x	\$100x	\$1,000x.
Percent of total plan costs	20%	20%	20%	30%	10%	
Percent subject to copayments	N/A	25%	25%	37.5%	12.5%	
		(200x/800x)	(200x/800x)	(300x/800x)	(100x/800x)	

The plan projects plan costs of \$800x to be subject to copayments (\$200x + \$200x + \$300x + \$100x = \$800x). Thus, 80 percent (\$800x/\$1,000x) of the benefits are projected to be subject to a copayment.

(ii) *Conclusion.* In this *Example 2*, the two-thirds threshold of the substantially all standard is met for copayments because 80 percent of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to a copayment (for the \$10 copayment, 25%; for the \$15 copayment, 25%; for the \$20 copayment, 37.5%; and for the \$50 copayment, 12.5%). The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to mental health or substance use disorder benefits. If the plan combines the highest levels of copayment, the combined projected payments for the two highest copayment levels, the \$50 copayment and the \$20 copayment, are not more than one-half of the outpatient, in-network medical/surgical benefits subject to a

copayment because they are exactly one-half (\$300x + \$100x = \$400x; \$400x/\$800x = 50%). The combined projected payments for the three highest copayment levels—the \$50 copayment, the \$20 copayment, and the \$15 copayment—are more than one-half of the outpatient, in-network medical/surgical benefits subject to the copayments (\$100x + \$300x + \$200x = \$600x; \$600x/\$800x = 75%). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that is more restrictive than the least restrictive copayment in the combination, the \$15 copayment.

Example 3. (i) Facts. A plan imposes a \$250 deductible on all medical/surgical benefits for self-only coverage and a \$500 deductible on all medical/surgical benefits for family coverage. The plan has no network of providers. For all medical/surgical benefits, the plan imposes a coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 3*, because the plan has no network of providers, all

benefits are provided out-of-network. Because self-only and family coverage are subject to different deductibles, whether the deductible applies to substantially all medical/surgical benefits is determined separately for self-only medical/surgical benefits and family medical/surgical benefits. Because the coinsurance is applied without regard to coverage units, the predominant coinsurance that applies to substantially all medical/surgical benefits is determined without regard to coverage units.

Example 4. (i) Facts. A plan applies the following financial requirements for prescription drug benefits. The requirements are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits. Moreover, the process for certifying a particular drug as “generic”, “preferred brand name”, “non-preferred brand name”, or “specialty” complies with the rules of paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations).

Tier description	Tier 1	Tier 2	Tier 3	Tier 4
	Generic drugs	Preferred brand name drugs	Non-preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)	Specialty drugs
Percent paid by plan	90%	80%	60%	50%

(ii) *Conclusion.* In this *Example 4*, the financial requirements that apply to prescription drug benefits are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits; the process for certifying drugs in different tiers complies with paragraph (c)(4) of this section; and the bases for establishing different levels or types of financial requirements are reasonable. The financial requirements applied to prescription drug benefits do not violate the parity requirements of this paragraph (c)(3).

Example 5. (i) *Facts.* A plan has two-tiers of network of providers: a preferred provider tier and a participating provider tier. Providers are placed in either the preferred tier or participating tier based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section, such as accreditation, quality and performance measures (including customer feedback), and relative reimbursement rates. Furthermore, provider tier placement is determined without regard to whether a provider specializes in the treatment of mental health conditions or substance use disorders, or medical/surgical conditions. The plan divides the in-network classifications into two sub-classifications (in-network/preferred and in-network/participating). The plan does not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in either of these sub-classifications that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in each sub-classification.

(ii) *Conclusion.* In this *Example 5*, the division of in-network benefits into sub-classifications that reflect the preferred and participating provider tiers does not violate the parity requirements of this paragraph (c)(3).

Example 6. (i) *Facts.* With respect to outpatient, in-network benefits, a plan

imposes a \$25 copayment for office visits and a 20 percent coinsurance requirement for outpatient surgery. The plan divides the outpatient, in-network classification into two sub-classifications (in-network office visits and all other outpatient, in-network items and services). The plan or issuer does not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in either of these sub-classifications that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in each sub-classification.

(ii) *Conclusion.* In this *Example 6*, the division of outpatient, in-network benefits into sub-classifications for office visits and all other outpatient, in-network items and services does not violate the parity requirements of this paragraph (c)(3).

Example 7. (i) *Facts.* Same facts as *Example 6*, but for purposes of determining parity, the plan divides the outpatient, in-network classification into outpatient, in-network generalists and outpatient, in-network specialists.

(ii) *Conclusion.* In this *Example 7*, the division of outpatient, in-network benefits into any sub-classifications other than office visits and all other outpatient items and services violates the requirements of paragraph (c)(3)(iii)(C) of this section.

(v) *No separate cumulative financial requirements or cumulative quantitative treatment limitations—*(A) A group health plan (or health insurance coverage offered in connection with a group health plan) may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for

medical/surgical benefits in the same classification.

(B) The rules of this paragraph (c)(3)(v) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a combined annual \$500 deductible on all medical/surgical, mental health, and substance use disorder benefits.

(ii) *Conclusion.* In this *Example 1*, the combined annual deductible complies with the requirements of this paragraph (c)(3)(v).

Example 2. (i) *Facts.* A plan imposes an annual \$250 deductible on all medical/surgical benefits and a separate annual \$250 deductible on all mental health and substance use disorder benefits.

(ii) *Conclusion.* In this *Example 2*, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

Example 3. (i) *Facts.* A plan imposes an annual \$300 deductible on all medical/surgical benefits and a separate annual \$100 deductible on all mental health or substance use disorder benefits.

(ii) *Conclusion.* In this *Example 3*, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

Example 4. (i) *Facts.* A plan generally imposes a combined annual \$500 deductible on all benefits (both medical/surgical benefits and mental health and substance use disorder benefits) except prescription drugs. Certain benefits, such as preventive care, are provided without regard to the deductible. The imposition of other types of financial requirements or treatment limitations varies with each classification. Using reasonable methods, the plan projects its payments for medical/surgical benefits in each classification for the upcoming year as follows:

Classification	Benefits subject to deductible	Total benefits	Percent subject to deductible
Inpatient, in-network	\$1,800x	\$2,000x	90
Inpatient, out-of-network	1,000x	1,000x	100
Outpatient, in-network	1,400x	2,000x	70
Outpatient, out-of-network	1,880x	2,000x	94
Emergency care	300x	500x	60

(ii) *Conclusion.* In this *Example 4*, the two-thirds threshold of the substantially all standard is met with respect to each classification except emergency care because

in each of those other classifications at least two-thirds of medical/surgical benefits are subject to the \$500 deductible. Moreover, the \$500 deductible is the predominant level in

each of those other classifications because it is the only level. However, emergency care mental health and substance use disorder benefits cannot be subject to the \$500

deductible because it does not apply to substantially all emergency care medical/surgical benefits.

(4) *Nonquantitative treatment limitations*—(i) *General rule.* A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification 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.

(ii) *Illustrative list of nonquantitative treatment limitations.* Nonquantitative treatment limitations include—

(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) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(D) Standards for provider admission to participate in a network, including reimbursement rates;

(E) Plan methods for determining usual, customary, and reasonable charges;

(F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(G) Exclusions based on failure to complete a course of treatment; and

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

(iii) *Examples.* The rules of this paragraph (c)(4) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. A plan requires prior authorization from the plan's utilization

reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan.

(ii) *Conclusion.* In this *Example 1*, the plan violates the rules of this paragraph (c)(4) because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits.

Example 2. (i) Facts. A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorders, but only 30 percent of medical/surgical conditions.

(ii) *Conclusion.* In this *Example 2*, the plan complies with the rules of this paragraph (c)(4) because the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.

Example 3. (i) Facts. A plan requires prior approval that a course of treatment is medically necessary for outpatient, in-network medical/surgical, mental health, and substance use disorder benefits and uses comparable criteria in determining whether a course of treatment is medically necessary. For mental health and substance use disorder treatments that do not have prior approval, no benefits will be paid; for medical/surgical treatments that do not have prior approval, there will only be a 25 percent reduction in the benefits the plan would otherwise pay.

(ii) *Conclusion.* In this *Example 3*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical necessity—is applied both to mental health and substance use disorder benefits and to medical/surgical benefits for outpatient, in-network services, it is not applied in a comparable way. The penalty for failure to obtain prior approval for mental health and substance use disorder benefits is not comparable to the penalty for failure to obtain prior approval for medical/surgical benefits.

Example 4. (i) Facts. A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations

made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition.

(ii) *Conclusion.* In this *Example 4*, the plan complies with the rules of this paragraph (c)(4) because the processes for developing the evidentiary standards used to determine medical appropriateness and the application of these standards to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.

Example 5. (i) Facts. A plan generally covers medically appropriate treatments. In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) *Conclusion.* In this *Example 5*, the plan violates the rules of this paragraph (c)(4). Although the standard for applying a nonquantitative treatment limitation is the same for both mental health and substance use disorder benefits and medical/surgical benefits—whether a drug has a black box warning—it is not applied in a comparable manner. The plan's unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning.

Example 6. (i) Facts. An employer maintains both a major medical plan and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical plan only after exhausting the counseling sessions provided by the EAP. No similar exhaustion requirement applies with respect to medical/surgical benefits provided under the major medical plan.

(ii) *Conclusion.* In this *Example 6*, limiting eligibility for mental health and substance use disorder benefits only after EAP benefits are exhausted is a nonquantitative treatment limitation subject to the parity requirements of this paragraph (c). Because no comparable requirement applies to medical/surgical benefits, the requirement may not be applied to mental health or substance use disorder benefits.

Example 7. (i) Facts. Training and State licensing requirements often vary among types of providers. A plan applies a general standard that any provider must meet the highest licensing requirement related to supervised clinical experience under applicable State law in order to participate in the plan's provider network. Therefore, the plan requires master's-level mental health therapists to have post-degree, supervised clinical experience but does not impose this requirement on master's-level general medical providers because the scope of their licensure under applicable State law does require clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or Ph.D. level psychologists since their licensing already requires supervised training.

(ii) *Conclusion.* In this *Example 7*, the plan complies with the rules of this paragraph (c)(4). The requirement that master's-level mental health therapists must have supervised clinical experience to join the network is permissible, as long as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers.

Example 8. (i) Facts. A plan considers a wide array of factors in designing medical management techniques for both mental health and substance use disorder benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these factors in a comparable fashion, prior authorization is required for some (but not all) mental health and substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. For example, the plan requires prior authorization for: outpatient surgery; speech, occupational, physical, cognitive and behavioral therapy extending for more than six months; durable medical equipment; diagnostic imaging; skilled nursing visits; home infusion therapy; coordinated home care; pain management; high-risk prenatal care; delivery by cesarean section; mastectomy; prostate cancer treatment; narcotics prescribed for more than seven days; and all inpatient services beyond 30 days. The evidence considered in developing its medical management techniques includes consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials). This evidence and how it was used to develop these medical management techniques is also well documented by the plan.

(ii) *Conclusion.* In this *Example 8*, the plan complies with the rules of this paragraph (c)(4). Under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its prior authorization requirement with respect to mental health and substance use disorder benefits are comparable to, and applied no

more stringently than, those applied with respect to medical/surgical benefits.

Example 9. (i) Facts. A plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) *Conclusion.* In this *Example 9*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of substance use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

Example 10. (i) Facts. A plan generally provides coverage for medically appropriate medical/surgical benefits as well as mental health and substance use disorder benefits. The plan excludes coverage for inpatient, out-of-network treatment of chemical dependency when obtained outside of the State where the policy is written. There is no similar exclusion for medical/surgical benefits within the same classification.

(ii) *Conclusion.* In this *Example 10*, the plan violates the rules of this paragraph (c)(4). The plan is imposing a nonquantitative treatment limitation that restricts benefits based on geographic location. Because there is no comparable exclusion that applies to medical/surgical benefits, this exclusion may not be applied to mental health or substance use disorder benefits.

Example 11. (i) Facts. A plan requires prior authorization for all outpatient mental health and substance use disorder services after the ninth visit and will only approve up to five additional visits per authorization. With respect to outpatient medical/surgical benefits, the plan allows an initial visit without prior authorization. After the initial visit, the plan pre-approves benefits based on the individual treatment plan recommended by the attending provider based on that individual's specific medical condition. There is no explicit, predetermined cap on the amount of additional visits approved per authorization.

(ii) *Conclusion.* In this *Example 11*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—prior authorization to determine medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits for outpatient services, it is not applied in a comparable way. While the plan is more generous with respect to the number of visits initially provided without pre-authorization for mental health benefits,

treating all mental health conditions and substance use disorders in the same manner, while providing for individualized treatment of medical conditions, is not a comparable application of this nonquantitative treatment limitation.

(5) *Exemptions.* The rules of this paragraph (c) do not apply if a group health plan (or health insurance coverage) satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(d) *Availability of plan information—*
(1) *Criteria for medical necessity determinations.* The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

(2) *Reason for any denial.* The reason for any denial under a group health plan (or health insurance coverage offered in connection with such plan) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in a form and manner consistent with the requirements of § 2560.503–1 of this chapter for group health plans.

(3) *Provisions of other law.* Compliance with the disclosure requirements in paragraphs (d)(1) and (d)(2) of this section is not determinative of compliance with any other provision of applicable Federal or State law. In particular, in addition to those disclosure requirements, provisions of other applicable law require disclosure of information relevant to medical/surgical, mental health, and substance use disorder benefits. For example, ERISA section 104 and § 2520.104b–1 of this chapter provide that, for plans subject to ERISA, instruments under which the plan is established or operated must generally be furnished to plan participants within 30 days of request. Instruments under which the plan is established or operated include documents with 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 nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan. In addition, §§ 2560.503–1 and 2590.715–2719 of this chapter set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with 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 nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

(e) *Applicability*—(1) *Group health plans*. The requirements of this section apply to a group health plan offering medical/surgical benefits and mental health or substance use disorder benefits. If, under an arrangement or arrangements to provide medical care benefits by an employer or employee organization (including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans), any participant (or beneficiary) can simultaneously receive coverage for medical/surgical benefits and coverage for mental health or substance use disorder benefits, then the requirements of this section (including the exemption provisions in paragraph (g) of this section) apply separately with respect to each combination of medical/surgical benefits and of mental health or substance use disorder benefits that any participant (or beneficiary) can simultaneously receive from that employer's or employee organization's arrangement or arrangements to provide medical care benefits, and all such combinations are considered for purposes of this section to be a single group health plan.

(2) *Health insurance issuers*. The requirements of this section apply to a health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits in connection with a group health plan subject to paragraph (e)(1) of this section.

(3) *Scope*. This section does not—

(i) Require a group health plan (or health insurance issuer offering

coverage in connection with a group health plan) to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a plan (or health insurance coverage) for one or more mental health conditions or substance use disorders does not require the plan or health insurance coverage under this section to provide benefits for any other mental health condition or substance use disorder;

(ii) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) that provides coverage for mental health or substance use disorder benefits only to the extent required under PHS Act section 2713 to provide additional mental health or substance use disorder benefits in any classification in accordance with this section; or

(iii) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan (or health insurance coverage) except as specifically provided in paragraphs (b) and (c) of this section.

(4) *Coordination with EHB requirements*. Nothing in paragraph (f) or (g) of this section changes the requirements of 45 CFR 147.150 and 45 CFR 156.115, providing that a health insurance issuer offering non-grandfathered health insurance coverage in the individual or small group market providing mental health and substance use disorder services, including behavioral health treatment services, as part of essential health benefits required under 45 CFR 156.110(a)(5) and 156.115(a), must comply with the provisions of 45 CFR 146.136 to satisfy the requirement to provide essential health benefits.

(f) *Small employer exemption*—(1) *In general*. The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (f), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (or one in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year. See section 732(a) of ERISA and § 2590.732(b), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering

coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size*. For purposes of paragraph (f)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Code are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(g) *Increased cost exemption*—(1) *In general*. If the application of this section to a group health plan (or health insurance coverage offered in connection with such plans) results in an increase for the plan year involved of the actual total cost of coverage with respect to medical/surgical benefits and mental health and substance use disorder benefits as determined and certified under paragraph (g)(3) of this section by an amount that exceeds the applicable percentage described in paragraph (g)(2) of this section of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for one plan year. An employer or issuer may elect to continue to provide mental health and substance use disorder benefits in compliance with this section with respect to the plan or coverage involved regardless of any increase in total costs.

(2) *Applicable percentage*. With respect to a plan or coverage, the applicable percentage described in this paragraph (g) is—

(i) 2 percent in the case of the first plan year in which this section is applied to the plan or coverage; and

(ii) 1 percent in the case of each subsequent plan year.

(3) *Determinations by actuaries*—(i) Determinations as to increases in actual costs under a plan or coverage that are attributable to implementation of the requirements of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations must be based on the formula specified in paragraph (g)(4) of

this section and shall be in a written report prepared by the actuary.

(ii) The written report described in paragraph (g)(3)(i) of this section shall be maintained by the group health plan or health insurance issuer, along with all supporting documentation relied upon by the actuary, for a period of six years following the notification made under paragraph (g)(6) of this section.

(4) *Formula.* The formula to be used to make the determination under paragraph (g)(3)(i) of this section is expressed mathematically as follows:

$$[(E_1 - E_0)/T_0] - D > k$$

(i) E_1 is the actual total cost of coverage with respect to mental health and substance use disorder benefits for the base period, including claims paid by the plan or issuer with respect to mental health and substance use disorder benefits and administrative costs (amortized over time) attributable to providing these benefits consistent with the requirements of this section.

(ii) E_0 is the actual total cost of coverage with respect to mental health and substance use disorder benefits for the length of time immediately before the base period (and that is equal in length to the base period), including claims paid by the plan or issuer with respect to mental health and substance use disorder benefits and administrative costs (amortized over time) attributable to providing these benefits.

(iii) T_0 is the actual total cost of coverage with respect to all benefits during the base period.

(iv) k is the applicable percentage of increased cost specified in paragraph (g)(2) of this section that will be expressed as a fraction for purposes of this formula.

(v) D is the average change in spending that is calculated by applying the formula $(E_1 - E_0)/T_0$ to mental health and substance use disorder spending in each of the five prior years and then calculating the average change in spending.

(5) *Six month determination.* If a group health plan or health insurance issuer seeks an exemption under this paragraph (g), determinations under paragraph (g)(3) of this section shall be made after such plan or coverage has complied with this section for at least the first 6 months of the plan year involved.

(6) *Notification.* A group health plan or health insurance issuer that, based on the certification described under paragraph (g)(3) of this section, qualifies for an exemption under this paragraph (g), and elects to implement the exemption, must notify participants and beneficiaries covered under the plan,

the Secretary, and the appropriate State agencies of such election.

(i) *Participants and beneficiaries—(A) Content of notice.* The notice to participants and beneficiaries must include the following information:

(1) A statement that the plan or issuer is exempt from the requirements of this section and a description of the basis for the exemption.

(2) The name and telephone number of the individual to contact for further information.

(3) The plan or issuer name and plan number (PN).

(4) The plan administrator's name, address, and telephone number.

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (g)(6)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN).

(6) The effective date of such exemption.

(7) A statement regarding the ability of participants and beneficiaries to contact the plan administrator or health insurance issuer to see how benefits may be affected as a result of the plan's or issuer's election of the exemption.

(8) A statement regarding the availability, upon request and free of charge, of a summary of the information on which the exemption is based (as required under paragraph (g)(6)(i)(D) of this section).

(B) *Use of summary of material reductions in covered services or benefits.* A plan or issuer may satisfy the requirements of paragraph (g)(6)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (g)(6)(i)(C) of this section) with a summary of material reductions in covered services or benefits consistent with § 2520.104b-3(d) of this chapter that also includes the information specified in paragraph (g)(6)(i)(A) of this section. However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (g)(6)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (29 U.S.C.

1024(b)(1)) and its implementing regulations (for example, first-class mail). If the notice is provided to the participant and any beneficiaries at the participant's last known address, then the requirements of this paragraph (g)(6)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the

participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Availability of documentation.* The plan or issuer must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. (For purposes of this paragraph (g), an individual who is not a participant or beneficiary and who presents a notice described in paragraph (g)(6)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (g)(6)(i) of this section with any personally identifiable information redacted.) The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan or coverage absent amendments required to comply with paragraphs (b) and (c) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any personally identifiable information.

(ii) *Federal agencies—(A) Content of notice.* The notice to the Secretary must include the following information:

(1) A description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost exemption under this paragraph (g) by such plan (or coverage);

(2) For both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical/surgical benefits and mental health and substance use disorder benefits; and

(3) For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(B) *Reporting.* A group health plan, and any health insurance coverage offered in connection with a group health plan, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (g)(6)(ii)(A) of this section identifying

the benefit package to which the exemption applies.

(iii) *Confidentiality.* A notification to the Secretary under this paragraph (g)(6) shall be confidential. The Secretary shall make available, upon request and not more than on an annual basis, an anonymous itemization of each notification that includes—

(A) A breakdown of States by the size and type of employers submitting such notification; and

(B) A summary of the data received under paragraph (g)(6)(ii) of this section.

(iv) *Audits.* The Secretary may audit the books and records of a group health plan or a health insurance issuer relating to an exemption, including any actuarial reports, during the 6 year period following notification of such exemption under paragraph (g)(6) of this section. A State agency receiving a notification under paragraph (g)(6) of this section may also conduct such an audit with respect to an exemption covered by such notification.

(h) *Sale of nonparity health insurance coverage.* A health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with paragraph (b) or (c) of this section, except to a plan for a year for which the plan is exempt from the requirements of this section because the plan meets the requirements of paragraph (f) or (g) of this section.

(i) *Applicability dates—(1) In general.* Except as provided in paragraph (i)(2) of this section, this section applies to group health plans and health insurance issuers offering group health insurance coverage on the first day of the first plan year beginning on or after July 1, 2014. Until the applicability date, plans and issuers are required to continue to comply with the corresponding sections of 29 CFR 2590.712 contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2013.

(2) *Special effective date for certain collectively-bargained plans.* For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan (or health insurance coverage offered in connection with the plan) for plan years beginning before the date on which the last of the collective bargaining agreements terminates (determined without regard to any extension agreed to after October 3, 2008).

■ 3. Section 2590.715–2719 is amended by adding a sentence to the end of the introductory text of paragraph (d) and revising paragraph (d)(1)(i) to read as follows:

§ 2590.712 Internal claims and appeals and external review processes.

* * * * *

(d) * * * A Multi State Plan or MSP, as defined by 45 CFR 800.20, must provide an effective Federal external review process in accordance with this paragraph (d).

(1) * * *

(i) *In general.* Subject to the suspension provision in paragraph (d)(1)(ii) of this section and except to the extent provided otherwise by the Secretary in guidance, the Federal external review process established pursuant to this paragraph (d) applies, at a minimum, to any adverse benefit determination or final internal adverse benefit determination (as defined in paragraphs (a)(2)(i) and (a)(2)(v) of this section), except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for the Federal external review process under this paragraph (d).

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Department of Health and Human Services

45 CFR Subtitle A

For the reasons set forth in the preamble, the Department of Health and Human Services adopts as final the interim final rule with comment period amending 45 CFR part 146, which was published on February 2, 2010, in the **Federal Register** at 75 FR 5410, with the following changes, and further amends part 147 as set forth below:

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ 1. The authority citation for Part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92).

■ 2. Section 146.136 is revised to read as follows:

§ 146.136 Parity in mental health and substance use disorder benefits.

(a) *Meaning of terms.* For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or health

insurance coverage offered in connection with such a plan) for any coverage unit.

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.

Coverage unit means coverage unit as described in paragraph (c)(1)(iv) of this section.

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.)

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.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

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).

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).

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).

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, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

(b) *Parity requirements with respect to aggregate lifetime and annual dollar limits.* This paragraph (b) details the application of the parity requirements with respect to aggregate lifetime and annual dollar limits. This paragraph (b) does not address the provisions of PHS Act section 2711, which prohibit imposing lifetime and annual limits on the dollar value of essential health benefits. For more information, see § 147.126 of this subchapter.

(1) *General*—(i) *General parity requirement.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraph (b)(2), (b)(3), or (b)(5) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan (or health insurance coverage) satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or health insurance

coverage) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan (or health insurance coverage) includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or

(ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. (For cumulative limits other than aggregate lifetime or annual dollar limits, see paragraph (c)(3)(v) of this section prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.)

(4) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits 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 aggregate lifetime or annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(5) *Plan not described in paragraph (b)(2) or (b)(3) of this section*—(i) *In general.* A group health plan (or health insurance coverage) that is not described in paragraph (b)(2) or (b)(3) of this section with respect to aggregate lifetime or annual dollar limits on medical/surgical benefits, must either—

(A) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or

(B) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(5)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated dollar limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(5), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(4) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(c) *Parity requirements with respect to financial requirements and treatment limitations*—(1) *Clarification of terms*—(i) *Classification of benefits.* When reference is made in this paragraph (c) to a classification of benefits, the term “classification” means a classification as described in paragraph (c)(2)(ii) of this section.

(ii) *Type of financial requirement or treatment limitation.* When reference is made in this paragraph (c) to a type of financial requirement or treatment limitation, the reference to type means its nature. Different types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits. See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.

(iii) *Level of a type of financial requirement or treatment limitation.* When reference is made in this paragraph (c) to a level of a type of financial requirement or treatment

limitation, level refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent; different levels of a copayment include \$15 and \$20; different levels of a deductible include \$250 and \$500; and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

(iv) *Coverage unit.* When reference is made in this paragraph (c) to a coverage unit, 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.

(2) *General parity requirement—(i) General rule.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The application of the rules of this paragraph (c)(2) to financial requirements and quantitative treatment limitations is addressed in paragraph (c)(3) of this section; the application of the rules of this paragraph (c)(2) to nonquantitative treatment limitations is addressed in paragraph (c)(4) of this section.

(ii) *Classifications of benefits used for applying rules—(A) In general.* If a plan (or health insurance coverage) provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits. To the extent that a

plan (or health insurance coverage) provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, the rules of this paragraph (c) apply separately with respect to that classification for all financial requirements or treatment limitations (illustrated in examples in paragraph (c)(2)(ii)(C) of this section). The following classifications of benefits are the only classifications used in applying the rules of this paragraph (c):

(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. See special rules for plans with multiple network tiers in paragraph (c)(3)(iii) of this section.

(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.

(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.

(4) *Outpatient, out-of-network.* Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers. See special rules for office visits in paragraph (c)(3)(iii) of this section.

(5) *Emergency care.* Benefits for emergency care.

(6) *Prescription drugs.* Benefits for prescription drugs. See special rules for multi-tiered prescription drug benefits in paragraph (c)(3)(iii) of this section.

(B) *Application to out-of-network providers.* See paragraph (c)(2)(ii)(A) of this section, under which a plan (or health insurance coverage) that provides mental health or substance use disorder benefits in any classification of benefits must provide mental health or substance use disorder benefits in every classification in which medical/surgical benefits are provided, including out-of-network classifications.

(C) *Examples.* The rules of this paragraph (c)(2)(ii) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. A group health plan offers inpatient and outpatient benefits and does not contract with a network of providers. The plan imposes a \$500 deductible on all benefits. For inpatient medical/surgical benefits, the plan imposes a coinsurance requirement. For outpatient medical/surgical benefits, the plan imposes copayments. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 1*, because the plan has no network of providers, all benefits provided are out-of-network. Because inpatient, out-of-network medical/surgical benefits are subject to separate financial requirements from outpatient, out-of-network medical/surgical benefits, the rules of this paragraph (c) apply separately with respect to any financial requirements and treatment limitations, including the deductible, in each classification.

Example 2. (i) Facts. A plan imposes a \$500 deductible on all benefits. The plan has no network of providers. The plan generally imposes a 20 percent coinsurance requirement with respect to all benefits, without distinguishing among inpatient, outpatient, emergency care, or prescription drug benefits. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 2*, because the plan does not impose separate financial requirements (or treatment limitations) based on classification, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance across all benefits.

Example 3. (i) Facts. Same facts as *Example 2*, except the plan exempts emergency care benefits from the 20 percent coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 3*, because the plan imposes separate financial requirements based on classifications, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance separately for—

(A) Benefits in the emergency care classification; and

(B) All other benefits.

Example 4. (i) Facts. Same facts as *Example 2*, except the plan also imposes a preauthorization requirement for all inpatient treatment in order for benefits to be paid. No such requirement applies to outpatient treatment.

(ii) *Conclusion.* In this *Example 4*, because the plan has no network of providers, all benefits provided are out-of-network. Because the plan imposes a separate treatment limitation based on classifications, the rules of this paragraph (c) apply with respect to the deductible and coinsurance separately for—

- (A) Inpatient, out-of-network benefits; and
 (B) All other benefits.

(3) *Financial requirements and quantitative treatment limitations*—(i) *Determining “substantially all” and “predominant”*—(A) *Substantially all*. For purposes of this paragraph (c), a type of financial requirement or quantitative treatment limitation 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. (For this purpose, benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation.) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

(B) *Predominant*—(1) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation 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 or quantitative treatment limitation.

(2) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan (or health insurance issuer) may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less

restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(C) *Portion based on plan payments*. For purposes of this paragraph (c), the determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation).

(D) *Clarifications for certain threshold requirements*. For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied. For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Similar rules apply for any other thresholds at which the rate of plan payment changes. (See also PHS Act section 2707(b) and Affordable Care Act section 1302(c), which establish limitations on annual deductibles for non-grandfathered health plans in the small group market and annual limitations on out-of-pocket maximums for all non-grandfathered health plans.)

(E) *Determining the dollar amount of plan payments*. Subject to paragraph (c)(3)(i)(D) of this section, any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation).

(ii) *Application to different coverage units*. If a plan (or health insurance coverage) applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits, the predominant level that applies to substantially all medical/surgical

benefits in the classification is determined separately for each coverage unit.

(iii) *Special rules*—(A) *Multi-tiered prescription drug benefits*. If a plan (or health insurance coverage) applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations) and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the plan (or health insurance coverage) satisfies the parity requirements of this paragraph (c) with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

(B) *Multiple network tiers*. If a plan (or health insurance coverage) provides benefits through multiple tiers of in-network providers (such as an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers), the plan may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or mental health or substance use disorder benefits. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder 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 using the methodology set forth in paragraph (c)(3)(i) of this section.

(C) *Sub-classifications permitted for office visits, separate from other outpatient services*. For purposes of applying the financial requirement and treatment limitation rules of this paragraph (c), a plan or issuer may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this paragraph (c)(3)(iii)(C). After the sub-classifications are established, the plan or issuer may not impose any financial

requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph (c)(3)(i) of this section. Sub-classifications other than these special rules, such as separate sub-

classifications for generalists and specialists, are not permitted. The two sub-classifications permitted under this paragraph (c)(3)(iii)(C) are:

(1) Office visits (such as physician visits), and

(2) All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

(iv) *Examples.* The rules of paragraphs (c)(3)(i), (c)(3)(ii), and

(c)(3)(iii) of this section are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. For inpatient, out-of-network medical/surgical benefits, a group health plan imposes five levels of coinsurance. Using a reasonable method, the plan projects its payments for the upcoming year as follows:

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

The plan projects plan costs of \$800x to be subject to coinsurance (\$100x + \$450x + \$100x + \$150x = \$800x). Thus, 80 percent (\$800x/\$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25 percent of the benefits subject to coinsurance are projected to be subject to the 15 percent coinsurance level.

(ii) *Conclusion.* In this *Example 1*, the two-thirds threshold of the substantially all

standard is met for coinsurance because 80 percent of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15 percent coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to

inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15 percent level of coinsurance.

Example 2. (i) Facts. For outpatient, in-network medical/surgical benefits, a plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

Copayment amount	\$0	\$10	\$15	\$20	\$50	Total.
Projected payments	\$200x	\$200x	\$200x	\$300x	\$100x	\$1,000x.
Percent of total plan costs	20%	20%	20%	30%	10%	
Percent subject to copayments	N/A	25%	25%	37.5%	12.5%	
		(200x/800x)	(200x/800x)	(300x/800x)	(100x/800x)	

The plan projects plan costs of \$800x to be subject to copayments (\$200x + \$200x + \$300x + \$100x = \$800x). Thus, 80 percent (\$800x/\$1,000x) of the benefits are projected to be subject to a copayment.

(ii) *Conclusion.* In this *Example 2*, the two-thirds threshold of the substantially all standard is met for copayments because 80 percent of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to a copayment (for the \$10 copayment, 25%; for the \$15 copayment, 25%; for the \$20 copayment, 37.5%; and for the \$50 copayment, 12.5%). The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to mental health or substance use disorder benefits. If the plan combines the highest levels of copayment, the combined projected payments for the two highest copayment levels, the \$50 copayment and the \$20 copayment, are not more than one-half of the outpatient, in-network medical/surgical benefits subject to a

copayment because they are exactly one-half (\$300x + \$100x = \$400x; \$400x/\$800x = 50%). The combined projected payments for the three highest copayment levels—the \$50 copayment, the \$20 copayment, and the \$15 copayment—are more than one-half of the outpatient, in-network medical/surgical benefits subject to the copayments (\$100x + \$300x + \$200x = \$600x; \$600x/\$800x = 75%). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that is more restrictive than the least restrictive copayment in the combination, the \$15 copayment.

Example 3. (i) Facts. A plan imposes a \$250 deductible on all medical/surgical benefits for self-only coverage and a \$500 deductible on all medical/surgical benefits for family coverage. The plan has no network of providers. For all medical/surgical benefits, the plan imposes a coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion.* In this *Example 3*, because the plan has no network of providers, all

benefits are provided out-of-network. Because self-only and family coverage are subject to different deductibles, whether the deductible applies to substantially all medical/surgical benefits is determined separately for self-only medical/surgical benefits and family medical/surgical benefits. Because the coinsurance is applied without regard to coverage units, the predominant coinsurance that applies to substantially all medical/surgical benefits is determined without regard to coverage units.

Example 4. (i) Facts. A plan applies the following financial requirements for prescription drug benefits. The requirements are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits. Moreover, the process for certifying a particular drug as “generic”, “preferred brand name”, “non-preferred brand name”, or “specialty” complies with the rules of paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations).

Tier description	Tier 1	Tier 2	Tier 3	Tier 4
	Generic drugs	Preferred brand name drugs	Non-preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)	Specialty drugs
Percent paid by plan	90%	80%	60%	50%

(ii) *Conclusion.* In this *Example 4*, the financial requirements that apply to prescription drug benefits are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits; the process for certifying drugs in different tiers complies with paragraph (c)(4) of this section; and the bases for establishing different levels or types of financial requirements are reasonable. The financial requirements applied to prescription drug benefits do not violate the parity requirements of this paragraph (c)(3).

Example 5. (i) *Facts.* A plan has two-tiers of network of providers: A preferred provider tier and a participating provider tier. Providers are placed in either the preferred tier or participating tier based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section, such as accreditation, quality and performance measures (including customer feedback), and relative reimbursement rates. Furthermore, provider tier placement is determined without regard to whether a provider specializes in the treatment of mental health conditions or substance use disorders, or medical/surgical conditions. The plan divides the in-network classifications into two sub-classifications (in-network/preferred and in-network/participating). The plan does not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in either of these sub-classifications that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in each sub-classification.

(ii) *Conclusion.* In this *Example 5*, the division of in-network benefits into sub-classifications that reflect the preferred and participating provider tiers does not violate the parity requirements of this paragraph (c)(3).

Example 6. (i) *Facts.* With respect to outpatient, in-network benefits, a plan

imposes a \$25 copayment for office visits and a 20 percent coinsurance requirement for outpatient surgery. The plan divides the outpatient, in-network classification into two sub-classifications (in-network office visits and all other outpatient, in-network items and services). The plan or issuer does not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in either of these sub-classifications that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in each sub-classification.

(ii) *Conclusion.* In this *Example 6*, the division of outpatient, in-network benefits into sub-classifications for office visits and all other outpatient, in-network items and services does not violate the parity requirements of this paragraph (c)(3).

Example 7. (i) *Facts.* Same facts as *Example 6*, but for purposes of determining parity, the plan divides the outpatient, in-network classification into outpatient, in-network generalists and outpatient, in-network specialists.

(ii) *Conclusion.* In this *Example 7*, the division of outpatient, in-network benefits into any sub-classifications other than office visits and all other outpatient items and services violates the requirements of paragraph (c)(3)(iii)(C) of this section.

(v) *No separate cumulative financial requirements or cumulative quantitative treatment limitations—*(A) A group health plan (or health insurance coverage offered in connection with a group health plan) may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for

medical/surgical benefits in the same classification.

(B) The rules of this paragraph (c)(3)(v) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a combined annual \$500 deductible on all medical/surgical, mental health, and substance use disorder benefits.

(ii) *Conclusion.* In this *Example 1*, the combined annual deductible complies with the requirements of this paragraph (c)(3)(v).

Example 2. (i) *Facts.* A plan imposes an annual \$250 deductible on all medical/surgical benefits and a separate annual \$250 deductible on all mental health and substance use disorder benefits.

(ii) *Conclusion.* In this *Example 2*, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

Example 3. (i) *Facts.* A plan imposes an annual \$300 deductible on all medical/surgical benefits and a separate annual \$100 deductible on all mental health or substance use disorder benefits.

(ii) *Conclusion.* In this *Example 3*, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

Example 4. (i) *Facts.* A plan generally imposes a combined annual \$500 deductible on all benefits (both medical/surgical benefits and mental health and substance use disorder benefits) except prescription drugs. Certain benefits, such as preventive care, are provided without regard to the deductible. The imposition of other types of financial requirements or treatment limitations varies with each classification. Using reasonable methods, the plan projects its payments for medical/surgical benefits in each classification for the upcoming year as follows:

Classification	Benefits subject to deductible	Total benefits	Percent subject to deductible
Inpatient, in-network	\$1,800x	\$2,000x	90
Inpatient, out-of-network	1,000x	1,000x	100
Outpatient, in-network	1,400x	2,000x	70
Outpatient, out-of-network	1,880x	2,000x	94
Emergency care	300x	500x	60

(ii) *Conclusion.* In this *Example 4*, the two-thirds threshold of the substantially all standard is met with respect to each classification except emergency care because

in each of those other classifications at least two-thirds of medical/surgical benefits are subject to the \$500 deductible. Moreover, the \$500 deductible is the predominant level in

each of those other classifications because it is the only level. However, emergency care mental health and substance use disorder benefits cannot be subject to the \$500

deductible because it does not apply to substantially all emergency care medical/surgical benefits.

(4) *Nonquantitative treatment limitations*—(i) *General rule.* A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification 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.

(ii) *Illustrative list of nonquantitative treatment limitations.* Nonquantitative treatment limitations include—

(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) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(D) Standards for provider admission to participate in a network, including reimbursement rates;

(E) Plan methods for determining usual, customary, and reasonable charges;

(F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(G) Exclusions based on failure to complete a course of treatment; and

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

(iii) *Examples.* The rules of this paragraph (c)(4) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) Facts. A plan requires prior authorization from the plan's utilization

reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan.

(ii) *Conclusion.* In this *Example 1*, the plan violates the rules of this paragraph (c)(4) because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits.

Example 2. (i) Facts. A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorders, but only 30 percent of medical/surgical conditions.

(ii) *Conclusion.* In this *Example 2*, the plan complies with the rules of this paragraph (c)(4) because the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.

Example 3. (i) Facts. A plan requires prior approval that a course of treatment is medically necessary for outpatient, in-network medical/surgical, mental health, and substance use disorder benefits and uses comparable criteria in determining whether a course of treatment is medically necessary. For mental health and substance use disorder treatments that do not have prior approval, no benefits will be paid; for medical/surgical treatments that do not have prior approval, there will only be a 25 percent reduction in the benefits the plan would otherwise pay.

(ii) *Conclusion.* In this *Example 3*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical necessity—is applied both to mental health and substance use disorder benefits and to medical/surgical benefits for outpatient, in-network services, it is not applied in a comparable way. The penalty for failure to obtain prior approval for mental health and substance use disorder benefits is not comparable to the penalty for failure to obtain prior approval for medical/surgical benefits.

Example 4. (i) Facts. A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations

made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition.

(ii) *Conclusion.* In this *Example 4*, the plan complies with the rules of this paragraph (c)(4) because the processes for developing the evidentiary standards used to determine medical appropriateness and the application of these standards to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.

Example 5. (i) Facts. A plan generally covers medically appropriate treatments. In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) *Conclusion.* In this *Example 5*, the plan violates the rules of this paragraph (c)(4). Although the standard for applying a nonquantitative treatment limitation is the same for both mental health and substance use disorder benefits and medical/surgical benefits—whether a drug has a black box warning—it is not applied in a comparable manner. The plan's unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning.

Example 6. (i) Facts. An employer maintains both a major medical plan and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical plan only after exhausting the counseling sessions provided by the EAP. No similar exhaustion requirement applies with respect to medical/surgical benefits provided under the major medical plan.

(ii) *Conclusion.* In this *Example 6*, limiting eligibility for mental health and substance use disorder benefits only after EAP benefits are exhausted is a nonquantitative treatment limitation subject to the parity requirements of this paragraph (c). Because no comparable requirement applies to medical/surgical benefits, the requirement may not be applied to mental health or substance use disorder benefits.

Example 7. (i) Facts. Training and State licensing requirements often vary among types of providers. A plan applies a general standard that any provider must meet the highest licensing requirement related to supervised clinical experience under applicable State law in order to participate in the plan's provider network. Therefore, the plan requires master's-level mental health therapists to have post-degree, supervised clinical experience but does not impose this requirement on master's-level general medical providers because the scope of their licensure under applicable State law does require clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or Ph.D. level psychologists since their licensing already requires supervised training.

(ii) *Conclusion.* In this *Example 7*, the plan complies with the rules of this paragraph (c)(4). The requirement that master's-level mental health therapists must have supervised clinical experience to join the network is permissible, as long as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers.

Example 8. (i) Facts. A plan considers a wide array of factors in designing medical management techniques for both mental health and substance use disorder benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these factors in a comparable fashion, prior authorization is required for some (but not all) mental health and substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. For example, the plan requires prior authorization for: Outpatient surgery; speech, occupational, physical, cognitive and behavioral therapy extending for more than six months; durable medical equipment; diagnostic imaging; skilled nursing visits; home infusion therapy; coordinated home care; pain management; high-risk prenatal care; delivery by cesarean section; mastectomy; prostate cancer treatment; narcotics prescribed for more than seven days; and all inpatient services beyond 30 days. The evidence considered in developing its medical management techniques includes consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials). This evidence and how it was used to develop these medical management techniques is also well documented by the plan.

(ii) *Conclusion.* In this *Example 8*, the plan complies with the rules of this paragraph (c)(4). Under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its prior authorization requirement with respect to mental health and substance use disorder benefits are comparable to, and applied no

more stringently than, those applied with respect to medical/surgical benefits.

Example 9. (i) Facts. A plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) *Conclusion.* In this *Example 9*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of substance use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

Example 10. (i) Facts. A plan generally provides coverage for medically appropriate medical/surgical benefits as well as mental health and substance use disorder benefits. The plan excludes coverage for inpatient, out-of-network treatment of chemical dependency when obtained outside of the State where the policy is written. There is no similar exclusion for medical/surgical benefits within the same classification.

(ii) *Conclusion.* In this *Example 10*, the plan violates the rules of this paragraph (c)(4). The plan is imposing a nonquantitative treatment limitation that restricts benefits based on geographic location. Because there is no comparable exclusion that applies to medical/surgical benefits, this exclusion may not be applied to mental health or substance use disorder benefits.

Example 11. (i) Facts. A plan requires prior authorization for all outpatient mental health and substance use disorder services after the ninth visit and will only approve up to five additional visits per authorization. With respect to outpatient medical/surgical benefits, the plan allows an initial visit without prior authorization. After the initial visit, the plan pre-approves benefits based on the individual treatment plan recommended by the attending provider based on that individual's specific medical condition. There is no explicit, predetermined cap on the amount of additional visits approved per authorization.

(ii) *Conclusion.* In this *Example 11*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—prior authorization to determine medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits for outpatient services, it is not applied in a comparable way. While the plan is more generous with respect to the number of visits initially provided without pre-authorization for mental health benefits,

treating all mental health conditions and substance use disorders in the same manner, while providing for individualized treatment of medical conditions, is not a comparable application of this nonquantitative treatment limitation.

(5) *Exemptions.* The rules of this paragraph (c) do not apply if a group health plan (or health insurance coverage) satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(d) *Availability of plan information—*
(1) *Criteria for medical necessity determinations.* The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

(2) *Reason for any denial.* The reason for any denial under a group health plan (or health insurance coverage offered in connection with such plan) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary. For this purpose, a non-Federal governmental plan (or health insurance coverage offered in connection with such plan) that provides the reason for the claim denial in a form and manner consistent with the requirements of 29 CFR 2560.503-1 for group health plans complies with the requirements of this paragraph (d)(2).

(3) *Provisions of other law.* Compliance with the disclosure requirements in paragraphs (d)(1) and (d)(2) of this section is not determinative of compliance with any other provision of applicable Federal or State law. In particular, in addition to those disclosure requirements, provisions of other applicable law require disclosure of information relevant to medical/surgical, mental health, and substance use disorder benefits. For example, § 147.136 of this subchapter sets forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies

of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with 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 nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

(e) *Applicability*—(1) *Group health plans*. The requirements of this section apply to a group health plan offering medical/surgical benefits and mental health or substance use disorder benefits. If, under an arrangement or arrangements to provide medical care benefits by an employer or employee organization (including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans), any participant (or beneficiary) can simultaneously receive coverage for medical/surgical benefits and coverage for mental health or substance use disorder benefits, then the requirements of this section (including the exemption provisions in paragraph (g) of this section) apply separately with respect to each combination of medical/surgical benefits and of mental health or substance use disorder benefits that any participant (or beneficiary) can simultaneously receive from that employer's or employee organization's arrangement or arrangements to provide medical care benefits, and all such combinations are considered for purposes of this section to be a single group health plan.

(2) *Health insurance issuers*. The requirements of this section apply to a health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits in connection with a group health plan subject to paragraph (e)(1) of this section.

(3) *Scope*. This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a plan (or health insurance coverage) for one or more mental health conditions or substance use disorders does not require the plan or health insurance coverage under this section to provide benefits for any other mental health condition or substance use disorder;

(ii) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) that provides coverage for mental health or substance use disorder benefits only to the extent required under PHS Act section 2713 to provide additional mental health or substance use disorder benefits in any classification in accordance with this section; or

(iii) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan (or health insurance coverage) except as specifically provided in paragraphs (b) and (c) of this section.

(4) *Coordination with EHB requirements*. Nothing in paragraph (f) or (g) of this section changes the requirements of §§ 147.150 and 156.115 of this subchapter, providing that a health insurance issuer offering non-grandfathered health insurance coverage in the individual or small group market providing mental health and substance use disorder services, including behavioral health treatment services, as part of essential health benefits required under §§ 156.110(a)(5) and 156.115(a) of this subchapter, must comply with the provisions of this section to satisfy the requirement to provide essential health benefits.

(f) *Small employer exemption*—(1) *In general*. The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer (as defined in section 2791 of the PHS Act).

(2) *Rules in determining employer size*. For purposes of paragraph (f)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(g) *Increased cost exemption*—(1) *In general*. If the application of this section to a group health plan (or health insurance coverage offered in connection with such plans) results in an increase for the plan year involved of

the actual total cost of coverage with respect to medical/surgical benefits and mental health and substance use disorder benefits as determined and certified under paragraph (g)(3) of this section by an amount that exceeds the applicable percentage described in paragraph (g)(2) of this section of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for one plan year. An employer or issuer may elect to continue to provide mental health and substance use disorder benefits in compliance with this section with respect to the plan or coverage involved regardless of any increase in total costs.

(2) *Applicable percentage*. With respect to a plan or coverage, the applicable percentage described in this paragraph (g) is—

(i) 2 percent in the case of the first plan year in which this section is applied to the plan or coverage; and

(ii) 1 percent in the case of each subsequent plan year.

(3) *Determinations by actuaries*—(i) Determinations as to increases in actual costs under a plan or coverage that are attributable to implementation of the requirements of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations must be based on the formula specified in paragraph (g)(4) of this section and shall be in a written report prepared by the actuary.

(ii) The written report described in paragraph (g)(3)(i) of this section shall be maintained by the group health plan or health insurance issuer, along with all supporting documentation relied upon by the actuary, for a period of six years following the notification made under paragraph (g)(6) of this section.

(4) *Formula*. The formula to be used to make the determination under paragraph (g)(3)(i) of this section is expressed mathematically as follows:

(i) E_1 is the actual total cost of coverage with respect to mental health and substance use disorder benefits for the base period, including claims paid by the plan or issuer with respect to mental health and substance use disorder benefits and administrative costs (amortized over time) attributable to providing these benefits consistent with the requirements of this section.

(ii) E_0 is the actual total cost of coverage with respect to mental health and substance use disorder benefits for the length of time immediately before the base period (and that is equal in

length to the base period), including claims paid by the plan or issuer with respect to mental health and substance use disorder benefits and administrative costs (amortized over time) attributable to providing these benefits.

(iii) T_0 is the actual total cost of coverage with respect to all benefits during the base period.

(iv) k is the applicable percentage of increased cost specified in paragraph (g)(2) of this section that will be expressed as a fraction for purposes of this formula.

(v) D is the average change in spending that is calculated by applying the formula $(E_1 - E_0)/T_0$ to mental health and substance use disorder spending in each of the five prior years and then calculating the average change in spending.

(5) *Six month determination.* If a group health plan or health insurance issuer seeks an exemption under this paragraph (g), determinations under paragraph (g)(3) of this section shall be made after such plan or coverage has complied with this section for at least the first 6 months of the plan year involved.

(6) *Notification.* A group health plan or health insurance issuer that, based on the certification described under paragraph (g)(3) of this section, qualifies for an exemption under this paragraph (g), and elects to implement the exemption, must notify participants and beneficiaries covered under the plan, the Secretary, and the appropriate State agencies of such election.

(i) *Participants and beneficiaries—(A) Content of notice.* The notice to participants and beneficiaries must include the following information:

(1) A statement that the plan or issuer is exempt from the requirements of this section and a description of the basis for the exemption.

(2) The name and telephone number of the individual to contact for further information.

(3) The plan or issuer name and plan number (PN).

(4) The plan administrator's name, address, and telephone number.

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (g)(6)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN).

(6) The effective date of such exemption.

(7) A statement regarding the ability of participants and beneficiaries to contact the plan administrator or health insurance issuer to see how benefits may be affected as a result of the plan's or issuer's election of the exemption.

(8) A statement regarding the availability, upon request and free of charge, of a summary of the information on which the exemption is based (as required under paragraph (g)(6)(i)(D) of this section).

(B) *Use of summary of material reductions in covered services or benefits.* A plan or issuer may satisfy the requirements of paragraph (g)(6)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (g)(6)(i)(C) of this section) with a summary of material reductions in covered services or benefits consistent with 29 CFR 2520.104b-3(d) that also includes the information specified in paragraph (g)(6)(i)(A) of this section. However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (g)(6)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (29 U.S.C. 1024(b)(1)) and its implementing regulations (for example, first-class mail). If the notice is provided to the participant and any beneficiaries at the participant's last known address, then the requirements of this paragraph (g)(6)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Availability of documentation.* The plan or issuer must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. (For purposes of this paragraph (g), an individual who is not a participant or beneficiary and who presents a notice described in paragraph (g)(6)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (g)(6)(i) of this section with any personally identifiable information redacted.) The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan or coverage absent amendments required to comply with paragraphs (b) and (c) of this section, the administrative costs related to those claims, and other administrative costs

attributable to complying with the requirements of this section. In no event should the summary of information include any personally identifiable information.

(ii) *Federal agencies—(A) Content of notice.* The notice to the Secretary must include the following information:

(1) A description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost exemption under this paragraph (g) by such plan (or coverage);

(2) For both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical/surgical benefits and mental health and substance use disorder benefits; and

(3) For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(B) *Reporting by health insurance coverage offered in connection with a church plan.* See 26 CFR 54.9812(g)(6)(ii)(B) for delivery with respect to church plans.

(C) *Reporting by health insurance coverage offered in connection with a group health plans subject to Part 7 of Subtitle B of Title I of ERISA.* See 29 CFR 2590.712(g)(6)(ii) for delivery with respect to group health plans subject to ERISA.

(D) *Reporting with respect to non-Federal governmental plans and health insurance issuers in the individual market.* A group health plan that is a non-Federal governmental plan, or a health insurance issuer offering health insurance coverage in the individual market, claiming the exemption of this paragraph (g) for any benefit package must provide notice to the Department of Health and Human Services. This requirement is satisfied if the plan or issuer sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (g)(6)(ii)(A) of this section identifying the benefit package to which the exemption applies.

(iii) *Confidentiality.* A notification to the Secretary under this paragraph (g)(6) shall be confidential. The Secretary shall make available, upon request and not more than on an annual basis, an anonymous itemization of each notification that includes—

(A) A breakdown of States by the size and type of employers submitting such notification; and

(B) A summary of the data received under paragraph (g)(6)(ii) of this section.

(iv) *Audits.* The Secretary may audit the books and records of a group health plan or a health insurance issuer relating to an exemption, including any actuarial reports, during the 6 year period following notification of such exemption under paragraph (g)(6) of this section. A State agency receiving a notification under paragraph (g)(6) of this section may also conduct such an audit with respect to an exemption covered by such notification.

(h) *Sale of nonparity health insurance coverage.* A health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with paragraph (b) or (c) of this section, except to a plan for a year for which the plan is exempt from the requirements of this section because the plan meets the requirements of paragraph (f) or (g) of this section.

(i) *Applicability dates—(1) In general.* Except as provided in paragraph (i)(2) of this section, this section applies to group health plans and health insurance issuers offering group health insurance coverage on the first day of the first plan year beginning on or after July 1, 2014. Until the applicability date, plans and issuers are required to continue to comply with the corresponding sections of § 146.136 contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2013.

(2) *Special effective date for certain collectively-bargained plans.* For a group health plan maintained pursuant to one or more collective bargaining

agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan (or health insurance coverage offered in connection with the plan) for plan years beginning before the date on which the last of the collective bargaining agreements terminates (determined without regard to any extension agreed to after October 3, 2008).

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKETS

■ 3. The authority citation for part 147 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

■ 4. Section 147.136 is amended by adding a sentence to the end of the introductory text of paragraph (d) and revising paragraph (d)(1)(i) to read as follows:

§ 147.136 Internal claims and appeals and external review processes.

* * * * *

(d) * * * A Multi State Plan or MSP, as defined by 45 CFR 800.20, must provide an effective Federal external review process in accordance with this paragraph (d).

(1) * * *

(i) *In general.* Subject to the suspension provision in paragraph (d)(1)(ii) of this section and except to the extent provided otherwise by the Secretary in guidance, the Federal

external review process established pursuant to this paragraph (d) applies, at a minimum, to any adverse benefit determination or final internal adverse benefit determination (as defined in paragraphs (a)(2)(i) and (a)(2)(v) of this section), except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for the Federal external review process under this paragraph (d).

* * * * *

■ 5. Section 147.160 is added to read as follows:

§ 147.160 Parity in mental health and substance use disorder benefits.

(a) *In general.* The provisions of § 146.136 of this subchapter apply to health insurance coverage offered by health insurance issuer in the individual market in the same manner and to the same extent as such provisions apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the large group market.

(b) *Applicability date.* The provisions of this section apply for policy years beginning on or after the applicability dates set forth in § 146.136(i) of this subchapter. This section applies to non-grandfathered and grandfathered health plans as defined in § 147.140.

[FR Doc. 2013-27086 Filed 11-8-13; 11:15 am]

BILLING CODE 4830-01; 4510-29; 4120-01-P

APPENDIX B

MHPAEA Enforcement Fact Sheet

MHPAEA ENFORCEMENT FACT SHEET

*United States Department of Labor
Employee Benefits Security Administration*

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act (“MHPAEA”) provides important protections for individuals with mental health and substance use disorder conditions. The statutory provisions became effective for plan years beginning on or after October 3, 2009. The Department published interim final regulations effective for plan years beginning on or after July 1, 2010 and final regulations became effective for plan years beginning on or after July 1, 2014.

Since October 2010, EBSA has conducted over 1,500 investigations related to MHPAEA and cited over 170 violations for noncompliance with these rules.

Examples of MHPAEA Violations

Insufficient Benefits

- Not offering out-of-network providers or inpatient benefits to treat mental health or substance use disorders even though these benefits are available for medical/surgical benefits.

Higher Financial Requirements

- Charging higher copays to see mental health providers than those charged for medical/surgical providers.

More Restrictive Quantitative Treatment Limitations (QTLs)

- Imposing visit limits on mental health benefits that are more restrictive than those applied to medical/surgical visits.

More Restrictive Non-Quantitative Treatment Limitations (NQTLs)

- Imposing broad preauthorization requirements on all mental health and substance use disorder treatments, even though these same plans only required pre-authorization on a select few medical/surgical treatments.
- Requiring written treatment plans for mental health services while not requiring similar plans to receive medical/surgical treatment.

Lower Annual Dollar Limits on Benefits

- Imposing annual dollar limits on coverage of mental health benefits when such limitations are not imposed on medical/surgical benefits.

Inadequate Disclosures

- Not disclosing the criteria used for determining medical necessity and/or reasons for benefit denials.

EBSA Process for Addressing MHPAEA Violations



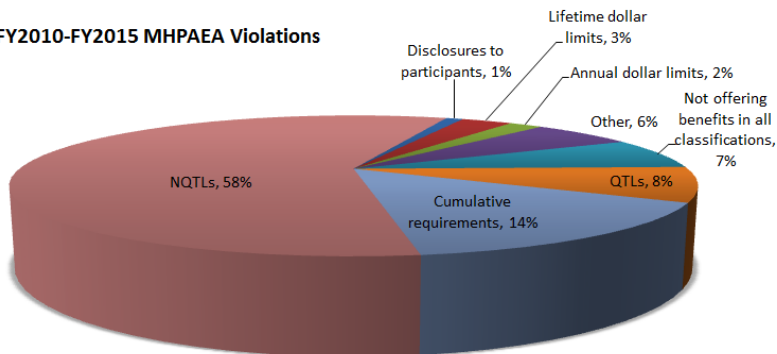
EBSA receives inquiries from participants all over the country who believe their mental health benefits were denied improperly. If the facts suggest the problem affects multiple people, EBSA may refer the issue for investigation.

To achieve the greatest impact, EBSA works with plans and their service providers to find other improperly denied claims and correct the problem for all those affected.

EBSA's New York Regional Office assisted a participant whose plan was not crediting mental health benefit payments towards their annual out-of-pocket maximum. EBSA's Benefit Advisor explained the relevant provisions of the law to plan officials. As a result, the plan reprocessed claims and paid more than \$35,000 in wrongfully denied benefits to five plan participants.

EBSA has worked with several large insurance companies to remove impermissible barriers to mental health benefits such as restrictive written treatment plan requirements and overly broad preauthorization requirements. These global changes have impacted hundreds of thousands of group health plans and millions of participants.

FY2010-FY2015 MHPAEA Violations



Need Help with Your Employee Benefits?

Contact EBSA

U.S. Department of Labor
 Frances Perkins Building, 200
 Constitution Ave., NW, Washington, DC
 20210
www.dol.gov
 Telephone: 1-866-444-EBSA (3272)

APPENDIX C

MHPAEA Compliance Study



**U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy**

**CONSISTENCY OF LARGE EMPLOYER
AND GROUP HEALTH PLAN BENEFITS
WITH REQUIREMENTS OF THE
PAUL WELLSTONE AND
PETE DOMENICI MENTAL HEALTH
PARITY AND ADDICTION EQUITY
ACT OF 2008**

November 2013

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract between HHS's ASPE/DALTCP and NORC at the University of Chicago. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/office_specific/daltcp.cfm or contact the ASPE Project Officer, Kirsten Beronio, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Kirsten.Beronio@hhs.gov.

**CONSISTENCY OF LARGE EMPLOYER AND GROUP
HEALTH PLAN BENEFITS WITH REQUIREMENTS OF
THE PAUL WELLSTONE AND PETE DOMENICI
MENTAL HEALTH PARITY AND ADDICTION
EQUITY ACT OF 2008**

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ACRONYMS

ABA	applied behavioral analysis
ABD	adverse benefit determination
ASAM	American Society of Addiction Medicine
BLS	DOL Bureau of Labor Statistics
CBO	Congressional Budget Office
CHIP	Children's Health Insurance Program
CMS	HHS Centers for Medicare and Medicaid Services
DOL	U.S. Department of Labor
DRG	diagnosis-related group
E&M	evaluation and management
ECT	electroconvulsive therapy
EHB	essential health benefit
EOB	explanation of benefit
ER	emergency room
ERISA	Employee Retirement Income Security Act
FEHBP	Federal Employee Health Benefit Plan
GAO	U.S. Government Accountability Office (previously General Accounting Office)
HHS	U.S. Department of Health and Human Services
HRET	Health Research and Education Trust
IFR	Interim Final Rule
IOP	intensive outpatient program
IP INN MH	Inpatient In-Network Mental Health
IP INN SUD	Inpatient In-Network Substance Use Disorder
IP OON MH	Inpatient Out-of-Network Mental Health
IP OON SUD	Inpatient Out-of-Network Substance Use Disorder
KFF	Kaiser Family Foundation
MBHO	managed behavioral healthcare organization
MH	mental health
MHPAEA	Mental Health Parity and Addiction Equity Act

NAICS	North American Industry Classification System
NCS	National Compensation Survey
NQTL	non-quantitative treatment limitation
OOP	out-of-pocket
OP INN MH	Outpatient In-Network Mental Health
OP INN SUD	Outpatient In-Network Substance Use Disorder
OP OON MH	Outpatient Out-of-Network Mental Health
OP OON SUD	Outpatient Out-of-Network Substance Use Disorder
OP OV INN MH	Outpatient Office Visit In-Network Mental Health
OP OV INN SUD	Outpatient Office Visit In-Network Substance Use Disorder
OP OV OON MH	Outpatient Office Visit Out-of-Network Mental Health
OP OV OON SUD	Outpatient Office Visit Out-of-Network Substance Use Disorder
OP-Other INN MH	Outpatient-Other In-Network Mental Health
OP-Other INN SUD	Outpatient-Other In-Network Substance Use Disorder
OP-Other OON MH	Outpatient-Other Out-of-Network Mental Health
OP-Other OON SUD	Outpatient-Other Out-of-Network Substance Use Disorder
PBM	pharmacy benefits management
PCP	primary care physician
PDD	Plan Design Database
PHS Act	Public Health Service Act
PMPM	per member per month
PPACA	Patient Protection and Affordable Care Act
QTL	quantitative treatment limitation
RFI	Request for Information
RTF	residential treatment facility
Rx	prescription drug
SCP	specialty care physician
SMI	serious mental illness
SNF	skilled nursing facility
SPD	summary plan description
SUD	substance use disorder
UCR	usual, customary, and reasonable

EXECUTIVE SUMMARY

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 was signed into law on October 3, 2008, and became effective for plan years beginning on or after October 3, 2009.¹ The history of parity legislation shows that implementation of requirements in this area is not always straightforward and ensuring equitable treatment of mental health (MH) and substance use disorder (SUD) treatment is often complicated. The Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services contracted with NORC at the University of Chicago to study how health plans and insurers have responded to MHPAEA in the first years after its effective date. NORC led a research team that included Milliman Inc., Aon Hewitt, Thomson Reuters/Truven Health Analytics, and George Washington University to perform an analysis of adherence to the MHPAEA and the Interim Final Rule (IFR)² among Employee Retirement Income Security Act (ERISA)-governed employer-sponsored group health plans and health insurance coverage offered in connection with such group health plans. Our analysis includes information from a variety of existing and complementary data sources, including MHPAEA testing databases compiled by both Milliman Inc. and Aon Hewitt, data from Aon Hewitt's Plan Design Database (PDD) which contains more than 10,000 unique plan designs for more than 300 employer clients, Summary Plan Descriptions of midsized establishments obtained from the U.S. Department of Labor (DOL) Bureau of Labor Statistics (BLS), and published and unpublished data from national employer health benefits surveys conducted by the Kaiser Family Foundation and Health Research and Educational Trust (KFF/HRET)³ and Mercer.⁴ To assess plan responses to MHPAEA's disclosure requirements, semi-structured interviews were conducted with a small number of health plan representatives who were responsible for their plans' compliance with MHPAEA.

The evaluation studied seven questions. The results are summarized below.

- 1. What types of financial requirements (e.g., copays, coinsurance) do group health plans use for MH/SUD benefits, and are such requirements consistent with the new MHPAEA standards for calculating the predominant level that applies to substantially all medical and surgical benefits?**
 - Inpatient.** According to Milliman's analysis of health plans in a representative sample of large group plans offered in 2010, 10% of large employers' behavioral health benefits had inpatient financial requirements that needed modification to comply with MHPAEA. In Aon Hewitt's analysis of large group plans offered in 2011, virtually all large employers' plans had inpatient benefit designs that conformed to MHPAEA standards. Aon Hewitt's analysis of changes in plan design between 2009 and 2011

showed that use of higher copays and coinsurance for inpatient MH/SUD decreased rapidly in large employers' plans following the implementation of MHPAEA.

A preliminary analysis of a small sample of behavioral health benefits offered by midsized employers indicates that those benefits appear to have followed a similar trajectory. Before the implementation of MHPAEA, between 10% and 16% of midsized plans in our sample appeared to offer inpatient financial requirements that did not appear to conform to MHPAEA standards. Following the implementation of parity, less than 7% of plans in our sample continued to do so.

- **Outpatient.** Deviations from MHPAEA standards for outpatient behavioral health benefits were substantially higher than for inpatient benefits. More than 30% of large employers' plans in Milliman's 2010 sample utilized copays or coinsurance rates for outpatient benefits that were inconsistent with MHPAEA standards. In-network outpatient benefits were more likely to be inconsistent with MHPAEA requirements than out-of-network MH/SUD outpatient benefits.

In Aon Hewitt's 2011 sample, fewer plans had unequal MH/SUD outpatient coverage. However, about one-fifth continued to utilize outpatient in-network copays that failed to meet MHPAEA standards. Year-by-year analyses from 2009 to 2011 confirm a dramatic decline in the use of more restrictive coinsurance, copays and other financial requirements for MH/SUD, but a minority of plans continued in 2011 to impose higher cost-sharing, especially for in-network outpatient MH/SUD treatment.

In our limited sample of plans offered by midsized employers prior to MHPAEA, one-half used higher cost-sharing for MH/SUD. After the effective date of MHPAEA, many plans offered by midsized businesses eliminated unequal cost-sharing for out-of-network MH/SUD outpatient treatment. But over 40% in our sample continued to have higher copays or coinsurance for in-network MH/SUD outpatient services than for medical/surgical primary care physician (PCP) visits. If the persistence of unequal financial requirements are borne out, that may suggest a need for greater education, oversight and accountability.

- **Emergency Care and Prescriptions.** In Milliman's sample of 2010 plan designs, the vast majority of plans offered to employees of large businesses provided prescription coverage that met MHPAEA standards for cost-sharing. But one-fifth required higher cost-sharing for behavioral health emergency services than other medical emergencies. The most commonly identified issue was higher coinsurance rates for emergency MH/SUD care. All of the 2011 plans examined by Aon Hewitt provided both emergency and

prescription coverage that appeared to comply with MHPAEA's cost-sharing standards.

The 2010 Mercer Survey found that only 3% of employers surveyed reported decreasing or planning to decrease copays or coinsurance rates in response to MHPAEA. Analyses of Milliman, Aon Hewitt, and BLS data suggest that these estimates are much lower than the actual percentage of plans that modified their copay and coinsurance rates during this time period, suggesting that some employers may not attribute changes in their health plan offerings during this time period to changes mandated by MHPAEA.

2. **What types of quantitative treatment limitations (QTLs) (e.g., day limits, visit limits) do group health plans use for MH/SUD, and are such limitations consistent with the MHPAEA standards?**

- **Inpatient.** In Milliman's sample of 2010 large group plans, nearly every plan offered by large employers used quantity and visit limits on MH inpatient benefits that conformed to MHPAEA standards. Inpatient SUD treatment was much more likely to be limited in ways that appeared to be inconsistent with MHPAEA. In 2010, almost 20% of these plans imposed more restrictive in-network SUD inpatient day limits than they did for medical/surgical benefits. In Aon Hewitt's sample of 2011 plan designs, fewer plans seemed to use unequal day and dollar limits for inpatient benefits. None imposed unequal dollar limits on MH/SUD inpatient treatment, and less than 8% had unequal day limits. The year-by-year analysis of the Aon Hewitt PDD (2009-2011) confirmed a dramatic decline in the proportion of plans with more restrictive inpatient MH/SUD benefits, with the greatest drop detected in the use of unequal day limits, from 50% in 2009 to 10% in 2010.

Analyses of information from our limited sample of midsized employer data suggests a similar pattern. In 2008, 84% of midsized employers' plans in our sample used inpatient day limitations that were more restrictive for MH/SUD conditions than for medical/surgical conditions. By 2011, the percentage of plans in our sample offering more restrictive MH/SUD day limitations had dropped to 13%.

- **Outpatient.** A similar pattern of increasing adherence to MHPAEA standards was found on the outpatient side. In Milliman's sample of 2010 plan designs, more than 50% of plans utilized unequal visit limits for MH/SUD services. In Aon Hewitt's sample of 2011 plan designs, less than 7% of the plans used unequal visit limits. Likewise, in Milliman's sample of 2010 plans, 30% of plans utilized unequal dollar limits. In Aon Hewitt's 2011 sample virtually all plans had equalized dollar limits for outpatient MH/SUD and medical care. The year-by-year analyses of the Aon Hewitt

PDD confirm substantial reductions in QTLs for MH/SUD on the plans offered by large employers following the introduction of MHPAEA.

MH/SUD benefits offered by mid-sized employers in our limited sample show a similar pattern to that of the large employer plans. In 2008, 81% used outpatient visit limitations that were more restrictive for MH/SUD than medical/surgical services. In 2011, only 13% of plans in our sample still used visit limitations that were more restrictive for MH/SUD than medical/surgical services.

Large, representative surveys of employers corroborate our detailed analyses of benefits. The 2010 KFF/HRET found that more than one-fifth of all firms claimed to have eliminated limits in coverage in response to MHPAEA. In the 2010 Mercer Survey, 17% of firms claimed to have removed QTLs in response to MHPAEA.

- **Emergency Care and Prescriptions.** Analyses of both 2010 and 2011 data suggests that 100% of participating plans offered emergency room (ER) and prescription benefits that appeared to conform to MHPAEA's treatment limitation requirements.

3. **What types of non-quantitative treatment limitations (NQTLs) are commonly used by plans and issuers for MH/SUD and how do these compare to NQTLs in place for medical/surgical benefits?**

Plan use of the six NQTL classifications outlined in the IFR (medical management standards; prescription drug formularies; network admission; usual, customary, and reasonable (UCR) payment amounts; step-therapy protocols; and requirements for patients to complete a course of treatment in order for payment to be provided) is almost universal. Our analysis indicated that plans frequently employ NQTLs for behavioral health conditions that are more restrictive than those used for other medical/surgical conditions. Analyses of large employer benefits in 2010 found numerous examples of NQTLs that were stricter for MH/SUD than for medical/surgical services. Some of the most common NQTLs include MH/SUD precertification requirements that were more stringent than medical/surgical requirements (28% of tested plans), medical necessity criteria that were applied to MH/SUD benefits but not to medical/surgical benefits (8% of tested plans), the use of routine retrospective reviews for MH/SUD services, and not for medical/surgical services, and reimbursement rates that were based on lower percentages of UCR rates for MH/SUD services than those provided for medical/surgical services. Mercer's 2010 employer survey found that 8% of employers reported adding or increasing their use of utilization management techniques in response to MHPAEA.

4. **Are group health plans and insurers using separate deductibles for MH/SUD benefits?**

Very few health plans offered by large employers used separate deductibles for MH/SUD and medical/surgical care after the IFR was released. In 2010, 3.2% of plans utilized separate deductibles for MH/SUD benefits in which MH/SUD out-of-pocket costs did not accumulate toward a single deductible combined with their medical/surgical benefits. In 2011, only 1.3% of plans in the Aon Hewitt sample employed separate deductibles for MH/SUD. Among midsized employers' plans in our limited sample, fewer than 3% appeared to use separate deductibles in the post-parity period (2009-2011).

5. **Have financial requirements and treatment limits on medical/surgical benefits become more restrictive in order to achieve parity, instead of requirements and limits for MH/SUD becoming less restrictive?**

We did not find any evidence that any plan had increased medical/surgical financial requirements in order to achieve parity.

6. **How many plans have eliminated MH/SUD treatment coverage altogether instead of complying with MHPAEA?**

There appears to be consistent evidence that a very small number of employers or health plans responded to MHPAEA by eliminating MH/SUD treatment coverage. In the Milliman dataset, no plan that offered MH/SUD benefits in 2009 failed to offer them in 2010/2011. The 2010 KFF/HRET and 2010 Mercer surveys report that fewer than 2% of firms having more than 50 workers, dropped coverage of MH/SUD benefits.

7. **How have plans responded to MHPAEA's requirements regarding the disclosure of medical necessity criteria and reasons for claim denials?**

- Each of the health plans representatives interviewed as part of this project reported using detailed medical necessity criteria that are applied to both MH/SUD conditions and medical/surgical conditions. A majority of respondents reported using standard criteria such as those provided by McKesson Interqual and the American Society of Addiction Medicine but several noted that they also use other criteria if required by specific employer contracts. Most health plan respondents reported that the scientific contents of the medical necessity criteria for MH/SUD coverage have not changed as a result of the parity law but some respondents reported that their application of the medical necessity criteria has been decreased to match their use for medical/surgical conditions. Overall, respondents reported that individual plan members and their health care providers can receive a copy of the plan's medical necessity criteria upon

request. One company makes medical necessity criteria publicly available on its website.

- Officials from the companies interviewed as part of this project stated that the Patient Protection and Affordable Care Act (PPACA), not MHPAEA, has been driving changes in their claim denials procedures. The PPACA, DOL rules, and state laws explicitly dictate the content and timing of claim denial letters. These laws and rules apply to both behavioral health and other medical services. Many of the requirements precede MHPAEA. If a claim is denied, a letter is sent to the member and to the provider or facility. The letter explains the reason for the denial and may also cite the medical necessity criteria used for the decision.

Taken as a whole, analyses presented in this report show that employers and health plans have made substantial changes to their plan designs in order to meet the standards set out by MHPAEA and the IFR. By 2011, ERISA-governed group health plans and health insurance offered in connection with group health plans seem to have removed most financial requirements that did not meet MHPAEA standards. Nearly all had eliminated the use of separate deductibles for MH/SUD treatment and medical/surgical treatment, although few were in use prior to the MHPAEA IFR. The number of plans that apply unequal inpatient day limits, outpatient visit limits or other QTLs for MH/SUD has dropped substantially, though a minority persist with limited, unequal MH/SUD benefits.

Although we document substantial changes since the enactment of MHPAEA, a substantial minority of employers and health plans were still offering benefits that were inconsistent with MHPAEA and the IFR in 2011. One out of five large employers required higher copays for in-network outpatient MH/SUD services than for equivalent medical/surgical treatments. Coinsurance was higher for in-network outpatient MH/SUD services than for medical/surgical services in 4% of large employers' plans. Among our limited sample of mid-sized plans, over 40% required greater cost-sharing for in-network outpatient MH/SUD office visits than for PCP office visits. And although the percentage of plans with more restrictive treatment limitations dropped substantially since the introduction of MHPAEA, a minority of plans in our post-parity sample, between 7% and 9%, still covered fewer MH and SUD inpatient days annually and fewer MH and SUD outpatient visits annually than they covered for medical/surgical conditions.

Assessing consistency with MHPAEA for NQTLs is difficult based on document reviews and self-report from employers and plans. Our analyses uncovered numerous areas that warrant more intensive investigation. We assessed NQTLs through a detailed review of plan documents and responses from an extensive questionnaire administered by Aon Hewitt to plans' MH/SUD and medical/surgical vendors. For example, in 2010, nearly three in ten plans used more stringent precertification and utilization management controls for MH/SUD than for medical/surgical conditions. Network management processes were inconsistent, with different standards and processes for including MH/SUD providers in plans' network than were used for

medical/surgical providers. MH/SUD provider reimbursement rates were sometimes found to be set at a lower percentage of prevailing community rates than comparable medical/surgical rates. Rates were sometimes determined by the plan based on its internal data, but set medical/surgical reimbursement rates from external, multi-payer databases.

Although we were able to identify areas where the application of NQTLs appeared to be inconsistent with the IFR, it is likely that our reliance on these limited sources of information drawn primarily from large employers' health plans resulted in a significant under-identification of problematic NQTLs. A careful, in-depth and longitudinal monitoring of plans' NQTL policies and practices would likely turn up correctable problems that our analysis could not detect. For example, the California Department of Mental Health's processes for monitoring plans' compliance with California's Mental Health Parity Act included onsite surveys, reviews of claims files, utilization review files, and internal management and performance reports. California was able to detect patterns in practice that could not be identified from the kind of reviews undertaken in the current report: plans incorrectly denying coverage for ER visits; plans failing to monitor whether beneficiaries had reasonable access to after-hours services; and plans failing to include required information in claim denial letters.⁵

Some concerns about the impact of MHPAEA were not borne out in our analyses. A very small proportion of employers, between 1% and 2%, claimed to have dropped or were planning to drop coverage for MH/SUD, or for specific MH/SUD diagnoses as a result of MHPAEA. No employers reduced medical/surgical benefits to comply with parity. A very small percentage excluded specific treatments, and most of those were for learning disabilities, developmental delays, and court-ordered services. We did not detect any movement to exclude residential or intensive outpatient services.

INTRODUCTION

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 was signed into law on October 3, 2008, and became effective for plan years beginning on or after October 3, 2009.⁶ For employers and group health insurance plans with more than 50 employees that offer coverage for mental illness and substance use disorders (SUDs), the law requires that coverage be no more restrictive than that for other medical and surgical procedures covered by the plan. MHPAEA does not require group health plans to cover mental health (MH) and SUD benefits, but when plans do cover these benefits, they must be covered at levels that are comparable to coverage levels for medical and surgical benefits offered by the plan. Specifically, MHPAEA renewed a preexisting requirement that employers and group health insurance plans eliminate more restrictive annual and lifetime dollar limits on MH coverage and MHPAEA added this requirement to SUD coverage as well. Furthermore, MHPAEA requires that employers and group health plans that provide both MH/SUD services and medical/surgical benefits ensure that:

- The financial requirements applicable to such MH or SUD benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost-sharing requirements that are applicable only to MH or SUD benefits.⁷
- The treatment limitations applicable to such MH or SUD benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only to MH or SUD benefits.⁸

MHPAEA also includes requirements that group health plans make available information related to MH/SUD medical necessity criteria and reasons for any denials for MH/SUD services. If requested, medical necessity criteria must be provided to plan administrators (or offerors), potential participants, beneficiaries, and contracting providers. In addition, if requested, explanations of denials must be provided to participants or beneficiaries.⁹

After extensive public comment, the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the Department of the Treasury released an Interim Final Rule (IFR)¹⁰ on February 2, 2010. The IFR provided guidance on the application of parity to financial, quantitative, and non-quantitative treatment limitations (NQTLs) and went into effect for plan years beginning on or after July 1, 2010. The IFR clarified several uncertainties:¹¹

- *Deductibles and out-of-pocket limits.* The IFR prohibited separately accumulating (separate but equal) financial requirements (e.g., deductibles) and quantitative treatment limitations (QTLs).
- *Separate coverage or benefits packages.* Even though behavioral health benefits are sometimes carved out and administered by a separate insurer, each combination of plan offerings must have parity in behavioral health benefits when considered as a whole.
- *Financial requirements and quantitative treatment limitations (i.e., limits that can be expressed numerically as a dollar, a percentage, or number of visits or episodes).* The compliance standard is that a particular type of financial requirement or QTLs (e.g., copays vs. coinsurance or limits on the number of outpatient visits) must apply to substantially all (i.e., at least two-thirds) of the medical/surgical benefits in a classification before it may be applied to MH/SUD benefits in that classification. If the requirement applies to at least two-thirds of all medical/surgical benefits in a classification, the permissible level of that financial requirement or treatment limit is set by determining the predominant level that applies to at least 50% of the medical/surgical benefits subject to that type of requirement or limit.
- *Non-quantitative treatment limitations (i.e., limits not expressed numerically that otherwise limit the scope or duration of benefits).* NQTLs include but are not limited to medical management standards; prescription drug formulary designs; standards for provider admission to participate in a network; determination of usual, customary, and reasonable (UCR) amounts; requirements for using lower-cost therapies before a plan will cover more expensive therapies; and conditional benefits based on completion of a course of treatment. The IFR requires that any processes, strategies, evidentiary standards, or other factors used in applying an NQTL to MH or SUD benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits, except to the extent that recognized clinically appropriate standards of care may permit a difference.
- *Classification of benefits.* Six benefit classifications are specified in the IFR, with parity required for each: inpatient in-network, inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency care; and prescription drugs. On July 1, 2010, DOL released “safe harbor” guidance that allows for the creation of office visit and outpatient/other (non-office visit) sub-classes within the outpatient classifications of benefits.
- *Interaction with state insurance laws.* MHPAEA does not supersede state parity law unless state law prevents the application of a MHPAEA requirement.

- *Availability of Plan Information.* The IFR specifies that group plans governed by the Employee Retirement Income Security Act (ERISA) must follow the ERISA claims procedure regulations that provide, for example, that such reasons for claims denials must be provided automatically and free of charge. Other plans are encouraged to follow the ERISA requirements.

Application of the MHPAEA to Insurance and Health Plan Markets. Whether the MHPAEA applies to a particular insurance or health plan market depends both on whether the governing law applies its terms to the insurance market in question and on whether exemptions apply.¹²

1. ***ERISA-governed fully-insured group health benefit plans and ERISA-governed self-insured group health benefit plans.*** MHPAEA applies to all ERISA-governed group health plans and health insurance offered in connection with group health plans that offer coverage for both medical and surgical benefits and MH or substance abuse disorder benefits.¹³ MHPAEA also applies to group health plans and health insurance offered in connection with such plans in the non-ERISA market.¹⁴ Thus, MHPAEA applies to group health plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully-insured arrangements. MHPAEA also applies to health insurance issuers who sell coverage to employers with more than 50 employees. MHPAEA exempts small employers (i.e., employers having an average of 50 or fewer employees).¹⁵ Under the Patient Protection and Affordable Care Act (PPACA), the small employer exemption in the Public Health Service (PHS) Act is increased to 100 or fewer employees.¹⁶ DOL has determined that this upward revision in the PPACA of the size of small employer groups for PHS Act purposes does not affect ERISA-governed plans, whose small employer exemption remains at 50.¹⁷
2. ***State-regulated insurance products sold in the small group health or individual markets.*** HHS has proposed¹⁸ to incorporate the MHPAEA requirements into the essential health benefit (EHB) requirements for coverage of MH and SUD benefits under the PPACA.¹⁹ According to this interpretation, the MHPAEA compliance will be a required feature of all health insurance plans sold in the individual and small group markets starting in 2014.²⁰
3. ***The state health insurance exchange market established under the PPACA.*** Because PPACA applies MHPAEA to all qualified health plans, health plans sold in state health insurance exchanges will be required to comply with federal parity requirements.
4. ***The Medicaid market, consisting of Medicaid fee-for-service, Medicaid managed care, Medicaid benchmark plans, and the separately administered Children's Health Insurance Program (CHIP) market.*** MHPAEA is incorporated by legislative reference into Medicaid, but only for certain forms of Medicaid coverage such as Medicaid Managed Care. MHPAEA also is

incorporated by legislative reference into CHIP, although in states in which CHIP operates as a Medicaid expansion, the Medicaid expansion component of CHIP would be subject to Medicaid standards rather than to standards applicable to separately administered CHIP programs.²¹ MHPAEA also applies to Medicaid benchmark (a.k.a. alternative benefit plans) that will be offered by states that opt to extend Medicaid coverage to the low-income childless adult population as authorized by the PPACA.

5. ***The Medicare Market, including the fee-for-service market and the Medicare Advantage market.*** MHPAEA is not incorporated by reference into the Medicare statute. A limited provision aimed at removing Medicare's longstanding more restrictive treatment limitation for outpatient treatment of MH conditions was enacted into law by section 102 of the Medicare Improvements for Patients and Providers Act of 2008. This provision amended Medicare to phase out the law's historic outpatient MH treatment limitation over a 5-year period between 2010 and 2014.²² As the Centers for Medicare and Medicaid Services (CMS) notes in interpretive policies, this change means that beginning January 1, 2014, Medicare will pay 80% of the physician fee schedule for covered services and 80% of the encounter rate for covered treatments in federally qualified health centers and rural health clinics subject to their upper payment limit.²³ With respect to the Medicare Advantage market, CMS interpretive regulations²⁴ clarify that Medicare Advantage organizations offering special needs plans will be expected to comply with parity requirements. Whether the CMS definition of parity for Medicare Advantage Special Needs Plan purposes parallels that adopted in the IFR rule is not clear. MHPAEA does not apply to "stand alone" Medicare Advantage plans or Medicare fee-for-service plans.
6. ***Church plans.*** Because of their ERISA exemption, church plans are not affected by the MHPAEA's ERISA requirements. However, to the extent that an ERISA-exempt church purchases a product through a state health insurance exchange, or a state-regulated group insurance product governed by the PHS Act, the product would be subject to parity requirements, unless the church is otherwise exempt under state law.
7. ***Non-Federal Government health plans offered to state and local public employees.*** Non-Federal Government health plans are likewise ERISA-exempt, but their coverage would be subject to the MHPAEA's PHS Act provisions, whose scope reaches both the insurance market and non-Federal Government plans. At the same time, the law permits non-federally administered self-insured government health plans to opt out of these provisions.²⁵
8. ***TriCare (the health program for uniformed service members, retirees, and their families) and the Federal Employee Health Benefit Plan (FEHBP).*** Although there is not a specific legislative requirement applying MHPAEA to the FEHBP program, these requirements do apply to the FEHBP through Executive Order and incorporation of these requirements into the purchasing and coverage

standards issued by the Office of Personnel Management. MHPAEA does not generally apply to TriCare. The U.S. Department of Defense has not incorporated the MHPAEA's provisions into their purchasing and coverage standards.

Table 1 summarizes the applicability of the MHPAEA to 14 distinct insurance and health plan markets.

TABLE 1. Legal Application of the MHPAEA to 14 Distinct Public and Private Insurer/Employer-Sponsored Health Plan Markets	
Market	Yes/No
1. ERISA-governed self-insured health benefit plans	Yes, MHPAEA and ERISA amendments apply; cost exemptions may apply, and size exemptions would apply in the case of small ERISA plans (fewer than 50 employees) that self-insure.
2. ERISA-governed fully-insured health benefit plans	Yes, MHPAEA, PHS Act, and ERISA amendments apply; employer size and cost exemptions apply.
3. State-regulated group and individual insurance markets	Yes, MHPAEA applies to health insurance issuers who sell coverage to employers with more than 50 employees and MHPAEA standards will extend to both the small group and individual markets through PPACA provisions and EHB requirements.
4. Medicaid fee-for-service	No, CMS Medicaid standards apply.
5. Medicaid managed care	Yes, CMS Medicaid managed care standards apply.
6. Medicaid benchmark plans	Yes, CMS benchmark standards apply.
7. Separately administered CHIP plans	Yes, MHPAEA standards apply.
8. Medicare fee-for-service market	No, CMS Medicare standards apply.
9. Medicare Advantage	No, CMS Medicare standards apply.
10. State health insurance exchanges	Yes, MHPAEA standards apply.
11. FEHBP	No, but FEHBP policies apply; FEHBP has explicitly adopted MHPAEA.
12. TriCare	No, TriCare standards apply; MHPAEA not adopted.
13. Church plans	No, churches are exempt from ERISA requirements, but PHS standards would apply to insured products unless churches have a state exemption.
14. Non-federal public employee health benefit plans	Yes, covered by the MHPAEA's PHS Act provisions, but plan sponsors may opt out.

BRIEF REVIEW OF THE EXISTING LITERATURE

Necessity of Compliance Testing. The history of parity legislation shows that implementation of requirements in this area is not always straightforward and ensuring equitable treatment of MH and SUD treatment is often complicated. Experience with implementation of the Mental Health Parity Act of 1996²⁶ is a case in point. The 1996 Act mandated elimination of unequal annual and lifetime dollar limits on MH coverage in employer-sponsored and group health insurance plans. Compliance monitoring found that most health plans complied by eliminating dollar limits but increased restrictions on the number of hospital days or outpatient visits for MH services.²⁷ Findings reported by the U.S. Government Accountability Office (GAO) are representative. Of 863 employer plans responding to its 1999 survey:

- 14% of employers had not complied with the law by 1999.²⁸
- 51% reduced the number of outpatient visits covered.
- 36% reduced hospital days covered.
- 20% increased outpatient visit copayments.
- 18% increased the cap on enrollee out-of-pocket costs.²⁹

Research studies focusing on implementation of previous parity requirements such as those applied to FEHBP can complement our other sources of information and enhance our understanding of the impact of MHPAEA.

FEHBP Parity. Monitoring of FEHBP parity implementation^{30,31} revealed that all FEHBPs complied with parity, that no plan reported major problems implementing parity, and that no plan left the program to avoid implementing the policy. Plans enhanced their pre-parity MH/SUD benefits as required by the policy change (84% enhanced MH, 75% enhanced SUD benefits)³² and were more likely to carve-out the behavioral health benefit. Other expected changes (e.g., increased gate keeping at the primary care provider level, reduced provider networks, concurrent or retrospective review, use of disease management programs for MH/SUD care, and increased financial risk sharing) occurred infrequently.

Evaluations of FEHBP parity found no significant increase in total behavioral health spending. Nor did evaluations find an increased probability of any MH/SUD service utilization resulting from parity.³³ In fact, the quantity of MH/SUD services patients received may have decreased slightly after parity was introduced. A recent study by Goldman and colleagues found that beneficiaries in plans that were subject to FEHBP parity demonstrated larger reductions in overall behavioral health visits, medication management visits, psychotherapy visits, and prescriptions for behavioral health medications (which the authors assume resulted from increased use of utilization management techniques by plans) following the introduction of parity than did a matched comparison group not subject to FEHBP parity.³⁴ However, introduction of

FEHBP parity was associated with a significant decrease in out-of-pocket spending for MH/SUD services.^{35,36,37}

A separate study of the impact of parity on substance abuse treatment in FEHBP plans found that although the rate of out-of-pocket spending declined significantly for substance abuse treatment and more patients had new diagnoses of a SUD, there were no differences in rates of initiation and engagement in treatment under parity and total plan spending per user and average utilization of substance abuse services did not change.³⁸

Researchers have examined the effects of FEHBP parity on specific populations, services, and diagnoses. A recent study examined utilization and costs for individuals having one of three diagnoses representing a continuum of condition severity: bipolar disorder, which was classified as both severe and chronic in nature; major depression, whose severity and chronicity vary considerably in the population; and adjustment disorder, which was classified as a less severe, non-chronic condition.³⁹ Results suggested that, compared to a matched control group, enrollees having each of these conditions demonstrated no significant changes in utilization associated with medication management, inpatient days, or prescriptions following the implementation of parity. In the adjustment disorder group, there was a small, but statistically significant, reduction in psychotherapy utilization. Additional analyses revealed no changes in total behavioral health spending for individuals with bipolar disorder or major depression and small decreases in spending associated with individuals diagnosed with adjustment disorder.⁴⁰ Out-of-pocket spending related to MH/SUD treatment decreased across all three diagnostic categories vs. the matched control group.

Another recent study of FEHBP parity attempted to identify specific subpopulations of beneficiaries who benefited most from the introduction of parity. Applying growth mixture modeling techniques to FEHBP data, Neelon and colleagues concluded that the effects of parity differed depending on an individual's pre-parity utilization patterns. Three distinct subgroups emerged: "low-spenders," (who had low levels of utilization of MH/SUD services in the pre-parity period) -- their utilization of MH/SUD services declined in the post-parity period; "moderate-spenders," (who had moderate pre-parity spending) -- their spending increased following the implementation of parity; and "high-users," (who had high MH/SUD spending during the pre-parity) -- their spending continued to be high in the post-parity period.⁴¹ Another study found that among enrollees who received MH treatment for a severe mental illness (e.g., schizophrenia, bipolar disorder, depression), the odds of using any MH/SUD services in subsequent years were more than 1.3 times greater than two matched control groups.⁴² The relative odds of using inpatient MH/SUD services in the parity group were 0.67 times that of the control groups, a decrease consistent with the hypothesis that managed care organizations might have guided patients toward more outpatient services in treating their severely ill enrollees. Prescription usage under parity appears to have increased. Individuals covered under FEHBP parity were 1.4 times more likely to fill any behavioral health prescription compared to their non-FEHBP counterparts. An analysis of the impact of FEHBP parity on rates of treatment for depression found no significant

changes in rates of diagnosis of depression following introduction of parity and very little change in measures of the quality of care.⁴³

Several additional evaluations of FEHBP parity have focused on the effects of the program on children and adolescents. Azrin and colleagues concluded that, following the introduction of FEHBP parity, children enrolled in the FEHBP program showed no significant increase in MH/SUD utilization compared to a matched control group.⁴⁴ These findings are consistent with analyses of the impact of state parity laws that show no significant impact on access for children and adolescents.⁴⁵ In evaluating only children and adolescents with high MH/SUD expenditures in the pre-parity period, a recent study concluded that compared to a matched control group, children enrolled in the FEHBP showed similar patterns of MH/SUD expenditures following the introduction of parity, but a statistically significant reduction (approximately \$258 in 2011 dollars) in average out-of-pocket spending associated with MH/SUD services.⁴⁶

In general, these studies of FEHBP parity found no significant increases in overall MH/SUD utilization rates, initiation or engagement rates, or total MH/SUD spending following the implementation of parity but significant decreases in out-of-pocket costs did result.

Vermont. Compliance monitoring of the MHPAEA can also be guided by the findings of studies examining the effects of state-level parity, such as Vermont.⁴⁷ The Vermont Parity Act took effect January 1, 1998.⁴⁸ The Vermont legislation mandated group health insurance to cover MH/SUD treatment equitably with other covered medical treatments (ERISA-governed self-insured plans are exempt from state parity legislation). An evaluation of the law's effects found an increased probability of an individual receiving any outpatient MH services and a decreased likelihood of an individual receiving any substance abuse services following the introduction of parity. The percentage of beneficiaries receiving outpatient MH services increased by a range of 6%-8%. The percentage of individuals receiving any substance abuse services decreased by a range of 16%-29%.⁴⁹ Results also indicated that, in general, consumer cost-sharing for MH and substance abuse treatment services declined, from 27% to 16% of total costs, following the implementation of parity. The evaluation of the Vermont law's effects found little evidence that the introduction of parity resulted in employers dropping health coverage or switching to self-insured plans to avoid complying with the regulation. Only 0.3% of Vermont employers reported that they dropped health coverage for their employees primarily due to the parity law, and only 0.1% of employers reported that parity played a role in their decision to self-insure (to avoid complying with state law).⁵⁰

Use of managed care techniques increased following Vermont's implementation of parity. Although one of the two major health plans already used managed care before the implementation of parity, the other health plan also shifted most of its members to a managed behavioral health care carve-out. In one plan, spending increased modestly by 19 cents per member per month (PMPM). Nonetheless, MH/SUD services accounted for only 2.5% of total spending in that plan after parity compared to 2.3%

before parity. The other plan experienced a 9% decrease in spending for MH/SUD services following implementation of the state parity law. This decrease in spending was largely attributed to a decrease in SUD treatment service utilization.

Employers' knowledge of the parity law remained low, even after its implementation. A survey conducted 2 years after the implementation of parity suggested that approximately 50% of all fully-insured employers in Vermont had never heard of the parity law and that nearly three-fifths of all employers had little to no knowledge of the parity law.⁵¹ Small and medium-sized businesses were least likely to be familiar with the law, with approximately 70% of those employers having little to no knowledge of the law. Although the two major health plans in Vermont complied with the law on paper, lack of information, confusion, and mistakes by the state's largest plan generated complaints from beneficiaries and providers that led to changes in administration and consumer education in succeeding years.⁵²

Oregon. Oregon's parity law, implemented January 1, 2007,⁵³ mandated that group health insurance plans provide coverage for MH and substance abuse treatment services at the same level as other medical conditions. Results from Oregon are particularly informative for the current project in that the Oregon law, like the MHPAEA, went beyond the regulation of financial and QTLs and specified that plans cannot utilize unequal, NQTLs for MH and substance abuse treatment services compared to medical/surgical services. A recent analysis of the Oregon law suggested that each of the four plans studied made substantial changes to their MH and substance abuse treatment benefits following the implementation of parity. Each plan removed coverage limits related to inpatient and outpatient MH/SUD treatment services. After implementation of the NQTL provisions in the Oregon law, the use of management techniques stayed the same or decreased in the insurance plans studied. These changes were made without significant increases in total MH/SUD treatment spending. Importantly, the researchers found that these effects were achieved without the increased use of utilization management techniques.⁵⁴ The authors also found no evidence of meaningful change in the rates of any behavioral health care service use.

In a separate analysis of only substance use spending, McConnell⁵⁵ found that expenditures for alcohol treatment services increased significantly and spending on other drug abuse treatment services did not. The introduction of parity was associated with a small, but not statistically significant, increase in overall substance use treatment spending. In another study analyzing the impact of parity in Oregon on access to various behavioral health specialists, McConnell found that parity was associated with a slight increase (from 0.5% to 0.8%) in behavioral health treatment initiations with masters-level specialists, and relatively few changes for generalist physicians, psychiatrists, and psychologists. Patients were particularly sensitive to distance for non-physician specialists:⁵⁶ the greater the distance between an individual and a non-physician specialist, the less likely that individual was to receive treatment. Following the introduction of parity, distance to the nearest psychiatrist, masters-level therapist, or psychologist tended to decrease.

California. California's Mental Health Parity Bill, which became effective on July 1, 2000, mandated that all group and individual health plans offer MH coverage as part of their overall health benefits and outlawed the use of MH treatment limitations and cost-sharing requirements that were more restrictive than those for physical health conditions.

The law required that health plans provide MH services to seriously mentally ill (SMI) adults and all children with serious emotional disturbances. Nine specific SMI diagnoses were included in the mandate: anorexia nervosa, bulimia nervosa, bipolar disorder, major depression, obsessive-compulsive disorder, panic disorder, pervasive developmental disorder/autism, schizophrenia, and schizoaffective disorder. SUDs were not covered by the California Parity Act. To assess health plan compliance with the Mental Health Parity Bill, the California Department of Mental Health undertook an intensive review of health plans that included an onsite survey, reviews of claims files, utilization review files, and internal management and performance reports. The report identified several areas of non-compliance. Six out of seven California plans that were subject to the legislation were incorrectly denying coverage for emergency room (ER) visits; five out of seven plans were failing to monitor whether beneficiaries had reasonable access to after-hours services; and five out of seven plans failed to include required information in claim denial letters.⁵⁷

Trends in MH/SUD Spending and the Costs of Parity. An analysis by Mark and colleagues examined trends in behavioral health spending between 2001 and 2009 for a sample of over 100 large, self-insured employer plans. Results concluded that the average contribution of behavioral health care spending to total health care spending across each of the years examined was 0.3%, and only 2% of employers experienced a rate increase of more than 1% per year attributable to behavioral health costs.⁵⁸

Given the small contribution of behavioral health care costs to overall health care costs, MHPAEA is expected to result in only very modest increases total health care expenditures. The Congressional Budget Office (CBO) estimated that MHPAEA itself would result in very modest cost increases, approximately 0.4%, in employer-sponsored group health care premiums and 0.2% in Medicaid payments to managed care plans.⁵⁹ Recent analyses by Mark and colleagues utilizing MarketScan data are consistent with the CBO's estimate. Their analyses have suggested that an overwhelming majority of privately insured beneficiaries who utilized behavioral health care benefits in the pre-parity era did so at a rate that was far below pre-parity health care limits.⁶⁰ Using econometric models to estimate the detailed effects of the MHPAEA on high-utilization beneficiaries who are likely to use its expanded coverage, these researchers estimated that the MHPAEA will likely increase total health care costs by 0.4%.

Early MHPAEA Compliance Analysis. In November 2011, GAO issued an early report on MHPAEA compliance in response to a statutory requirement.⁶¹ One hundred sixty-eight employers responded to a GAO survey asking detailed questions about changes in their behavioral health benefits between 2008 and 2010/2011 out of 707 employers who received the survey. Although the findings from this survey are not

generalizable given the response rate of 24%, the survey did generate information on some questions regarding diagnoses covered not addressed in other studies. The vast majority of responding employers offered MH/SUD coverage in both 2008 and in 2010/2011, and most employers reported covering the same broad range of MH/SUD diagnoses in their current plan year as they also did in 2008. The remaining employers reported including more broad diagnoses.

In keeping with findings in other studies, employers responding to the GAO survey reported reducing their use of MH/SUD office visit and inpatient day limitations. In 2008, a significant percentage of these employers reported utilizing office visit limitations for SUDs. In 2010/2011, far fewer of these employers reported having such limitations. Likewise, in 2008, a significant percentage of employers reported utilizing limitations on inpatient days related to behavioral health conditions. By 2010/2011, the percentage of employers reporting using such limitations had dropped. The GAO did not assess NQTLs used by employers and health plans. While the results of the GAO survey should be interpreted with caution due to its small sample size and low response rate, the results from the survey suggest that employers were generally able to implement changes required by MHPAEA with little disruption to the insurance market.

STUDY BACKGROUND AND PURPOSE

Project Objective. NORC at the University of Chicago led a research team that included Milliman Inc., Aon Hewitt, Thomson Reuters/Truven Health Analytics, and George Washington University to perform an analysis of compliance with the MHPAEA and the IFR⁶² among ERISA-governed employer-sponsored group health plans and health insurance coverage offered in connection with such group health plans. Our analysis includes information from a variety of existing and complementary data sources. Information on coverage provided by large health plans and insurers was provided by testing databases compiled by both Milliman Inc. and Aon Hewitt as well as data from Aon Hewitt's Plan Design Database (PDD) which contains more than 10,000 unique plan designs for more than 300 employer clients. Taken together, information from these sources was used to track health plan coverage in this market and estimate changes in coverage that apply to the 111 million covered lives that are included in this large employer market. Health plan offerings provided by midsized establishments was assessed using information from Summary Plan Descriptions (SPDs) of midsized establishments obtained from the DOL Bureau of Labor Statistics (BLS). Information from the BLS SPDs was used to track changes in health plan coverage that apply to approximately 39 million lives that are covered in the midsized market. Additional information on both markets was provided by published and unpublished data from national employer health benefits surveys conducted by the Kaiser Family Foundation and Health Research and Educational Trust (KFF/HRET)⁶³ and Mercer.⁶⁴ To assess plan responses to the MHPAEA's disclosure requirements, semi-structured interviews were conducted with a small number of health plan representatives who were responsible for their plans' compliance with MHPAEA.

Table 2 presents the study's key research questions and the data sources used to address each question.

TABLE 2. Key Research Questions and Data Source Used to Address Each Question	
Research Question	Data Sources
1. What types of financial requirements (e.g., copays, coinsurance) do group health plans use for MH and SUD benefits, and are such requirements consistent with the new MHPAEA standards for calculating the predominant level that applies to substantially all medical and surgical benefits?	<ul style="list-style-type: none"> • Aon Hewitt PDD • Aon Hewitt Compliance Testing Data • Milliman Compliance Testing Data • SPDs from BLS • Mercer Employer Benefits Survey Data (2010)
2. What types of QTLs (e.g., day limits, visit limits) do group health plans use for MH and substance use conditions, and are such limitations consistent with the MHPAEA standards?	<ul style="list-style-type: none"> • Aon Hewitt PDD • Aon Hewitt Compliance Testing Data • Milliman Compliance Testing Data • SPDs from BLS • KFF Survey Data (2010) • Mercer Employer Benefits Survey Data (2010)
3. What types of NQTLs are commonly used by plans and issuers for MH and/or substance abuse disorders and how do these compare to NQTLs in place for medical/surgical benefits?	<ul style="list-style-type: none"> • Aon Hewitt PDD • Milliman Compliance Testing Data • Aon Employer Survey Data • KFF Survey Data (2010) • Mercer Employer Benefits Survey Data (2010)
4. Are group health plans and insurers using separate deductibles for MH and/or SUD benefits?	<ul style="list-style-type: none"> • Milliman Compliance Testing Data • Aon Employer Survey Data • SPDs from BLS
5. Have financial requirements and treatment limits on medical/surgical benefits become more restrictive in order to achieve parity (instead of requirements and limits for MH and substance use becoming less restrictive)?	<ul style="list-style-type: none"> • Aon Hewitt PDD • Milliman Compliance Testing Data
6. How many plans have eliminated MH and/or substance abuse treatment coverage altogether instead of complying with the MHPAEA?	<ul style="list-style-type: none"> • Aon Hewitt PDD • Milliman Compliance Testing Data • KFF Survey Data (2010) • Mercer Employer Benefits Survey Data (2010)
7. How have plans responded to the MHPAEA's requirements regarding the disclosure of medical necessity criteria and reasons for claim denials?	<ul style="list-style-type: none"> • Interviews with managed behavioral healthcare organizations (MBHOs)

Overview of Key Data Sources and Methodologies

Milliman Compliance Testing Database. Information from Milliman's MHPAEA compliance testing database was used to evaluate 2010 plan design data for adherence to MHPAEA standards. This database includes detailed quantitative financial requirements and treatment limitations for post-parity, pre-IFR benefit levels for medical/surgical benefits and MH/SUD benefits. It also contains details regarding any NQTLs when they could be identified through SPDs.

Of approximately 1,500 plans available in the database, 124 were analyzed to obtain an unbiased and representative distribution of large group plans by geographic

region and industry, including self-insured and fully-insured plans. To obtain sufficient information for testing, detailed plan documents and benefit descriptions were requested to identify any financial requirements or treatment limits by detailed service category. To test plan designs for adherence to the quantitative aspects of the legislation, we utilized Milliman's testing model that completes the "substantially all" and "predominant" tests described in the IFR for quantitative financial requirements and treatment limitations. The actuarial-based model relies on Milliman's *Health Cost Guidelines* for health plans or employers whose membership is not large enough to be statistically reliable, and it includes specific adjustments for variables that impact health care costs such as geographic area, provider contract arrangements, and degree of health care management. If the health plan's or employer's membership was large enough to be statistically reliable (typically more than 10,000 members), the compliance testing model was based on the health plan's or employer's claim costs, usually on a book-of-business basis.

If plan or group-specific costs were used, detailed health care cost data for the most recent complete plan year were requested from the health plan or offeror. Either total allowed dollars or allowed dollars on a PMPM basis were acceptable. Participating health plans and plan sponsors were provided with a template for the level of detail requested by service category, which align with the service categories in Milliman's *Health Cost Guidelines*. Approximately 50 different medical/surgical categories are included.

Quantitative testing was performed on an allowed claim dollar basis (before application of any financial requirements). After the testing model was set up with the costs by detailed health care service category, each medical/surgical service category is mapped into one of the six classifications as prescribed by the IFR, including the two outpatient sub-classifications. Detailed financial requirements and treatment limits by service category were then entered into the model and calculations were performed to determine which quantitative financial requirements (deductibles, coinsurance, copays, and so forth) and treatment limitations (calendar year limits, lifetime limits, other quantity limits, and so forth) meet the "substantially all" criteria required by the IFR. For those quantitative financial requirements and treatment limitations that met this test, the "predominant" level was identified. The results identified the benefit plan changes that are necessary in each benefit classification to be consistent with MHPAEA requirements. To confirm that the MH and SUD coverage was complete in all classifications, covered MH and SUDs were reviewed to determine if coverage is provided in all classifications where medical/surgical benefits are provided.

When a scope of service issue (such as the exclusion of residential treatment for substance use rehabilitation) was identified, it was discussed with the health plan or plan sponsor as being currently acceptable under the IFR, but potentially capable of becoming non-compliant if rules on required scope of services are enacted. In addition to the quantitative testing, detailed plan documents were reviewed to identify potential compliance problems with NQTLs. The IFR is less specific regarding where the line for non-compliance is drawn for NQTLs. Different interpretations exist among health plans

and employers on what is allowable and compliant. Plan documents often contain details for some, but not all, NQTLs. Sometimes, information can be found on precertification requirements, step therapies, prescription drug formulary design, and conditioning benefits on the completion of a course of treatment. When this information is in the plan documents, we determined whether it appeared that the plan applied them in a “comparable” manner and in a manner “no more stringently” than those applied to medical/surgical benefits.

Aon Hewitt Compliance Testing Database. Aon Hewitt plan designs were reviewed to assess compliance with MHPAEA and the IFR standards. The plan design review and compliance testing was conducted in 2010, based on the plan designs each employer expected to implement in the 2011 plan year.

The Aon Hewitt testing database encompasses plan designs from more than 60 employers, ranging in size from 400 to more than 300,000 employees and representing 230 plan options. Each plan option represented a single combination of benefits (a combination of medical/surgical and MH/SUD benefits) that is available to an employer’s participants. Plans whose adherence could not be assessed through a review of summary plan documents were subjected to detailed testing procedures. Of the 230 plan options reviewed, 140 required detailed testing to determine the benefit design that would apply to MH/SUD benefits. Plans that used identical coverage criteria for both MH/SUD and medical surgical services were considered to adhere to MHPAEA standards, and did not required detailed testing.

For most employer plans, the benefit type and level within the inpatient in-network and out-of-network, outpatient out-of-network, prescription drug, and emergency care classifications were consistent for both medical/surgical and MH/SUD and, as a result, demonstrated consistency with the parity regulations. For these benefit classifications, detailed testing was not required. Benefit design for the outpatient in-network classification, however, most frequently required detailed testing across employer programs. Within this classification, employer programs typically applied a variety of benefit types (copay or coinsurance) and benefit levels (primary care, specialty care, other). Detailed testing was required within this benefit classification to determine whether benefits met the “substantially all” and “predominant” requirements for MH/SUD services.

For each plan option requiring detailed testing, Aon Hewitt requested the employer’s program administrator (vendor) to submit plan costs associated with each covered service category within the classification or sub-classification included in the testing process.

We first conducted the “substantially all” test for each plan option to determine which benefit type represents at least two-thirds of the plan costs in the benefit sub-classification. Plan cost data were grouped according to benefit type (e.g., copay, coinsurance, etc.) and were evaluated to determine the percentage of the total plan costs represented by each type. Once the benefit type representing “substantially all”

was determined, we grouped the plan cost data associated with each benefit level (e.g., \$15, \$20, etc.) within that benefit type to determine the predominant benefit level in that sub-classification.

Aon Hewitt's Plan Design Database. Information obtained from Aon Hewitt's PDD included a review of 2009, 2010, and 2011 plan design data to determine how group health plan and employer-sponsored plan designs have evolved since federal parity was enacted in 2008. The information contained in the PDD allowed us to report on the plan designs that were in place before the implementation of federal parity in 2009 and evaluate how plan designs have changed since the implementation of the MHPAEA and the IFR. For most employers, the MHPAEA legislative requirements were implemented effective January 1, 2010. Further changes were made to employer plan designs effective January 1, 2011, to comply with the February 2010 IFR.

Information obtained from the database allows us to evaluate trends in how employer plan designs have changed since the implementation of the MHPAEA. The 2009 plan year serves as the baseline year, as the MHPAEA was not in effect until October 2009. Plan options in the 2010 plan year reflect plan designs that were in effect after the implementation of the MHPAEA. The plan options included in the 2011 plan year reflect plan designs that were in effect after the release of the IFR, which went into effect for most employers on January 1, 2011.

A total of 12,384 plan options, reflecting 252 employers, were included in the 2009, 2010, and 2011 plan design analysis. Of those options, 2,983 plan options (24.1%) were in the database in all three plan years. Not all plan options are reflected in the database all 3 years for a number of reasons, such as the option was terminated or the option was added in 2010 and 2011.

For many plan options, information on all fields included in this review was available. However, for some plan options certain information was unavailable, the information was unclear, or the information was potentially inaccurate. Therefore, the data for those plan options were excluded from our analyses. Therefore, although 12,384 plan options were included in the database, the actual number of plan options considered valid and used in the analysis for each comparison is much lower. We have reported the size of the sample included in each plan design analysis in Appendix C.

Summary Plan Description Data Provided by BLS. To supplement parity information from large employers that are heavily represented in the Aon Hewitt and Milliman databases, we analyzed a sample of 240 SPDs from mid-sized employers (establishments between 51 and 500 employees) collected by the BLS between 2008 and 2011 as part of the National Compensation Survey (NCS).⁶⁵ Under ERISA, employers are required to provide their employees with SPDs of their health, pension, and welfare benefit plans. SPDs must include:

- Any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts.

- Any annual or lifetime maximums or other limits on benefits.
- The extent to which preventive services are covered.
- Whether and under what circumstance existing and new drugs are covered.
- Whether, and under what circumstance, coverage is provided for medical tests, devices or procedures.
- Any provisions requiring preauthorization or utilization review as a condition of obtaining a benefit or service under the plan.

BLS requests that employers participating in the NCS submit full SPDs. However, many only provide summary tables of benefits, a more circumscribed description of benefits than the complete SPDs. BLS permitted NORC to abstract data from plan documents submitted by midsized employers between 2008 and 2011 to assess changes since the introduction of the MHPAEA and the IFR. The total sample size of abstracted documents was 240. One hundred sixty-seven covered the pre-parity era (plan years 2008-2009), and 73 covered the post-parity era (plan years 2010-2011). Not all documents included every data element of interest, but, when available, information related to the provision of quantitative limits (e.g., copays, coinsurance, and deductibles) was abstracted and analyzed. Observation level characteristics provided by BLS for each SPD was limited to principal industry. In order to increase the generalizability of the information obtained from the SPDs, analysis weights were constructed for each observation.⁶⁶

To create the analysis weights, the sample was first divided into pre-parity observations (plan year 2008-2009; n = 167) and post-parity observations (plan years 2010-2011; n = 73) subsamples. Each subsample was treated as a separate sample with respect to weight construction. Within each subsample, the observations were assigned to one of seven industry categories based on the observation's North American Industry Classification System (NAICS) code.⁶⁷

It should be noted that the utility of our analyses is limited by several factors. Many of the documents submitted to BLS were in fact not full SPDs, but brief tables of benefits that lacked many of the elements necessary to carefully track changes in financial requirements and treatment limitations. Our ability to construct weights to analyze the data that was abstracted was further limited by the lack of detailed establishment information available from the plan documents. Ideally, the weights would have been created using information including the number of workers at each establishment, detailed industry classification, and the physical location of the establishment. We were only provided information on basic industry categories. Therefore, we believe the weights as created, and applied in our analyses, are insufficient to remove all potential bias from the sample, and appropriate caution should be exercised when interpreting these results.

Employer Surveys. We reviewed the results of published national employer surveys from the KFF/HRET and Mercer. These surveys provided generalizable information on employers' coverage of MH/SUD. The 2010 KFF/HRET survey included 2,046 randomly selected public and private employers with more than three workers.

The sample is randomly selected from a sample frame constructed by Survey Sampling Incorporated from Dun & Bradstreet's listing of public and private employers. KFF/HRET then stratifies the sample by industry and employer size. The 2010 Mercer Health Benefits Survey is also a random survey of employers identified from Dun & Bradstreet. The 2010 survey included 1,977 employers that offered health benefits. The survey uses sampling weights to calculate estimates both nationwide and for four geographic regions. The Mercer survey contains information for large employers (i.e., those with 500 or more employees), and for smaller employers (i.e., those with fewer than 500 employees).

Semi-structured Interviews with Health Plan Representatives. Lastly, we conducted detailed interviews with a non-generalizable sample of senior health plan officials who are responsible for seven major health insurers' compliance with the MHPAEA. The purpose of the interviews was to obtain specific information about plans' disclosure policies and practices required by the MHPAEA. Two behavioral health plan associations, the Association for Behavioral Health and Wellness and the National Behavioral Consortium recruited health plans to participate in the interviews.

Each of the seven individuals interviewed is a senior staff member responsible for leading the company's review of policies and procedures to bring the plan into compliance with MHPAEA and the IFR. The seven companies that participated collectively provide coverage for more than 100 million individuals and are among the largest health plans in the nation. Several of the plans exclusively provide behavioral health care services, and others provide behavioral health services within a larger health plan covering health, disability, and other benefits as well. Collectively, the companies operate in all 50 states, serving self-insured employers and employers purchasing fully-insured group health insurance products. Each interview elicited detailed information about:

- The use of medical necessity criteria for medical and MH/SUD services.
- The process for informing beneficiaries of reasons for claim denials for medical and MH/SUD services and any changes in the processes for informing beneficiaries since implementation of the MHPAEA.
- The use of utilization management techniques for medical and MH/SUD services and any changes in the use of utilization management techniques.
- The management of out-of-network care.
- The presence of any unmet demand for residential and intensive outpatient substance abuse services since the implementation of the MHPAEA.
- The management of prescription medications, if the company is involved in this service.

STUDY RESULTS

Research Question #1: Health Plan and Employer Use of Financial Requirements

What types of financial requirements (e.g., copays, coinsurance) do group health plans use for MH and SUD benefits and are such requirements consistent with the new MHPAEA standards for calculating the predominant level that applies to substantially all medical and surgical benefits?

According to the IFR regulations, a plan must meet two testing requirements within each benefit classification in order to comply with parity financial requirements:

- **Substantially all.** A requirement or limitation applies to substantially all if it applies to at least two-thirds of the benefits in that classification. If a type of requirement or limit does not apply to at least two-thirds of the medical/surgical benefits in a classification, then it cannot be applied to MH/SUD benefits in that classification.
- **Predominant.** A requirement or limitation is considered predominant if it applies to at least one-half of the benefits in that classification.

Determination of “substantially all” and “predominant” is based on the dollar amount of all plan payments for medical/surgical benefits in the classification that are expected to be paid under the plan for the plan year. Plan design compliance must be assessed within the six benefit classifications specified by the regulations. Regulatory guidance defined two sub-classifications for outpatient services. The classifications and sub-classifications recognized by the regulations are:

- Inpatient in-network
- Inpatient out-of-network
- Outpatient in-network
 - Office visits
 - All other outpatient items and services
- Outpatient out-of-network
 - Office visits
 - All other outpatient items and services
- Emergency care
- Prescription drugs

Detailed testing was performed for each of these six classifications and two sub-classifications. Results for each of the six classifications are presented here, and results

pertaining to the “office visit” and “other services” sub-classifications and the Safe Harbor provision can be found in Appendix A.

It should be noted that the testing models used in these analyses are based on Milliman’s and Aon Hewitt’s interpretation of provisions outlined in the IFR. The development of these models required Milliman and Aon Hewitt to make interpretations on issues that were not entirely settled by the IFR, or may be interpreted differently by regulators.

Results of the testing illustrate both the substantial changes that most plans have made since 2008 to comply with the MHPAEA’s financial parity requirements and the specific areas where a small proportion of plans must still make changes to be consistent with MHPAEA standards. Milliman and Aon Hewitt data were analyzed using similar, though not identical, testing procedures. The two analyses provide glimpses into two successive time slices: The Milliman database included information on 2010 benefits, whereas the Aon Hewitt database included information on 2011 benefits. It should be noted that the IFR became effective for plan years beginning on or after July 1, 2010. Thus for calendar year plans, the IFR was not effective until January 1, 2011. Therefore, our 2010 testing results do not suggest that plans failing to meet the “substantially all” or “predominant” tests were non-compliant with MHPAEA requirements at the time, only that they were required to make additional changes in order to be consistent with MHPAEA standards going forward.

2010 Inpatient Financial Requirements

TABLE 3. Financial Requirements: Percentage of Plans in 2010 Requiring Changes to Inpatient Benefits to be Consistent With MHPAEA				
	Deductible	Out-of-Pocket Maximum	Copay	Coinsurance
Inpatient in-network MH services	6.7%	8.7%	6.7%	7.5%
Inpatient out-of-network MH services	1.0%	7.8%	0%	5.8%
Inpatient in-network SUD Services	6.7%	8.4%	6.7%	7.6%
Inpatient out-of-network SUD services	1.0%	8.7%	0%	5.8%
SOURCE: Milliman’s Testing Data of 2010 plan designs.				

Analyses of Milliman’s data focused on identifying specific areas where a plan needed to make changes in its 2010 benefits to achieve consistency with MHPAEA. Analyses of Milliman’s inpatient benefit designs found that overall, approximately 10% of plans offering inpatient MH/SUD benefits needed to make some changes to their 2010 inpatient financial requirements in order to be consistent with MHPAEA standards. Table 3 presents the percentage of participating plans that appeared to offer benefits that were not consistent with MHPAEA’s financial requirements (deductibles, out-of-pocket maximums, copays, and coinsurance). Relatively few plans needed to modify copays for inpatient in-network MH/SUD benefits, and no plans needed to make changes to their inpatient out-of-network MH or SUD benefits. Approximately one plan

in 12 needed to change its member out-of-pocket maximums for inpatient MH and SUD to be equivalent to its medical/surgical inpatient maximums.

2010 Outpatient Financial Requirements

Analyses of Milliman’s 2010 data suggest that substantially more plans required changes to their outpatient MH/SUD benefits than required changes to their inpatient benefits. More than one-quarter of plans were required to change deductible limits, one-third required changes to copays or coinsurance, and one-fifth needed to change out-of-pocket maximums. An almost identical pattern was found for in-network outpatient SUD treatment. A much smaller percentage of plans, less than 10%, needed to change out-of-network financial limitations. Table 4 presents the percentage of participating plans that were required to change outpatient financial requirements in order to be consistent with MHPAEA standards.

TABLE 4. Financial Requirements: Percentage of Plans in 2010 Requiring Changes to Outpatient Benefits to the Consistent With MHPAEA				
	Deductible	Out-of-Pocket Maximum	Copay	Coinsurance
Outpatient in-network MH services	26.7%	21.7%	33.3%	34.2%
Outpatient out-of-network MH services	3.9%	8.7%	1.0%	10.7%
Outpatient in-network SUD services	26.1%	18.5%	31.9%	33.6%
Outpatient out-of-network SUD services	3.9%	9.7%	1.0%	8.7%
SOURCE: Milliman’s Testing Data of 2010 plan designs.				

2010 Emergency Care and Prescription Drug Financial Requirements

Analyses of 2010 benefit designs suggest that the vast majority of plans offered emergency and prescription drug benefits that were consistent with MHPAEA’s financial requirements. Table 5 presents the percentage of participating plans that needed to make changes in their emergency and prescription drug benefits in order to be consistent with MHPAEA’s financial parity requirements. Fewer than 1% of plans needed any changes to their prescription drug benefits. But one-fifth needed to change coinsurance rates for behavioral health emergency care, and a smaller proportion needed to make changes in copay and deductible benefits.

TABLE 5. Financial Requirements: Percentage of Plans in 2010 Requiring Changes in ER and Prescription Drug Benefits to the Consistent With MHPAEA				
	Deductible	Out-of-Pocket Maximum	Copay	Coinsurance
Emergency care -- MH/SUD	5.6%	0%	7.2%	19.2%
Prescription drugs -- MH/SUD	0%	0%	0%	0%
SOURCE: Milliman’s Testing Data of 2010 plan designs.				

2011 Inpatient Financial Requirements

Analyses of Aon Hewitt inpatient plan designs suggest that by 2011, the vast majority of health plans appeared to meet MHPAEA's financial requirements. As shown in Table 6, only a very small percentage of plans utilized inpatient financial requirements that did not comply with MHPAEA standards. None needed to modify copay or coinsurance levels, and less than 2% required modifications of their deductibles or out-of-pocket maximums.

Comparison of the 2010 Milliman data and the 2011 Aon Hewitt data indicates that most large employer plans met the inpatient financial parity standards by 2011. Small, but consistent improvements can be seen in each area tested.

TABLE 6. Financial Requirements: Percentage of Plans in 2011 Requiring Changes to Inpatient Benefits to the Consistent With MHPAEA				
	Deductible	Out-of-Pocket Maximum	Copay	Coinsurance
Inpatient in-network MH services	1.3%	1.3%	0%	0%
Inpatient out-of-network MH services	1.3%	1.3%	0%	0%
Inpatient in-network SUD services	1.3%	1.3%	0%	0%
Inpatient out-of-network SUD services	1.3%	1.3%	0%	0%

SOURCE: Aon Hewitt Compliance Testing Database of 2011 plan designs.

2011 Outpatient Financial Requirements

Analyses of 2011 outpatient benefit designs suggest that nearly all large employer plans appeared to meet parity's financial requirements for deductibles, out-of-pocket maximums, and coinsurance requirements. However, nearly one-fifth had outpatient in-network copay requirements for MH and SUD that appeared not to conform to MHPAEA's financial parity requirements.

Comparison of the 2010 outpatient data to the 2011 data again suggests substantial improvement between the two periods. For example, the 2010 data indicated that more than one-third of plans had outpatient coinsurance requirements that appeared not to conform to MHPAEA standards. By 2011, that number had dropped to less than 4%. Likewise, more than 25% of 2010 plans were required to make changes to their outpatient in-network deductible benefits in order to be consistent with MHPAEA's standards. By 2011, the data suggested that less than 2% of plans still appeared to offer benefits that were not consistent with MHPAEA standards. However, adherence to MHPAEA standards was not universal. Although there was clearly improvement in the proportion of plans that appeared to conform to MHPAEA's outpatient in-network copay requirements, nearly one-fifth of 2011 plan designs continued to offer benefits that appeared not to conform to MHPAEA's financial requirements.

TABLE 7. Financial Requirements: Percentage of Plans in 2011 Requiring Changes to Outpatient Benefits to the Consistent With MHPAEA Standards				
	Deductible	Out-of-Pocket Maximum	Copay	Coinsurance
Outpatient in-network MH services	1.3%	1.3%	19.6%	3.9%
Outpatient out-of-network MH services	1.3%	1.3%	0%	0%
Outpatient in-network SUD services	1.3%	1.3%	19.6%	3.9%
Outpatient out-of-network SUD services	1.3%	1.3%	0%	0%
SOURCE: Aon Hewitt Compliance Testing Database of 2011 plan designs.				

2011 Emergency Care and Prescription Drug Financial Requirements

Analyses of 2011 benefit designs suggest that 100% of tested plans offered ER and prescription drug benefits that appeared to be consistent with MHPAEA’s financial requirements.

TABLE 8. Financial Requirements: Percentage of Plans in 2011 Requiring Changes in ER and Prescription Drug Benefits to be Consistent With MHPAEA Standards				
	Deductible	Out-of-Pocket Maximum	Copay	Coinsurance
Emergency care -- MH/SUD	0%	0%	0%	0%
Prescription drugs -- MH/SUD	0%	0%	0%	0%
SOURCE: Aon Hewitt Compliance Testing Database of 2011 plan designs.				

Changes in Health Plans’ Behavioral Health Financial Requirements, 2009-2011

Aon Hewitt’s PDD was used to assess changes in group health plan and employer-sponsored plan designs between the 2009 and 2011. A total of 12,384 plan options, reflecting 252 employers, were included in the 2009, 2010, and 2011 plan design analysis.

It is important to note that data reported in this section do not indicate whether or not the plan design reported in the PDD is compliant with MHPAEA requirements. Rather, the information summarizes the data contained in the PDD within each plan year. Many factors influence the compliance status of each plan design, most notably, a review of the “substantially all” and “predominant” standards.

Inpatient Financial Requirements. Copay and coinsurance requirements for inpatient medical/surgical services were compared to those for inpatient MH/SUD services to determine if plans’ behavioral health benefits were the same as, more restrictive, or less restrictive than medical/surgical services. Table 9 presents the percentage of plans in which the inpatient benefits were found to be more restrictive for MH/SUD than for medical/surgical benefits.

TABLE 9. Financial Requirements: Percentage of Plans With More Restrictive Inpatient MH/Substance Abuse Treatment Benefits Than Medical/Surgical Benefits, 2009-2011			
	2009 Percent of Plans	2010 Percent of Plans	2011 Percent of Plans
Inpatient in-network MH services	6.5%	4.5%	4.9%
Inpatient out-of-network MH services	9.4%	6.5%	5.6%
Inpatient in-network SUD services	6.4%	5.3%	4.0%
Inpatient out-of-network SUD services	11.1%	5.8%	3.8%
SOURCE: Aon Hewitt's Plan Design Database (2009-2011).			

These data suggest a slight decrease between 2009 and 2011 in the percentage of plans that applied more restrictive financial requirements for inpatient MH/SUD services than for medical/surgical inpatient services. By 2011, approximately one in 20 plans still had more restrictive financial requirements (higher copays or greater coinsurance rates) for inpatient MH and SUD treatment than for comparable medical/surgical inpatient treatment. Examples of the more restrictive benefit designs found in the analysis include:

- MH/SUD services covered at 90% coinsurance after hospital copay vs. medical/surgical services covered at 100% coinsurance after hospital copay.
- MH/SUD services covered at 90% coinsurance vs. medical/surgical services covered at 100%.

Outpatient Financial Requirements. Analysis of outpatient benefits compared copayment and coinsurance requirements for routine outpatient MH/SUD services and financial requirements for medical/surgical office visits to primary care physicians (PCPs) or to specialty care physicians (SCPs).

Table 10 presents the percentage of plans in which the outpatient benefits were found to be more restrictive for MH/SUD than for medical/surgical benefits.

TABLE 10. Financial Requirements: Percentage of Plans Using the Same Copay/Coinsurance for PCPs/SCPs and With More Restrictive Outpatient MH/Substance Abuse Treatment Benefits Than Medical/Surgical Benefits, 2009-2011			
	2009 Percent of Plans	2010 Percent of Plans	2011 Percent of Plans
Outpatient in-network MH services	12.9%	5.3%	2.0%
Outpatient out-of-network MH services	24.5%	7.5%	8.3%
Outpatient in-network SUD Services	24.0%	20.8%	1.3%
Outpatient out-of-network SUD services	22.3%	6.8%	7.4%
SOURCE: Aon Hewitt's Plan Design Database (2009-2011).			

Before the passage of the MHPAEA, many employers and group health plans considered MH/SUD professionals to be specialists and applied coinsurance or copay requirements that were aligned with the financial requirements applied to SCPs. The MHPAEA requires that the test for financial parity compliance be based on a comparison of “substantially all” and “predominant” medical/surgical requirements and the IFR did not allow the separate classification of generalists and specialists in determining the predominant financial requirement or treatment limit that applies to substantially all medical/surgical benefits in a classification. A plan may still be able to impose the specialist level of a financial requirement or QTL if it is the predominant level that applies to substantially all medical/surgical benefits within a classification. Our analysis of the Aon Hewitt PDD compares plans’ MH/SUD outpatient benefits with outpatient PCP and SCP services. Some plans apply the same copay or coinsurance to both PCPs and SCPs. Others apply different copays or coinsurance rates to PCP services and SCP services. Often the PCP copay or coinsurance is lower than that for SCP services (split copay/coinsurance). Table 10 and Table 11 present the percentage of plans using more restrictive outpatient MH/SUD services than medical/surgical services using both methods of handling financial requirements for PCPs and SCPs.

TABLE 11. Financial Requirements: Percentage of Plans Using Split Copay/Coinsurance for PCPs/SCPs that have More Restrictive Outpatient MH/Substance Abuse Treatment Benefits Than Medical/Surgical Benefits, 2009/2011			
	2009 Percent of Plans	2010 Percent of Plans	2011 Percent of Plans
Outpatient in-network MH services	28.2%	8.6%	4.9%
Outpatient out-of-network MH services	6.1%	9.8%	2.1%
Outpatient in-network SUD services*	25.8%	10.9%	10.6%
SOURCE: Aon Hewitt’s Plan Design Database (2009-2011).			
* Results for outpatient out-of-network SUD services are not reported due to small sample size.			

Plan Options With Same Copay/Coinsurance for PCPs/SCPs

Plans using the same copay/coinsurance structure for PCPs/SCPs rapidly reduced more restrictive financial requirements for outpatient MH/SUD following enactment of the MHPAEA. For example, these plans reduced disparities in copays and coinsurance for in-network MH services from 12.9% in 2009 to 2% in 2011. Unequal in-network SUD financial requirements declined from 24% in 2009 to 1.3% in 2011.

Plan Options With Split Copay/Coinsurance for PCPs/SCPs

Plans using split copay/coinsurance for PCPs/SCPs also rapidly reduced their use of more restrictive financial requirements following enactment of the MHPAEA. In 2009, one-quarter of plans used more restrictive benefit designs for in-network SUD services. By 2011, fewer than 11% used a more restrictive benefit design. And the decrease was

even more dramatic for outpatient in-network MH services (from 28% to 9%) but for out-of-network MH the disparities increased in 2010 (from 6% to 9%) and then went down to 2%.

As seen in Table 12, in 2009, approximately one-third of plan options that had split copay/coinsurance designs aligned the outpatient MH benefit with their PCP benefit and one-third aligned the MH benefit with SCP. In 2010, a distinct change occurred in the benefit for MH services. Almost two-thirds of plan designs aligned the MH outpatient benefit with the SCP copay/coinsurance levels. In 2011, plans changed once again. More than half aligned the outpatient MH benefit with the PCP benefit.

TABLE 12. Financial Requirements: Percentage of Plans Using a Split Copay/Coinsurance Structure that Aligned Their Benefits with PCPs vs. SCPs, 2009-2011			
	2009 Percent of Plans	2010 Percent of Plans	2011 Percent of Plans
Mental Health			
Outpatient MH benefit the same as PCP	33.7%	25.8%	55.8%
Outpatient MH benefit same as SCP	32.0%	61.2%	25.2%
Outpatient MH benefit is less restrictive than PCP	6.2%	4.3%	14.1%
Outpatient MH benefit more restrictive than SCP	20.4%	3.5%	3.7%
Outpatient MH benefit is more restrictive than PCP but less restrictive than SCP	7.7%	5.1%	1.2%
Substance Use Disorder			
Outpatient SUD benefit the same as PCP	54.8%	55.0%	52.6%
Outpatient SUD benefit same as SCP	15.1%	13.2%	39.7%
Outpatient SUD benefit is less restrictive than PCP	2.9%	3.9%	3.1%
Outpatient SUD benefit more restrictive than SCP	16.8%	17.4%	2.6%
Outpatient SUD benefit is more restrictive than PCP but less restrictive than SCP	10.4%	10.4%	1.9%

These changes suggest that employers and health plans were modifying benefits to comply with MHPAEA requirements as they understood them at the time. In 2010, after the enactment of MHPAEA, many employers aligned the outpatient MH benefit with the SCP level, suggesting that they interpreted the MHPAEA to mean that treating a MH provider as a specialist would comply with the legislation. The IFR clarified that compliance is instead governed by the “substantially all” and “predominant” criteria and the IFR did not allow the separate classification of generalists and specialists in determining the predominant financial requirement or treatment limit that applies to substantially all medical/surgical benefits. The 2011 benefit data suggest that employers

and health plans once again reevaluated their designs and made adjustments, aligning outpatient MH copays and deductibles with their PCP benefits.

Results for SUD followed a slightly different pattern. As seen in Table 12, over half of the plan options using a split copay/coinsurance structure aligned their outpatient SUD benefits with the PCP benefit level in all 3 years (2009, 2010, and 2011). In 2009 and 2010, approximately 27% of plan options applied a benefit for outpatient SUD services that was either more restrictive than the SCP benefit level or in between the PCP and SCP benefit levels. This changed in 2011 when it appears that plans moved away from this approach and more plan options aligned outpatient SUD benefits with the SCP benefit level.

Midsized Employers. To investigate how plan designs used by midsized employers have changed since the implementation of MHPAEA, NORC conducted a separate analysis of financial requirements used by midsized employers. When available, information on copay, coinsurance, deductibles, and out-of-pocket maximums was abstracted from 240 SPDs collected between 2008 and 2011 by the BLS for the NCS.

TABLE 13. Financial Requirements: Percentage of Midsized Employers' Plans in Our Limited Sample That Appear to Provide More Restrictive MH/Substance Abuse Treatment Benefits Than Medical/Surgical Benefits: Pre and Post-Parity		
	Pre-Parity (2008-2009) Percent of Plans (n = 167)	Combined Post-Parity Sample (2010-2011) Percent of Plans (n = 73)
Inpatient care: cost-sharing for in-network MH/SUD treatment higher than inpatient medical/surgical care	10.2%	0%
Inpatient care: cost-sharing for out-of-network MH/SUD treatment higher than inpatient medical/surgical care	16.4%	4.7%
Outpatient care: cost-sharing for in-network MH/SUD office visits higher than medical/surgical PCP visits	51.5%	41.3%
Outpatient care: cost-sharing for in-network MH/SUD office visits higher than medical/surgical specialist office visits	23.7%	8.5%
Outpatient care: cost-sharing for out-of-network MH/SUD treatment higher than outpatient medical/surgical treatment	32.7%	7.1%

Table 13 presents the percentage of plans using more restrictive QTLs before and after the effective date of MHPAEA. As was the case with large employer plans, midsized plans appeared to be more likely to offer outpatient benefits that did not conform to MHPAEA's financial standards than inpatient benefits. Before the effective implementation date of the MHPAEA (2008-2009), more than 50% of midsized employers' plans in our sample used cost-sharing measures for outpatient MH/SUD office visits that were higher than those for medical/surgical PCP visits. In the post-

parity sample (2010-2011), that percentage had decreased to a still-substantial 41% of mid-sized employers' plans. Likewise, nearly 24% of plans in the pre-parity sample had cost-sharing requirements for outpatient in-network behavioral health office visits that were higher than for SCP office visits. That percentage declined to 9% following implementation of MHPAEA. Before MHPAEA, in our sample, mid-sized employers' out-of-network MH/SUD outpatient benefits were more restrictive than medical/surgical outpatient benefits in approximately one-third of the plans. This rate decreased to 7% after implementation of MHPAEA.

Among mid-sized employers, inpatient MH/SUD coverage differs from the pattern observed for other cost-sharing requirements. Both before and after the implementation of parity, relatively few plans used more restrictive cost-sharing techniques. Only one plan in six applied more restrictive deductibles, out-of-pocket maximums, copay or coinsurance requirements for inpatient in-network MH/SUD than for medical/surgical inpatient care before parity, and even fewer plans used more restrictive inpatient MH/SUD requirements after the implementation of MHPAEA. This pattern is consistent with the findings for large employers in the Milliman and Aon Hewitt datasets.

TABLE 14. Financial Requirements: Results From the 2010 Mercer Survey		
Category	Sample Size	Decrease MH/SUD Copay or Coinsurance
Total	1,433	3%
Employer Size		
Fewer than 500 employees	332	3%
500 or more employees	1,101	8%
Industry		
Manufacturing	228	9%
Wholesale/retail	86	5%
Services	261	6%
Trans./comm.	59	5%
Health care	180	13%
Finance	86	10%
Government	173	4%
Other	28	6%
Region		
Northeast	216	5%
Midwest	334	7%
South	359	10%
West	192	10%
SOURCE: 2010 Mercer Health Benefits Survey.		

A closer examination of the pre and post-parity mid-sized employer data suggests that the proportion of plans using more restrictive financial limits on MH/SUD care declined each year following the effective date of parity. Even though the sample sizes are relatively small for each of the post-parity years and less reliable due to the small sizes, by 2011, the large majority of plans in this sample had eliminated unequal limits on MH/SUD. The table in Appendix D shows these year-to-year trends. Although the year-to-year results for mid-sized employers correspond to the decreases observed in

large employers' health benefits, caution is warranted because only a small number of SPDs were available each year.

Employer Surveys. Employer use of different financial requirements for MH/SUD and medical surgical benefits following the implementation of MHPAEA is also assessed in Mercer's Health Benefits Survey. The 2010 survey asked employers to describe actions they had taken or planned to take to ensure that MH/SUD benefits are provided at the same level as medical/surgical benefits. Table 14 presents the results from 1,433 employers who responded to the survey. Results suggest that, overall, 3% of employers claim to have already decreased, or had plans to decrease MH/SUD copay or coinsurance levels to comply with the MHPAEA. Although these data provide some evidence of employer response to MHPAEA, they do not provide any evidence that employers who did not make adjustments to their QTLs were out of compliance with MHPAEA standards.

Research Question #2: Health Plan and Employer Use of Treatment Limitations

What types of QTLs (e.g., day limits, visit limits) do group health plans use for MH and SUD conditions, and do such limitations comply with the MHPAEA standards?

2010 Inpatient Quantitative Treatment Limits

Analyses of Milliman's 2010 data suggest that few plans used by large employers were required to make adjustments to their MH/SUD inpatient treatment limitations to be consistent with parity requirements. As shown in Table 15, almost one-fifth of plans (19.3%) covered fewer in-network inpatient days annually for SUD treatment and 16% covered fewer MH inpatient days than medical/surgical inpatient days. About one plan in 20 were required to remove dollar maximums for inpatient MH/SUD treatment.

	Day Limits	Dollar Maximum (Annual)
Inpatient in-network MH services	12.5%	4.2%
Inpatient out-of-network MH services	6.8%	4.9%
Inpatient in-network SUD services	19.3%	6.7%
Inpatient out-of-network SUD services	15.5%	6.8%

SOURCE: Milliman's Testing Database of 2010 plan designs.

2010 Outpatient Quantitative Treatment Limits

Outpatient MH/SUD visits were more frequently limited than were inpatient services. Table 16 shows that in 2010 half of the plans covered fewer in-network MH and SUD visits than they covered for medical/surgical outpatient treatment. Nearly two-

thirds of the plans needed to modify visit limits for out-of-network outpatient substance use benefits and 14% need to change outpatient out-of-network MH visit limits.

TABLE 16. QTLs: Percentage of Plans in 2010 Requiring Changes to Outpatient Benefits to be Consistent with MHPAEA		
	Visit Limits	Dollar Maximum (Annual)
Outpatient in-network MH services	50.0%	0%
Outpatient out-of-network MH services	13.6%	0%
Outpatient in-network SUD services	50.0%	30.0%
Outpatient out-of-network SUD services	63.6%	9.1%
SOURCE: Milliman's Testing Database of 2010 plan designs.		

2010 Emergency Care and Prescription Drug Quantitative Treatment Limits

As presented in Table 17, none of the tested plans needed to change their behavioral health emergency care benefits or prescription benefits to comply with MHPAEA and the IFR.

TABLE 17. QTLs: Percentage of Plans in 2010 Requiring Changes to Emergency and Prescription Drug Benefits to be Consistent with MHPAEA				
	Day Limits	Visit Limits	Quantity Limits	Dollar Maximums (Annual)
Emergency care -- MH/SUD	N/A	0%	N/A	0%
Prescriptions -- MH/SUD	N/A	N/A	0%	0%
SOURCE: Milliman's Testing Database of 2010 plan designs.				

2011 Inpatient Quantitative Treatment Limits

Table 18 present the results of analyses examining consistency with MHPAEA's treatment limitation standards in 2011. By 2011, 100% of Aon Hewitt plans had removed unequal dollar limitations, and there was a significant reduction in the percentage of plans utilizing unequal day limits. These changes suggest substantial movement toward consistency with MHPAEA standards. Still, there was a minority of plans that continued to provide unequal benefits in 2011.

TABLE 18. QTLs: Percentage of Plans in 2011 Requiring Changes to Inpatient Benefits to be Consistent with MHPAEA Standards		
	Day Limits	Dollar Maximum
Inpatient in-network MH services	7.0%	0%
Inpatient out-of-network MH services	6.5%	0%
Inpatient In-network SUD Services	7.8%	0%
Inpatient out-of-network SUD services	7.0%	0%
SOURCE: Aon Hewitt's Testing Database of 2011 plan designs.		

2011 Emergency Care and Prescription Drug Quantitative Treatment Limits

As presented in Table 19, none of the plans analyzed needed to change their behavioral health emergency care benefits or prescription benefits to be consistent with MHPAEA and the IFR.

TABLE 19. QTLs: Percentage of Plans Requiring Changes to Emergency and Prescription Drug Benefits to be Consistent with MHPAEA Standards				
	Day Limits	Visit Limits	Quantity Limits	Dollar Maximums (Annual)
Emergency care -- MH/SUD	N/A	0%	N/A	0%
Prescriptions -- MH/SUD	N/A	N/A	0%	0%
SOURCE: Aon Hewitt's Testing Database of 2011 plan designs.				

2011 Outpatient Quantitative Treatment Limits

Aon Hewitt's analysis of quantitative outpatient treatment limits in 2011 plans suggests substantial progress from the 2010 Milliman findings. As shown in Table 20, plans apparently made significant strides to improve their quantitative limits in their outpatient MH/SUD benefit designs. None of the plans failed to comply with parity in dollar limitations on outpatient MH/SUD benefits. There were also substantially fewer plans with unequal MH/SUD visit limitations. The percentage of 2011 plans with unequal outpatient SUD benefits ranged between 4% and 6%. These results contrast sharply with results from 2010, when more than 50% of plans tested needed to modify their more restrictive visit limits for outpatient SUD services.

TABLE 20. QTLs: Percentage of Plans Requiring Changes to Outpatient Benefits to Comply with MHPAEA		
	Visit Limits	Dollar Limits
Outpatient in-network MH services	6.1%	0%
Outpatient out-of-network MH services	4.3%	0%
Outpatient in-network SUD services	6.1%	0%
Outpatient out-of-network SUD services	4.3%	0%
SOURCE: Aon Hewitt's Testing Database of 2011 plan designs.		

Changes in Health Plans' Behavioral Health Quantitative Treatment Limits 2009-2011

Inpatient Quantitative Treatment Limits

Aon Hewitt's PDD was used to assess changes in quantitative limits in plan designs between 2009 and 2011. As shown in Table 21 and Table 22, the data suggest that most plans that appeared not to conform to MHPAEA standards in 2009 modified their quantitative limits by 2011 to eliminate more restrictive MH/SUD quantitative limits. For example, in 2009, approximately 50% of the plans covered fewer MH and SUD inpatient in-network days annually than they covered for treatment of medical/surgical conditions. In 2010, that percentage dropped to 12% for MH services and 13.8% for SUD. By 2011, 7.5% of plans covered fewer MH inpatient in-network days and 8.5%

covered fewer SUD inpatient days than they covered for medical/surgical conditions. Plans with more restrictive out-of-network inpatient MH day limits declined from more than 48% in 2009 to 10.5% in 2010 and 5.8% in 2011. More limited SUD out-of-network inpatient days were found in 40% of plans in 2009, decreasing to 7.6% in 2011. Similar declines were observed in lifetime MH and SUD inpatient day limitations. Although these declines are notable, one in 12 plans continued to impose annual in-network inpatient MH and SUD day limits that were more restrictive than medical/surgical benefits, and 4% had lifetime MH and SUD day limits that were more restrictive.

TABLE 21. QTLs: MH/SUD Inpatient In-Network Treatment Limitations That Were More Restrictive Than Medical/Surgical Treatment Limitations, 2009-2011			
	2009 Percent of Plans	2010 Percent of Plans	2011 Percent of Plans
Mental Health			
Day limits (annual)	54.0%	12.0%	7.5%
Day limits (lifetime)	13.0%	5.4%	4.0%
Dollar limits (annual)	0.5%	0.2%	0.2%
Dollar limits (lifetime)	0%	0%	0%
Episode limits	1.9%	1.2%	0.8%
Substance Abuse			
Day limits (annual)	46.2%	13.8%	8.5%
Day limits (lifetime)	21.4%	5.4%	4.1%
Dollar limits (annual)	0.1%	0.1%	0.0%
Dollar limits (lifetime)	0%	0%	0%
Episode limits	2.5%	1.1%	0.4%
SOURCE: Aon Hewitt's Plan Design Database (2009-2011).			

TABLE 22. QTLs: MH/SUD Inpatient Out-of-Network Treatment Limitations That Were More Restrictive Than Medical/Surgical Treatment Limitations, 2009-2011			
	2009 Percent of Plans	2010 Percent of Plans	2011 Percent of Plans
Mental Health			
Day limits (annual)	48.2%	10.5%	5.8%
Day limits (lifetime)	8.1%	1.4%	1.1%
Dollar limits (annual)	0.2%	0.2%	0.2%
Dollar limits (lifetime)	0%	0%	0%
Confinement limits	0.9%	0.3%	0.1%
Substance Abuse			
Day limits (annual)	40.4%	12.7%	7.6%
Day limits (lifetime)	8.1%	1.4%	1.1%
Dollar limits (annual)	0.1%	0.1%	0.1%
Dollar limits (lifetime)	0%	0%	0%
Confinement limits	1.7%	1.0%	0.7%
SOURCE: Aon Hewitt's Plan Design Database (2009-2011).			

Very few plans applied more restrictive annual and lifetime dollar limits or covered-episode limits on inpatient MH/SUD services than medical/surgical benefits in 2009. There were small declines in 2010 and 2011 in the proportion of plans that had more restrictive dollar or episode limits. The Mental Health Parity Act of 1996 prohibited unequal MH annual and lifetime dollar and covered episodes limits. Our analyses

confirm that plans overwhelmingly complied for MH and for SUD, even though the latter conditions were not covered by the 1996 Act.

Outpatient Quantitative Treatment Limitations

As shown in Table 23 and Table 24, more restrictive MH/SUD quantitative outpatient treatment limits decreased sharply between 2009 and 2011. In 2009, more than half of the plans analyzed had more restrictive outpatient in and out-of-network MH and SUD visit and dollar limits than medical/surgical benefits. In 2010, unequal coverage dropped to approximately 11%, and by 2011, the proportion that appeared to offer benefits that were not consistent with MHPAEA standards was about 6%. Very few plan options (less than 1%) had more restrictive annual dollar limits for outpatient MH services than for medical/surgical care. But, consistently, SUD outpatient dollar limits were more likely to be lower than medical/surgical coverage. In 2009, nearly 10% of plans had more restrictive annual dollar limits on outpatient SUD. The percentage of plans with lower annual dollar limits for in-network outpatient SUD decreased to 1.5% in 2010 and to 1.0% in 2011. Similarly, the proportion of plans with lower annual dollar limits for out-of-network SUD outpatient treatment declined from 9.8% in 2009 to 2.9% in 2010 and 1.3% in 2011. The 1996 Mental Health Parity Act did not cover disparities in outpatient SUD dollar or treatment episode limits. Instead, these changes may suggest movement by plans to comply with provisions of the PPACA prohibiting lifetime dollar limits and phasing out annual dollar limits that became effective in 2010.

TABLE 23. QTLs: MH/SUD Outpatient In-Network Treatment Limitations That Were More Restrictive Than Medical/Surgical Treatment Limitations, 2009-2011			
	2009 Percent of Plans	2010 Percent of Plans	2011 Percent of Plans
Mental Health			
Visit limitations	56.1%	11.1%	6.5%
Dollar limitations (annual)	0.8%	0.6%	0.7%
Substance Abuse			
Visit limitations	51.1%	12.7%	8.5%
Dollar limitations (annual)	9.4%	1.5%	1.0%
SOURCE: Aon Hewitt's Plan Design Database (2009-2011).			

TABLE 24. QTLs: MH/SUD Outpatient Out-of-Network Treatment Limitations Were More Restrictive Than Medical/Surgical Treatment Limitations, 2009-2011			
	2009 Percent of Plans	2010 Percent of Plans	2011 Percent of Plans
Mental Health			
Visit limitations	59.6%	11.0%	6.4%
Dollar limitations (annual)	0.5%	0.3%	0.2%
Substance Abuse			
Visit limitations	53.2%	14.0%	9.0%
Dollar limitations (annual)	9.8%	2.9%	1.3%
SOURCE: Aon Hewitt's Plan Design Database (2009-2011).			

Quantitative Limits Among Midsized Employers. Information on day limitations and visit limitations were abstracted from SPDs provided by BLS. As shown in Table 25, in 2008, before MHPAEA implementation, 88% of midsized employers' plans in our limited sample had inpatient day limitations that were more restrictive for MH/SUD conditions than for medical/surgical conditions. Following the implementation of parity, the percentage dropped to 24%. As seen in Appendix D, in each year following parity there were fewer plans utilizing more restrictive day limits for inpatient MH/SUD care than medical/surgical care, so that by 2011, only 13% of plans in our sample still appeared to provide more restrictive MH/SUD day limitations. Likewise, before the implementation of parity, 84% of midsized plans in our sample used outpatient visits limitations that were more restrictive for MH/SUD than medical/surgical benefits. Following the implementation of parity, 26% of these plans provided more restrictive visit limitations for MH/SUD services than medical/surgical services. Again, the percentage of plans providing more restrictive MH/SUD services dropped each year following the implementation of MHPAEA, so that by 2011, only 13% of plans in our sample provided outpatient visit limitations that were more restrictive for MH/SUD than medical/surgical services. Caution is warranted so as to not over-interpret the decline, as only a small number of SPDs were available for analysis for each of the post-parity years. Nevertheless, it appears that the pattern of decreasing percentages of plans serving midsized employers that had more restricted MH/SUD quantitative limits is consistent with the pattern observed among large employers' health benefits.

TABLE 25. Treatment Limitations: Percentage of Midsized Employers' Plans in Our Limited Sample That Appear to Include More Restrictive MH/Substance Abuse Treatment Limitations Than Medical/Surgical Limitations		
	Pre-Parity (2008-2009) Percent of Plans (n = 167)	Combined Post-Parity Sample (2010-2011) Percent of Plans (n = 73)
Inpatient care: day limits for MH/SUD treatment higher than inpatient medical/surgical care	73%	17%
Outpatient care: visit limits for MH/SUD treatment higher than inpatient medical/surgical care	79%	18%
SOURCE: Author's weighted analysis of data abstracted from SPDs provided by BLS.		

Employer Surveys. The nationally representative employer health benefits surveys conducted by KFF/HRET and Mercer in 2010 provide additional perspectives on QTLs following the effective date of MHPAEA. In 2010, the KFF/HRET survey asked whether employers had eliminated limits in MH/SUD as a result of MHPAEA. Table 26 shows that one in five employers reported eliminating limits in coverage in response to MHPAEA. Employers with more than 1,000 workers, firms with self-insured plans, and firms in the transportation and communication industries were most likely to report removing limits on MH/SUD benefits. It cannot be determined from the KFF/HRET data, however, whether firms that did not report changing their benefits already had equitable benefits and did not need to make changes, or if they had inequitable benefits

but did not take steps to change. The findings do indicate that a sizeable percentage of employers and health plans are making MHPAEA-related benefit adjustments.

TABLE 26. Percentage of Firms That Changed MH Benefits As a Result of MHPAEA by Firm and Worker Characteristics	
	Eliminated Limits In Coverage
All Firms	20.6%
Firm Size	
50-199 employees	15.7%*
200-999 employees	24.1%
More than 1,000 employees	50.3%*
Geography	
Northeast	14.6%*
Midwest	27.1%
South	24.6%*
West	14.7%
Plan Funding	
Underwritten by insurer	14.2%*
Self-insured	34.7%
SOURCE: Estimates are from author analysis of data from 2010 Henry J. Kaiser Family Foundation/Health Research and Educational Trust 2010 Employer Health Benefits Survey public use file.	
* Estimate is statistically different from reference group ($P < 0.05$). Reference groups were assigned as follows: firm size = 200-999 employees; region = South; plan funding = self-insured.	

The 2010 Mercer Health Benefits Survey also asked employers whether they had made changes in benefit designs to meet parity requirements. More than seven in ten employers (74%) responded that no changes were necessary because their benefits already complied with MHPAEA. As shown in Table 27, of the 1,433 employers responding to the 2010 Mercer survey, 17% reported removing limitations in the number of office visits, inpatient days or dollar limits for MH/SUD benefits in response to MHPAEA requirements. Although the 2010 KFF/HRET and Mercer surveys differ somewhat in the proportion of respondents who report making quantitative changes in their MH/SUD benefits in response to MHPAEA, both reflect considerable activity among employers in response to MHPAEA.

TABLE 27. Employer Response to MHPAEA: Results From the 2010 Mercer Survey		
	Sample Size	Remove Limits
Total	1,433	17%
Firm Size		
Fewer than 500 employees	332	15%
More than 500 employees	1,101	35%
Region		
Northeast	216	34%
Midwest	334	42%
South	359	32%
West	192	32%
SOURCE: 2010 Mercer Health Benefits Survey.		

Research Question #3: Health Plan and Insurer Use of Non-Quantitative Treatment Limits

What types of NQTLs are commonly used by plans and issuers for MH and/or substance abuse disorders and how do these compare to NQTLs in place for medical/surgical benefits?

According to the MHPAEA regulations, NQTLs limit the scope or duration of benefits and can include, but are not limited to, plan provisions related to:

- Medical management.
- Prescription drug formularies.
- Provider admission to a network.
- Determination of UCR amounts.
- Step-therapy requirements.
- Conditioning benefits on completion of a course of treatment.

Any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to medical/surgical benefits. However, these requirements allow variations to the extent that recognized clinically appropriate standards of care may permit a difference. Assessing whether NQTLs that appear to be non-compliant are acceptable is difficult due to variations allowed by these requirements.

2010 NQTL Analysis

During Milliman's 2010 testing process of a nationally representative sample of 124 large employers' health plans, a number of NQTLs were identified that appeared to be non-consistent with MHPAEA standards. These NQTLs were identified through careful analysis of SPDs and other plan documentations and appeared to apply unequally to MH/SUD conditions when compared to medical/surgical conditions. However, no follow-up was completed with the plans in order to assess whether these variations were the result of differences in clinically appropriate standards of care. Therefore, the results of Milliman's NQTL analysis should be interpreted with caution as some of the identified NQTLs may be permissible as allowed by the IFR.

The analyses were conducted to determine changes that employers and health plans would need to take to make their 2010 plans consistent with IFR requirements for NQTLs for the 2011 plan year. As outlined in Table 28, almost 30% of plans used precertification procedures that were more stringent for MH/SUD services than for medical/surgical services.

TABLE 28. Percentage of 2010 Plans Utilizing NQTLs that Appeared to be Not Consistent With MHPAEA Standards if Continued into the 2011 Plan Year	
NQTL Description	Percent of Plans
MH/SUD precertification requirements were more stringent than for medical/surgical benefits.	28.2%
Medical necessity was applied to MH/SUD benefits but not to medical/surgical benefits.	8.2%
No MH/SUD benefits were provided outside the state of residence, but medical/surgical benefits were provided.	0.9%
Pre-approval was required starting with the 13th outpatient MH/SUD office visit.	1.8%
Out-of-network treatment was covered only if in-network treatment was unavailable. This applied only to MH/SUD benefits.	0.9%
Plans imposed a probationary period only for substance abuse treatment.	0.9%
Out-of-network eating disorder treatment was covered only if in-network services were unavailable; no such requirement applied to out-of-network medical/surgical benefits.	0.9%
SOURCE: Analysis of 2010 Milliman plan information.	

Detailed 2010 NQTL Assessment

Aon Hewitt conducted detailed NQTL assessments in 2010 for 22 large national employers, each employing more than 1,000 workers. The analysis included the NQTL designs and practices of 17 national health vendors. The majority of these employers (72%) had 10,000 or more employees. The intensive NQTL review included a detailed assessment of how MH/SUD treatment is handled beyond plan design. The review encompassed precertification, concurrent and retrospective review, determination of reimbursement rates, and other medical management procedures to ensure that the processes in place for NQTLs are not more restrictive for MH/SUD than they are for medical/surgical treatment. Areas of potential concern identified by the NQTL testing frequently resulted in book-of-business benefit adjustments for these national vendors.

Each vendor that administered an employer's medical and MH/SUD benefit plans was requested to respond to an extensive questionnaire that collected details about the vendor's NQTL processes and procedures in place in 2010. The following NQTL areas were assessed:

- Precertification
 - Procedures and services requiring precertification
 - Responsibility for precertification (provider or member)
 - Documentation required
 - Medical necessity review conducted
 - Guidelines used
- Concurrent Review
 - Levels of care considered for review
 - Source of guidelines

- Process
 - Frequency of reviews
- Discharge Planning
 - Process
 - Frequency of reviews
 - Follow-up after discharge
- Case Management
 - Case identification process
 - Case management process
- Retrospective Review
 - Process
 - Services included
- UCR Determination
 - Data source
 - Frequency of updates
 - Percentile
- Reimbursement Rates
 - Source
 - Process
- Experimental and Investigational
 - Definition

Each MH/SUD policy and procedure was compared with corresponding medical/surgical policies and procedures. Any procedures or requirements that could be considered to be more stringent for MH/SUD than medical/surgical were identified as potentially non-compliant with the MHPAEA regulations. Results of the assessment were communicated to the employer as well as to each vendor involved in the assessment process. Discussions were held between the employer and each vendor to review the findings and determine whether clinically appropriate differences in care explained the variance, and whether any actions were necessary to comply with MHPAEA regulations. Our initial review identified many areas that were deemed potentially non-compliant. However, after further investigation and follow-up documentation from the vendors, it was determined, in some instances, that the MH/SUD process was not more stringent than medical/surgical. Areas of concern, and proposed modifications are presented in Table 29.

TABLE 29. NQTLs: Areas of Concern and Modifications Made to Ensure Consistency With the MHPAEA and the IFR

NQTL Category	Process/Procedure	Potential Concern	Outcome
Medical management	Outpatient precertification	<p>Precertification required for all outpatient MH/SUD services.</p> <p>Precertification not required for all outpatient medical/surgical services.</p>	Precertification requirement removed for all outpatient services, but maintained for services requiring greater oversight and supported by recognized clinically appropriate standards of care (e.g., psychiatric testing, electroconvulsive therapy [ECT], etc.)
	Outpatient medical necessity review	<p>All outpatient MH/SUD counseling services authorized for 8-12 visits (varied by vendor); after 8th or 12th visit, clinical/medical necessity review conducted.</p> <p>Similar procedure not in place for outpatient medical/surgical services</p>	Some vendors extended the threshold for conducting medical necessity review on outpatient MH/SUD counseling services to allow for review of cases that represent outliers (e.g., 20 visits).
	Concurrent review	<p>Concurrent review conducted for MH/SUD cases include a medical necessity review as well as a review for adherence to benefit provisions.</p> <p>Concurrent review conducted for medical/surgical cases includes a review for adherence to benefit provisions; no medical necessity reviews.</p>	Concurrent review conducted for MH/SUD cases will include only a review for adherence to benefit provisions; no medical necessity reviews.
	Retrospective review	<p>Retrospective review process for MH/SUD included a review for medical necessity, as well as a review for adherence to benefit provisions.</p> <p>Retrospective review process for medical/surgical included a review for adherence to benefit provisions and only when no prior notification was provided.</p>	MH/SUD retrospective review will include a review for adherence to benefit provisions only when no prior notification was provided. No medical necessity review will be conducted.

TABLE 29. (continued)			
NQTL Category	Process/Procedure	Potential Concern	Outcome
Medical management (continued)	Inpatient medical necessity review	All inpatient MH/SUD cases require precertification, with a medical necessity review conducted during the precertification process. For medical/surgical inpatient cases, members notify the vendor; no medical necessity review is conducted.	Notification process implemented for MH/SUD (eliminated medical necessity review requirement). Medical necessity reviews conducted only for cases considered to be outliers based on diagnosis, high-cost and complex cases, and provider outliers.
Provider network management	Reimbursement rates	MH/SUD provider reimbursement rates were determined based on vendor's internal set of data. Medical/surgical provider reimbursement rates were determined using an external database.	MH/SUD provider reimbursement rates were modified to reflect a similar process and data source as medical/surgical provider reimbursement rates.
	UCR percentile	Percentile used to determine reimbursement rates for MH/SUD services was set at the 50th percentile. Medical/surgical services were reimbursed at the 80th percentile.	Reimbursement percentile rate modified to the 80th percentile for MH/SUD services.
	Network admission criteria	Site visits required for some MH/SUD network providers but not for medical network providers.	Requirement maintained, as the requirement is essential to ensuring quality and safety of MH/SUD network providers; site visits conducted at facilities and programs that are not accredited.
Prescription drugs	Smoking cessation drug requirements	Member is required to participate in a smoking disease management program in order to receive coverage for smoking cessation medication. Similar requirement not in place for any other drug or drug class.	Program revised to eliminate the requirement that members participate in a smoking disease management program in order to receive coverage for smoking cessation medication.
	Smoking cessation drug limits	Smoking cessation drugs limited to 12 or 24 weeks per year, depending on brand; similar limits not imposed on other drugs or drug classes.	Limitation removed for smoking cessation drugs.
SOURCE: Analysis of Aon Hewitt plan information and plan/vendor questionnaire.			

Results from Employer Surveys. The 2010 KFF/HRET survey provides additional information on employer use of utilization management techniques in response to MHPAEA. Table 30 presents results from this question, based on employer weights. Results suggest that, overall, 4.9% of employers reported increasing their use

of utilization management techniques in response to MHPAEA. Very large employers (1,000 or more employees) were significantly more likely to report an increased reliance on utilization management techniques (8.5%) than were midsized employers. Employers in the South (9.8%) were also more likely to report increasing their use of utilization management than were employers in the Northeast (2.3%) and Midwest (3.0%). Employers in the health care and retail industries were least likely to report an increased use of utilization management techniques, and self-insured employers (9%) were significantly more likely to report increased use of utilization management than their fully-insured counterparts (3.1%).

TABLE 30. Percentage of Firms that Changed Utilization Management as a Result of the MHPAEA by Firm and Worker Characteristics: Results from KFF/HRET	
	Increased Utilization Management of MH Benefits
All Firms	4.9%
Firm Size	
50-199 employees	4.6%
200-999 employees	4.6%
1,000 or more employees	8.5%*
Plan Funding	
Underwritten by insurer	3.1%*
Self-insured	9.0%
SOURCE: Estimates are from author analysis of data from 2010 Henry J. Kaiser Family Foundation/Health Research and Educational Trust 2010 Employer Health Benefits Survey public use file.	
* Estimate is statistically different from reference group ($P < 0.05$).	

This issue is also addressed in the 2010 Mercer Survey, which asked responding employers to describe planned or implemented changes made to their health benefits in response to the MHPAEA. Of the 1,433 participating employers, approximately 8% of employers reported adding or adjusting their use of utilization management techniques in response to MHPAEA.

Research Question #4: Health Plan and Insurer Use of Separate Deductibles

Are group health plans and insurers using separate deductibles for MH and/or SUD benefits?

Very few health plans continued to use separate deductibles after MHPAEA was enacted. Milliman's analysis of 2010 benefit designs found that only 3.2% of health plans had separate deductibles for MH/SUD benefits in which MH/SUD out-of-pocket costs did not accumulate toward a single deductible combined with medical/surgical benefits. Aon Hewitt's analysis of 2011 plan designs found only 1.3% of plans had separate deductibles for MH/SUD.

Among the midsized employers' plans analyzed by NORC from the BLS sample, none of the SPDs indicated a separate deductible for MH/SUD in the years before parity implementation (2008-2009), and fewer than 3% used separate deductibles in the post-parity period (2010-2011).

Research Question #5: Health Plan and Insurer Restriction of Medical/Surgical Benefits Following the Implementation of MHPAEA

Have financial requirements and treatment limits on medical/surgical benefits become more restrictive in order to achieve parity (instead of requirements and limits for MH/SUD becoming less restrictive)?

Analyses of the Aon Hewitt and Milliman testing databases identified no evidence of any plan that had increased medical/surgical financial requirements or treatment limits in order to achieve parity.

Research Question #6: Health Plan and Insurer Elimination of MH and Substance Abuse Services Following the Implementation of the MHPAEA

How many plans have eliminated MH and/or SUD treatment coverage altogether instead of complying with the MHPAEA?

Analyses of Milliman's database suggest that participating plans did not respond to MHPAEA and the IFR's parity requirements by eliminating MH/SUD benefits. No plans in Milliman's database failed to offer any MH/SUD benefits during 2009-2011.

Results from Aon Hewitt's yearly Request for Information (RFI) provide further evidence that plans have continued to offer MH/SUD benefits following the introduction of the MHPAEA and the IFR. In their 2011 Annual RFI, Aon Hewitt requested behavioral health care organizations to respond to several questions regarding the impact of the MHPAEA. Responses to the MHPAEA questions were received from seven national behavioral health care organizations, representing all major carve-in and carve-out vendors. Vendor responses indicated that very few employers reported eliminating MH or SUD coverage following the implementation of the MHPAEA. In 2010, 57% of responding vendors reported that no employers had eliminated coverage, and 43% of vendors reported that 1% of employers had eliminated coverage. In 2011, 43% of responding vendors reported that no employers had limited coverage, and 57% reported that 1% had eliminated coverage.

Information obtained from BLS data provides further evidence that the vast majority of midsized employers' plans did not eliminate MH coverage following the

implementation of MHPAEA. Results of analyses comparing benefits outlined in a pre-parity (2008-2009) sample of SPDs suggest that 100% of analyzed plans provided MH/SUD benefits. In the post-parity (2010-2011) sample, 97.2% of plans provided MH/SUD benefits.

Additional confirmation can be found in results from the 2010 KFF/HRET and 2010 Mercer surveys. Results from both surveys suggest that very few employers reported dropping coverage of MH/SUD benefits. Based on employer weights, Table 31 presents results from the KFF/HRET survey. Approximately 1.6% of firms reported dropping MH/SUD benefits.

TABLE 31. Percentage of Firms That Reported Eliminating MH Benefits as a Result of MHPAEA: Results from the 2010 KFF/HRET Survey	
	Dropped MH Coverage
All Firms	1.6%
Geography	
Northeast	0.0%
Midwest	0.3%
South	0.5%
West	5.1%
SOURCE: Estimates represent author analysis of data from 2010 Henry J. Kaiser Family Foundation/Health Research and Educational Trust 2010 Employer Health Benefits Survey public use file.	

Overall, approximately 2% of employers responding to Mercer’s 2010 survey claimed to have dropped or to be planning to drop MH/SUD benefits in response to the implementation of the MHPAEA. Employers were also asked to report whether they had increased the number of excluded MH/SUD conditions. Overall, less than 1% of employers reported increasing the number of exclusions covered under their insurance benefits in response to MHPAEA.

In 2010, Mercer reported that 18% of employers offered no coverage for autism spectrum disorders. In the 2011 report, 22% offered no autism spectrum coverage. Whether this increase represents a change in employer’s actual coverage rates or is an artifact of the survey, it is notable that about one of five employers offered no coverage for autism screening, medication management or other treatments. In both years, approximately two-thirds of employers reported covering diagnostic services for autism, and more than half covered medications, inpatient and outpatient treatments.

The 2011 GAO report⁶⁸ on MHPAEA provides additional context on how employers utilized condition exclusions before and after the implementation of parity (Table 32). GAO elicited responses from 168 employers that detailed treatment exclusions utilized in 2008 and 2010/2011. Although response rates were low (168 responses from 707 employers initially surveyed), the GAO results suggest that employers’ use of condition limitations has decreased since the introduction of parity. For example, in 2008, eight out of 81 responding plans reported excluding treatment for smoking cessation/tobacco dependence. In 2010/2011, only two out of 96 responding

plans reported that exclusion. Likewise, in 2008, nine plans reported excluding treatment for learning disorders, but by 2010, that number had decreased to five.

TABLE 32. Excluded MH/SUD Conditions and Diagnoses: Results From the GAO Survey

Excluded Diagnosis/Condition	2008 (n = 81)	2010/2011 (n = 96)
Alcoholism	2	3
Attention deficit disorder	2	0
Autism	4	2
Conduct/impulse disorders	2	3
Developmental Disorders/disabilities/delays	10	6
Learning disorders	9	5
Mental retardation	7	3
Organic mental disorders	7	3
Sexual dysfunction/deviancy	9	2
Smoking cessation/tobacco dependence	8	2

Research Question #7: Health Plan Response to the MHPAEA’s Disclosure Requirements

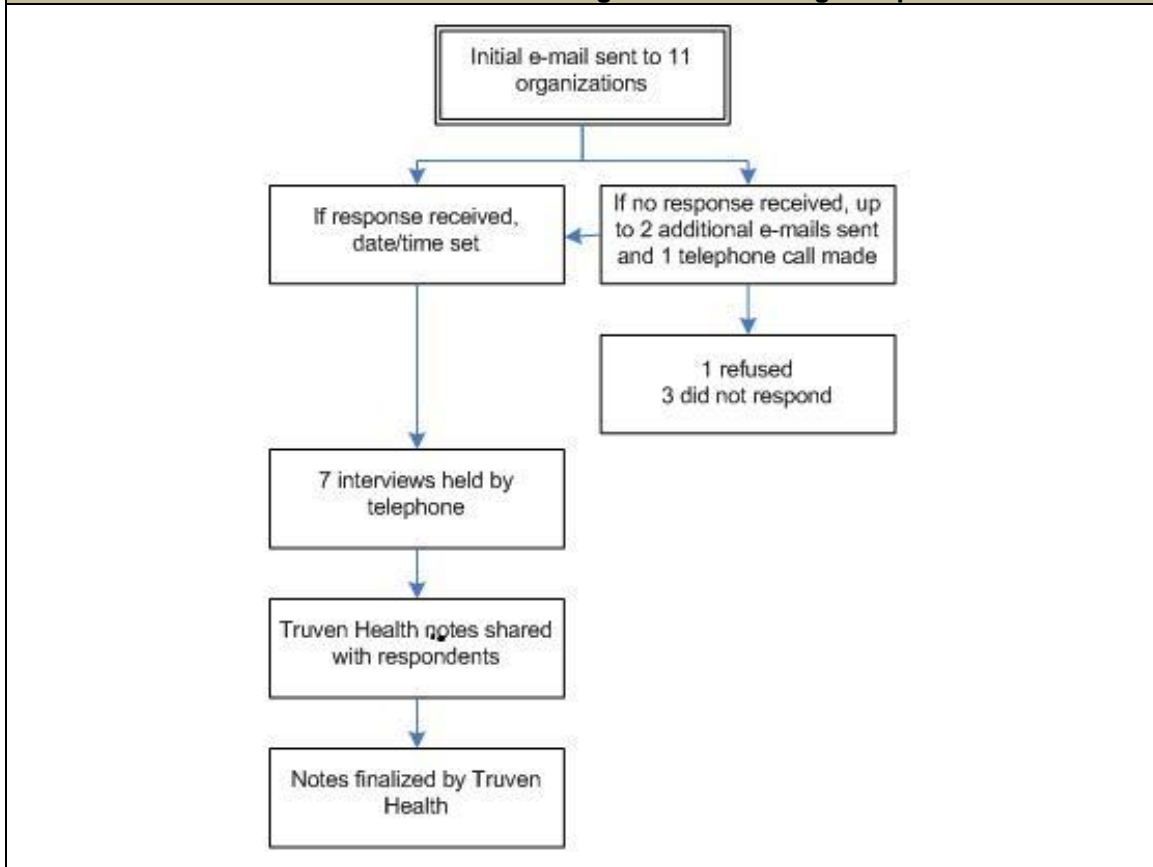
How have plans responded to the MHPAEA’s requirements regarding the disclosure of medical necessity criteria and reasons for claim denials?

To assess plan response to MHPAEA’s disclosure requirements, NORC and its research partners conducted a series of semi-structured interviews with a small number of representatives from health plans and MBHOs. Although the number of individuals interviewed was small, representatives from the seven companies that participated collectively provide coverage for more than 100 million covered lives and are among the largest health plans in the nation. Figure 1 outlines the process for contacting respondents. Potential respondents received an initial e-mail from Truven Health Analytics that explained the purpose of the study, listed several topics of interest, and requested a 30-minute telephone call. Seven of the 11 companies contacted responded affirmatively, and a semi-structured interview was conducted with each. Notes were taken during every call, and each participant had the opportunity to review and provide feedback on a draft version of the notes before they were finalized. Six of the seven companies provided feedback on the notes.

Results

The results are organized by interview topic. Additional detail appears in Appendix E. Identifying personal or corporate names have been excluded from the results, and the order of responses varies across topics -- measures taken to assure the anonymity of participants’ responses.

FIGURE 1. Process for Contacting and Interviewing Companies



Medical Necessity Criteria

Most respondents (four MBHOs) reported that the content of medical necessity criteria have not changed as a result of the parity law. Two sets of criteria that are commonly used for behavioral health services are McKesson’s InterQual criteria and the American Society of Addiction Medicine (ASAM) criteria. Some companies have developed their own criteria through consultation with experts and a regular review and improvement process. One company that had developed its own, proprietary medical necessity criteria expressed concern regarding copyright infringements because the PPACA requires companies to share the criteria with members. Some states have developed their own set of criteria that their public plans must use, or they specify criteria that must be used, such as those of ASAM.

Although the MHPAEA has not affected the scientific content of the necessity criteria, the application of the criteria has sometimes changed. According to a representative of one MHBO, in the late 1990s and early 2000s, health plans had moved away from medical necessity criteria for medical care, but by 2008 the plans had begun to increase their use again. Following the MHPAEA, health plans served by this MHBO had to decrease use of medical necessity criteria for behavioral health services in order to match similar medical services. Since then, the use of medical necessity criteria has grown at equal levels for behavioral and medical services. The other

MHBOs interviewed did not report a similar circumstance in the plans they work with, however, so the extent of this phenomenon is unclear.

Another MBHO explained that, due to the parity law, medical necessity criteria are not used to manage the utilization of behavioral health services when utilization management techniques are not used for other medical services within the same plan.

Respondents reported that individual members may receive a copy of the medical necessity criteria upon request. One company also stated that it makes its medical necessity criteria publicly available on its website.

Informing About Claim Denials

Companies interviewed stated that the PPACA, not the MHPAEA, has been driving changes in procedures for claim denials. The PPACA, DOL rules, and state law dictate the content and timing of the letters, and these rulings applied to both behavioral health and other medical services.

If a claim is denied, a letter is sent to the member and to the provider or facility. The letter explains the reason for the denial and may also cite the medical necessity criteria used for the decision. Denials made in advance of treatment are delivered in *adverse benefit determination (ABD)* letters. Denials of reimbursement for services rendered come in *explanation of benefits (EOB)* statements.

Utilization Management Techniques

Respondents reported that among NQTLs, particularly for outpatient services, utilization management has changed the most since implementation of the parity law. Prior authorization had not traditionally been used for medical services except for non-routine outpatient services such as ambulatory surgery. As a result of MHPAEA, five MBHOs interviewed stated that they have moved away from using prior authorization for outpatient services, except for unusual services such as ECT.

In its place, four respondents reported having moved to a process of managing individuals who use significantly more MH or SUD services than is “normal” and “expected.” They reported that the process is similar to the management of medical services such as physical therapy, radiology, or skilled nursing. For example, if a company identifies an individual who has received 20 sessions of therapy when the average length of treatment is 6-8 sessions, the company will start to manage the case more closely through reviews and reauthorization for future outpatient services. One company noted, however, that, with the implementation of the parity law, it has seen an increase in the average length of treatment and a larger percentage of individuals are receiving more than eight therapy sessions.

Three respondents also reported that they have focused more on managing the quality of treatment. For example, one company identifies enrollees who are not

receiving treatment according to best practice clinical guidelines. In these situations, the company works with the providers to better understand why the best practice guidelines have not been followed. If the provider is not willing to provide treatment for the patient more consistent with the guidelines, he or she will not be reauthorized for coverage of additional treatments. Another company uses the reauthorization process to ask providers whether they collaborate with family members and other medical providers in treatment.

Another company reported that rather than managing claims for individuals, it has reduced its administrative burden by managing providers and facilities. Among providers that serve a substantial number of its enrollees, the company examines the average length of treatment for its enrollees. If the provider meets a specific standard, reauthorization over the course of its enrollees' treatment is not required. If the provider does not meet the standard or has patients with extremely long lengths of treatment, and the provider does not change, the provider may be moved to a lower tier and stop receiving referrals from the company. For inpatient care, this company has established a similar program in which concurrent review is waived for facilities that maintain a certain standard of care. If these practices are only used with MH/SUD services, this may suggest a potential area of NQTL non-compliance.

Respondents report that utilization management techniques for inpatient services generally have remained the same after the implementation of parity. Because health plans often require preauthorization for medical and surgical inpatient services, preauthorization is still frequently required for non-emergent inpatient behavioral health services. Respondents reported that a significant difference between inpatient medical and behavioral health services is the incentive to increase length of stay. Most medical services are paid based on the diagnosis-related group (DRG) assigned, regardless of the length of stay, whereas behavioral health services are typically paid on a per-diem basis. This means that longer stays result in greater revenue for treating hospitals. To manage length of stay, most MBHOs carry out concurrent reviews, monitoring the need for additional inpatient services every few days. The respondents reported that this follows a similar pattern of utilization management for medical services that are not paid on the DRG system.

One company found that prior authorization was not as common for inpatient medical services as for behavioral health services. As a result, it slightly decreased the use of prior authorization but increased the use of retrospective authorization, which is authorization for reimbursement after a service is performed. Retrospective review is also commonly used for out-of-network services, where other types of utilization management are challenging to employ.

Managing Out-of-Network Care

Respondents reported different methods for managing out-of-network services. One MBHO noted that commercial plans that covered out-of-network behavioral health services did not manage those services before the parity law. Since the implementation

of the MHPAEA, however, more commercial accounts have covered out-of-network behavioral health services in order to establish parity with medical and surgical benefits. That MBHO has also observed that many more of the commercial plans want to manage their out-of-network services, with retrospective review being the most common method to do so.

Another MBHO that uses retrospective review to manage out-of-network care mentioned that providers do not like the uncertainty of reimbursement that comes with retrospective reviews. The company has compensated for this by working with the providers to change treatment patterns prospectively. This company also remarked that most plans' strategy is to have lower copayments and cost-sharing for in-network care, thereby producing a financial incentive to use in-network care. Some companies interviewed do not manage out-of-network services.

Demand for Residential or Intensive Outpatient Substance Abuse Services

Four of the companies interviewed reported that they have not observed a significant increase in the overall frequency of residential or intensive outpatient services for substance use treatment. In some benefit designs, plans do not cover residential substance use treatment. In other designs, there have been changes in how these services are used. For example, one company has noted more individuals using out-of-network residential services. Another has seen an increase in the average length of treatment and the average number of visits for structured substance use intensive outpatient services per week. One company reported experiencing an increase in the number of beneficiaries seeking residential SUD treatment. The two companies reporting increased substance use treatment utilization reported that states in which they work had recently expanded the scope of required benefits to include residential treatment or intensive outpatient services, and that increased demand appeared to be associated with increases in the number of licensed residential treatment facilities (RTFs) in specific geographic areas that they cover.

Plans report eliminating quantitative day limitations for residential treatment because of the parity law. Residential treatment is often classified as an inpatient service. Since most plans do not limit the number of days of medical inpatient services, substance use residential days cannot be limited. Some MBHOs reported considering comparing residential treatment to skilled nursing facilities (SNFs), which usually have day limitations. However, the parity law does not include a SNF category among the six categories of services specified in the IFR for comparing behavioral health and physical health services. As a result, plans cannot make a SNF to residential substance use treatment comparison. One company mentioned that the removal of day limitations has not resulted in a significant change in use or costs because many health plans did not limit total days before implementation of the parity law.

One MBHO reported that some plans considered excluding residential substance use treatment completely following passage of MHPAEA. The company reported that, from a legal perspective, residential care could have been eliminated as long as other

inpatient behavioral health services were covered. However, the MBHO determined that residential treatment is a part of a continuum of care, and that residential treatment could prevent the need for more acute (and expensive) inpatient care.

Establishing parity for intermediate substance use treatments, such as intensive outpatient programs (IOPs), has been more challenging for plans than decisions about covering residential treatment. IOPs could be classified as either an inpatient or an outpatient service. If intermediate care is classified as an outpatient service, the challenge to the plan is in making the copayments comparable to those of medical services. Intensive outpatient treatment requires 3-5 visits per week, for example, so using a standard medical copayment could result in large out-of-pocket expenses. One company recommended to employers and health plans that it contracts with that patients either make a single copayment for an entire course of intermediate treatment or be liable for much smaller copays per visit.

Quantitative day limitations have also been removed for intermediate services. One company noted that, even with the removal of these limitations, the length of IOPs has not increased significantly. It has, however, allowed for individuals who have a relapse after finishing the program to go through the program again.

Management of Prescriptions

Only one of the MBHOs interviewed manages prescription medications for beneficiaries with behavioral health conditions, and even the one plan that does manage prescription medications does so only for certain public insurance plans in states that specify formularies. Most health plans manage prescriptions through a pharmacy benefits management (PBM) vendor. In some cases, the companies interviewed knew that the health plans with which they work had found that formulary tiers were no more restrictive of psychiatric drugs than of other medical drugs.

Additional Comments About Parity

Four respondents reported that they had seen increased use of behavioral health services after the parity law was implemented. One reported that this increase was less than what was expected. Another observed that increased utilization and cost of behavioral health services have now begun to plateau as new management techniques have taken effect. One company observed that states have been so preoccupied with health care reform that parity requirements, regulations and enforcement have been ignored. If the parity law had been in effect a few years prior to enactment of PPACA, oversight by state insurance commissioners and the speed of parity implementation within the state-regulated environment would likely have been very different.

Before the parity law, many health plans had deductibles and lifetime spending maximums that applied solely to behavioral health benefits, entirely separate from copayments and coinsurance for medical benefits. MHPAEA requires that health plans use a unified set of financial and QTLs that accumulate spending for both behavioral

and physical health benefits. These are called *shared accumulators*. One MBHO expressed concern that this has increased the administrative burden of collaborating with health plans to determine whether the maximums have been met. Working with small commercial plans to establish the shared accumulators for each enrollee has been especially challenging.

A few respondents reported that providers have become more aware of the implications of the parity law in recent years. In some cases, plan representatives believe that providers have tried to take advantage of parity to justify new or more extensive treatments. For example, some psychiatrists argue that their services should be reimbursed at the same level as obstetrician/gynecologists or other primary medical care and medical specialists, using the general evaluation and management (E&M) procedure code. As a result, one MBHO reported seeing an increase in psychiatrists using E&M codes to bill for services. Another MBHO observed that the removal of QTLs has coincided with increases among some providers in treating individual patients more than once weekly. This company has advised its providers that open-access to care does not eliminate the need to monitor quality of care and that treatment goals and progress are still necessary for continued payment of claims.

One company raised the challenges it experiences in trying to determine if and how to cover treatments for autism. The plan representative reported an absence of consensus on whether autism should be categorized as a behavioral health condition, a birth defect, or a medical condition. Treatments for autism may be very expensive and lengthy and lack scientific evidence of clinical effectiveness. States have been active in regulating insurance coverage for autism. Many states with mandates have annual dollar limits on the services covered. To limit plans' exposure to very high autism treatment expenses and avoid conflict with the MHPAEA requirements, some states designate autism as a medical condition or a birth defect. This designation permits coverage limitations. New Jersey is the only state that precludes a dollar limit for any plan that covers autism if the plan is subject to federal parity; plans not subject to federal parity may enforce a benefit limit.

Some respondents report that they still have questions about parity, including issues such as:

- Whether it is necessary to harmonize MBHO and medical contracts with facilities and providers.
- Whether parity applies to network access.
- How to reconcile different payment strategies for medical and behavioral health inpatient services.
- How parity applies to the reimbursement of providers.

Summary of Interview Results

Health plans and their subcontracted MBHOs have made significant changes to their management of behavioral health services in response to the MHPAEA.

Companies have moved away from managing the initiation of outpatient treatment by preauthorization and now focus on managing treatment patterns. They target management of individuals receiving more services than what is “expected” or “normal”. Another strategy used is to focus on managing providers, using providers’ distribution of patients’ lengths of treatment to identify outliers. Plans are using claims data to determine if providers are frequently providing care that is not consistent with best practice guidelines. Plans work with the providers to change practice patterns, and if changes are not observed, to move the providers out-of-network.

Preauthorization and concurrent reviews remain respondents’ most common methods for managing inpatient behavioral health services. MBHOs continue to require preauthorization because this is comparable to medical/surgical inpatient service procedures. Concurrent review for behavioral health services is also used in a comparable way to medical and surgical inpatient services that are not paid through the DRG system.

Some health plans now cover more out-of-network behavioral health services in order to maintain parity with other medical services. Parity has also affected some of the treatment patterns of residential treatment or intensive outpatient services. Most respondents found that increased out-of-network benefits and coverage of substance use IOP and residential care have not led to significantly increased utilization by beneficiaries.

MBHOs are rarely responsible for pharmacy benefits. More intensive study of the practices of PBMs and general health plans is needed to determine whether behavioral health pharmacy benefits and formulary practices conform to parity requirements.

SUMMARY OF FINDINGS

Taken as a whole, analyses presented in this report show that employers and health plans have made substantial changes to their plan designs in order to comply with MHPAEA and the IFR. Our sources indicate that by 2011, most ERISA-governed group health plans and health insurance offered in connection with group health plans removed most financial requirements that did not meet MHPAEA standards. Nearly all eliminated the use of separate deductibles for MH/SUD treatment and medical/surgical treatment. The number of plans that apply unequal inpatient day limits, outpatient visit limits or other QTLs for MH/SUD dropped substantially.

Although we document substantial changes since the enactment of MHPAEA, a substantial minority of large employers and health plans still offer some benefits that appear to be inconsistent with MHPAEA and the IFR. Data from 2011 suggests that one out of five large employers required higher copays for in-network outpatient MH/SUD services than for equivalent medical/surgical treatments. Coinsurance rates were still higher for in-network outpatient MH/SUD services than for medical/surgical services in 4% of large employers' plans.

Likewise, preliminary analyses of our limited sample of midsized employer SPDs suggests that in 2010-2011, a substantial minority of the health plans offered by businesses with between 51 and 500 employees required greater cost-sharing for in-network outpatient MH/SUD office visits than for equivalent PCP office visits.

Although the percentage of plans providing benefits that appeared not to conform to MHPAEA's other quantitative limits was much lower in our sample of plans for 2011 compared to 2010, a minority of plans in 2011, between 7% and 9%, still covered fewer MH and SUD inpatient days annually and fewer MH and SUD outpatient visits annually than they covered for medical/surgical conditions.

Assessing compliance with NQTLs is difficult from document review and self-report from employers and plans. We assessed NQTLs through a detailed review of plan documents and responses from an extensive questionnaire administered to plans' MH/SUD and medical/surgical vendors. Our analyses uncovered numerous areas of concern which warrant more intensive investigation. For example, in 2010, nearly three in ten plans used more stringent precertification and utilization management controls for MH/SUD than for medical/surgical conditions. Network management processes were inconsistent, with different standards and processes for including MH/SUD providers in plans' network than were used for medical/surgical providers. MH/SUD provider reimbursement rates were sometimes found to be set at a lower percentage of prevailing community rates than comparable medical/surgical rates. Rates were sometimes determined by the plan based on its internal data, but set medical/surgical reimbursement rates from external, multi-payer databases. Although we were able to

identify some areas of non-compliant NQTLs, it is likely that our reliance on these limited sources of information drawn primarily from large employers' health plans resulted in a significant under-identification of non-complaint NQTLs. A careful, in-depth and longitudinal compliance monitoring of plans' NQTL policies and practices would be likely to turn up correctable problems that our analysis could not detect. The California Department of Mental Health's processes for monitoring plans' compliance with California's Mental Health Parity Act included onsite surveys, reviews of claims files, utilization review files, and internal management and performance reports. California was able to detect patterns in practice that could not be identified from the kind of reviews undertaken in the current report: plans incorrectly denying coverage for ER visits; plans were failing to monitor whether beneficiaries had reasonable access to after-hours services; and plans failed to include required information in claim denial letters.⁶⁹

Some concerns about the impact of MHPAEA were not borne out in our analyses. A very small proportion of employers, between 1% and 2%, dropped or plan to drop coverage for MH or SUD, or for specific MH/SUD diagnoses as a result of MHPAEA. No employers reduced medical/surgical benefits to comply with parity. A very small percentage excluded specific conditions, and most of those were for learning disabilities, developmental delays, and court-ordered services. We did not detect any movement to exclude residential or intensive outpatient services.

Whether the changes that we observed in employers' and health plans' benefit designs constitute compliance with MHPAEA will have to be tested over time in actual practice. Parity should result in greater access to care, improved quality of services, and better outcomes for people with mental illnesses and SUDs.

Limitations. Although it is reasonable to assume that many of the changes we have documented were made in reaction to the implementation of the MHPAEA, it is important also to recognize that other legislative and employer-specific initiatives may have influenced plan design changes that occurred during this time period. Therefore, caution should be used when interpreting these changes as solely attributable to MHPAEA and the IFR.

It is also important to note that many of the comparisons made in this report rely on data obtained from two distinct data sources: the Aon Hewitt database and the Milliman database. Although the general characteristics of employers included in these two databases are similar, there is insufficient information on employers included in each sample to conclude that they are statistically comparable. Therefore, some of the observed differences between these two datasets may be attributable to inherent differences between the two samples, rather than to changes attributable to the implementation of MHPAEA.

In addition, there are significant limitations associated with our analyses of the BLS dataset. One notable limitation is the lack of detailed establishment information provided with the data. The most important characteristic needed to describe differences in

establishments is the number of workers at the establishment. Of secondary importance are the industry classification and the physical location of the establishment. We were only provided information on basic industry categories. Therefore, we believe the weights as created, and applied in our analyses, are insufficient to remove all potential bias from the sample.

Our BLS analyses are also limited by the small number of health plans included in each subsample and the amount of information that could be obtained from each SPD. In some cases, plan information was limited to data obtained from a one-page table of benefits, making abstraction of some data points problematic, and further reducing our sample sizes. Because the number of plans included in each subsample is relatively small, it is only possible to detect relatively large changes between the pre-parity and post-parity samples with any certainty. Therefore, caution should be exercised when interpreting the results of these analyses.

Finally, the results of our health plan/vendor interviews should be interpreted with appropriate caution. Participating respondents represent only a small convenience sample of MBHOs. Although they include some of the largest firms in the field, they represent only a fraction of all MBHOs in the United States. Because the MBHOs work with many health plans, the responses tended toward commonalities; they will not reflect the experiences of every patient or plan associated with these MBHOs. Finally, we made no attempt to verify the information provided by respondents. Their comments should be viewed as the informed opinions of employees.

END NOTES

1. MHPAEA Public Law 110-343.
2. See 75 Fed. Reg. 5410-5451 (February 2, 2010). See 45 C.F.R. §146.136(a) defining the scope of parity in relation to both qualitative and QTLs.
3. KFF/HRET annually surveys a random, stratified sample of employers to assess year-to-year changes in health benefits. Employers are stratified by industry and employer size. For the most recently completed annual survey -- conducted from January 2010 to May 2010 and published in September 2010 -- 2,046 employers responded to the full survey, a 47% response rate.
4. Mercer surveys a stratified random sample of employers annually through mail questionnaires and telephone interviews. Mercer selects a random sample of private sector employers from a Dun & Bradstreet database, stratified into eight categories, and randomly selects public sector employers -- state, county, and local governments -- from the Census of Governments. A total of 2,833 employers responded to the 2010 survey. By using statistical weights, Mercer projected its results nationwide and for four geographic regions. The Mercer survey report contains information for large employers -- those having ≥ 500 employees -- and for categories of large employers with certain numbers of employees as well as information for small employers -- those having fewer than 500 employees. Mercer used the same methodology for its 2008 survey, which was published in 2009.
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http://www.hmohelp.ca.gov/library/reports/med_survey/parity/sfor.pdf.
6. MHPAEA Public Law 110-343.
7. Ibid.
8. Ibid.
9. Ibid.
10. See 75 Fed. Reg. 5410-5451 (February 2, 2010). See 45 C.F.R. §146.136(a) defining the scope of parity in relation to both qualitative and quantitative treatment limits.

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13. 29 U.S.C. §1185a(a)(3).
14. 42 U.S.C. §330(g)(2).
15. 29 U.S.C. §1185a(c)(1).
16. 42 U.S.C. §300gg-91(e)(4) as applied to MHPAEA by PPACA §1563(c)(4).
17. See U.S. Department of Labor, FAQs about Affordable Care Act Implementation Part V and Mental Health Parity Implementation, Q. 8. Available at: <http://www.dol.gov/ebsa/faqs/faq-aca5.html>. Accessed May 5, 2012.
18. Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed rule, 77 Fed. Reg. 70644-70677 (amending 45 CFR Parts 147, 155, and 156) (November 26, 2012).
19. 42 U.S.C. §18022, added by PPACA §1302.
20. 42 U.S.C. §300gg-6(a).
21. 42 U.S.C. §1397cc(c)(6).
22. Social Security Act §1833(c)(1), 42 U.S.C. §1395l(c)(1).
23. CMS Manual System Pub. 100-02, Transmittal 114, Medicare Benefit Policy.
24. 76 Fed. Reg. 54600, 54605 (September 1, 2011).
25. PHS Act §2722(a)(2), 42 U.S.C. §300gg-21(a)(2).
26. P.L. 104-204.
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61. For its 2012 parity study, the GAO surveyed a stratified random sample of 707 small, medium, large, and very large employers about the MH/SUD covered in their health plans that covered the greatest number of lives for the most current plan year -- either 2011 or 2010 -- as well as for 2008. A total of 168 employers submitted usable survey responses, for a response rate of 24%. It may be difficult to generalize from this sample to the universe of employers and health plans subject to MHPAEA and the IFR.
62. See 75 Fed. Reg. 5410-5451 (February 2, 2010). See 45 C.F.R. §146.136(a) defining the scope of parity in relation to both qualitative and quantitative treatment limits.

63. KFF/HRET annually surveys a random, stratified sample of employers to assess year-to-year changes in health benefits. Employers are stratified by industry and employer size. For the most recently completed annual survey -- conducted from January 2010 to May 2010 and published in September 2010 -- 2,046 employers responded to the full survey, a 47% response rate.
64. Mercer surveys a stratified random sample of employers annually through mail questionnaires and telephone interviews. Mercer selects a random sample of private sector employers from a Dun & Bradstreet database, stratified into eight categories, and randomly selects public sector employers -- state, county, and local governments -- from the Census of Governments. A total of 2,833 employers responded to the 2010 survey. By using statistical weights, Mercer projected its results nationwide and for 4 geographic regions. The Mercer survey report contains information for large employers -- those having ≥ 500 employees - - and for categories of large employers with certain numbers of employees as well as information for small employers -- those having fewer than 500 employees. Mercer used the same methodology for its 2008 survey, which was published in 2009.
65. Methodology for sample selection and technical specifications at http://www.bls.gov/ncs/ebs/smb_health.htm. The sample for the NCS is selected on the basis of a three-stage design. The first stage involved the selection of areas consisting of 152 metropolitan and non-metropolitan areas. In the second stage, the sample of establishments is drawn from a sampling frame comprised of state unemployment insurance reports within sampled areas. The third stage is a probability sample of occupations within a sampled establishment. BLS field economists visit sampled establishments or contact them by telephone to collect data for the survey. To reduce the reporting burden, field economists ask respondents to provide Summary Plan Provision documents for health and retirement plans. Approximately 3,300 establishments provide data for each annual NCS.
66. The analysis weights were calibrated to establishment and worker counts from the 2010 County Business Patterns created by the Department of Census. The end result is two sets of weights -- an establishment and a worker weight for pre-parity and an establishment and a worker weight for post-parity. The weight sums for the respective weights are identical between pre-parity and post-parity. Following describes the detailed process used to construct analysis weights.

Step 1: Calculate the proportion of observations within each subsample and industry such that:

$$r_{pi} = \frac{n_{pi}}{\sum_i n_{pi}}$$

Where n = number of observations within subsample p and industry i .

Step 2: Calculate the share of establishments within each industry such that:

$$R_i = \frac{N_i}{\sum_i N_i}$$

Where N = the number of establishments from the 2010 County Business Patterns within industry i .

Step 3: Calculate the share of workers within each industry such that:

$$RW_i = \frac{NW_i}{\sum_i NW_i}$$

Where NW = the number of workers from the 2010 County Business Patterns within industry i .

Step 4: Calculate the final weights as the ratio of the share of establishments or workers within each industry and the proportion of observations within each subsample and industry such that:

$$\textit{Establishment Weight} = \frac{R_i}{r_{pi}}$$

$$\textit{Worker Weight} = \frac{RW_i}{r_{pi}}$$

Where r_{pi} = the proportion of observations within each subsample and industry, R_i = the share of establishments within each industry, and RW_i = the share of workers within each industry.

The sum of both the establishment weight and the worker weight within each subsample equals the sample size within each subgroup. Each weight has a different impact on analyses. For example, the health care industry tends to have more workers as a share of the total workforce than establishments as a share of total establishments. Thus, the worker weight will grant health care observations more influence on an estimate than will the establishment weight. Comparisons of results obtained using both sets of weights demonstrated very minimal differences between the two sets of estimates. The estimates presented in this report were calculated using the establishment weights.

67. The industry categories are as follows: (1) Agriculture, Mining, Utilities, Construction, and Manufacturing (NAICS = 11, 21, 22, 23, 31, 32, 33); (2) Wholesale (NAICS = 42); (3) Retail (NAICS = 44, 45); (4) Transportation and Information (NAICS = 48, 49, 51); (5) Finance, Real Estate, Professional Services, and Management (NAICS = 52, 53, 54, 55, 56); (6) Health care (NAICS = 62); and (7) Education, Recreation, Food Service and Other (NAICS = 61, 71, 72, 81).
68. Government Accountability Office (GAO). Mental Health and Substance Use: Treatment Exclusions in Employers' Health Insurance Coverage. GAO-12-761R. Available at: <http://www.gao.gov/assets/600/591261.pdf>.
69. California Department of Managed Health Care. Mental Health Parity in California. Mental Health Parity Focused Survey Project: A Summary of Survey Findings and Observations. Available at: http://www.hmohelp.ca.gov/library/reports/med_survey/parity/sfor.pdf.

APPENDIX A. DETAILED COMPLIANCE TESTING RESULTS: MILLIMAN DATABASE (2010)

1. **There were no plans in the Milliman sample that did not offer any MH/SUD benefits during 2009-2011.**

2. **The percentage of plans with separate deductibles and/or out-of-pocket (OOP) maximums for MH/SUD in their 2010 benefit designs is as follows:**
 - 3.2% of plans had separate deductibles for MH/SUD benefits. That is, MH/SUD member OOP costs did not accumulate towards a single deductible combined with their medical/surgical benefits.
 - 7.2% of plans had separate OOP maximums for MH/SUD and medical/surgical benefits.
 - 3.2% of plans had separate deductibles and separate OOP maximums for MH/SUD benefits and medical/surgical benefits.

These separate MH/SUD deductibles and OOP maximums were removed such that the post-parity benefits had integrated deductibles and OOP maximums for MH/SUD and medical/surgical benefits.

3. **We were not able to identify any plan that increased medical/surgical financial requirements or eliminated certain coverage for MH/SUD disorders to achieve parity.**

The following sections present the testing results in tables that summarize the percentage of plans and the specific changes that had to be made to become parity compliant. There are tables for each classification of MH/SUD benefits as defined by the IFR (Inpatient In-Network, Inpatient Out-of-Network, Outpatient In-Network, Outpatient Out-of-Network, Emergency Care, and Prescription Drug (Rx). Results also report when the outpatient benefits safe harbor was used to separately test Outpatient Office Visits from Outpatient-Other benefits.

Nearly all the tables have the identical format. The first column displays the type of quantitative financial requirement or treatment limitation applicable to the benefit classification in question. The subsequent columns summarize the percentage of plans where each type of financial requirement was unchanged, added, converted to a different type of cost-sharing, increased, decreased, or modified in other ways.

- “No Change” shows the percentage of plans where no changes were required to become compliant with MHPAEA.
- “Added” indicates the percentage of plans that did not have a certain type of financial requirement when one was allowed by MHPAEA, and had the option of adding one.
- “Converted” indicates the percentage of plans that had to change the type of member cost-sharing. Typically, plans had to either switch from a dollar copay to the use of the deductible with coinsurance and OOP maximum structure, or vice versa.
- “Removed” indicates the percentage of plans that had to completely remove the financial requirement (and were not allowed to convert it to a different form of cost-sharing).
- “Increased” indicates the percentage of plans that were charging a lower cost-sharing (or OOP maximum) than was allowed by MHPAEA, and had the option of increasing it.
- “Decreased” indicates the percentage of plans that were charging a higher cost-sharing (or OOP maximum) than was allowed by MHPAEA, and were required to reduce it.
- “Exception” indicates the percentage of plans that had to make changes that are not adequately described by any of the other options in the table.

Please note that in several of the tables that describe cost-sharing changes (subsection “a”), the percentages across rows may not sum to 100%. For example, in section 4a, the percentage of plans that did not have to make any changes to their deductible is 93.3% (second column). The percentage of plans that had to make a change to their deductible was 5.7% (sum of the next six columns). These two percentages sum to only 99.0%. The reason for this is that 1.0% of the plans had copays which had to be converted to a deductible/coinsurance structure. This conversion was counted under the “Converted” column of the copay line. To avoid double counting, they did not include these plans anywhere in the “Deductible” row, resulting in total percentages below 100%.

4. **Inpatient MH benefits.**

- a. Copay/coinsurance/deductible/OOP maximum levels (quantitative financial requirements).

The table below shows summarized results of compliance testing of the Inpatient In-Network Mental Health (IP INN MH) benefits.

Percent of Plans Covering IP INN MH Services: 96.0%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible ^{1,2}	93.3%	3.3%	0.0%	0.8%	0.0%	0.8%	0.8%
OOP max ¹	91.7%	7.5%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay ¹	93.3%	2.5%	0.8%	0.8%	0.0%	1.7%	0.0%
Coinsurance ¹	92.5%	0.0%	0.8%	0.0%	0.0%	5.8%	0.0%
1. Note that some percentages do not add up to 100%. The difference is due to plans where deductible, coinsurance, and OOP max were added to replace a copay or vice versa. These conversions are recorded under the row that represents the original cost-sharing. 2. Indicated exceptions include plans where a partial hospital benefit deductible was removed but could be replaced by a per admit deductible with coinsurance up to OOP max.							

Over 90% of the plans that provided IP INN MH benefits did not have to make any changes to their financial requirements to comply with MHPAEA and the IFR.

About 7.5% of the plans were required to accumulate the member OOP payments for these benefits towards the same OOP maximum that was applicable to medical/surgical benefits.

Nearly 6% of the plans were required to reduce their coinsurance on this benefit to be parity compliant.

The table below shows summarized results of the compliance testing of the Inpatient Out-of-Network Mental Health (IP OON MH) benefits.

Percent of Plans Covering IP OON MH Services: 82.4%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible ¹	99.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%
OOP max	92.2%	7.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance	94.2%	0.0%	0.0%	0.0%	0.0%	5.8%	0.0%
1. Indicated exceptions include plans where a partial hospital benefit deductible was removed but could be replaced by a per admit deductible with coinsurance up to OOP max.							

Over 90% of the plans that provided IP OON MH benefits did not have to make any changes to their cost-sharing to comply with MHPAEA and the IFR.

About 8% of the plans were required to accumulate the member out-of-payments for these benefits towards the same OOP maximum that was applicable to corresponding medical/surgical benefits.

Nearly 6% of the plans were required to reduce their coinsurance on this benefit to be parity compliant.

b. Quantitative treatment limitations.

The following table summarizes the percentage of plans that had to remove various QTLs placed on their IP INN MH benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	12.5%
Percent of plans where visit limits were removed	N/A
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	4.2%

The most common IP INN MH treatment limitation removed was the day limit in a calendar year on inpatient stays (12.5% of the plans).

Other changes that certain plans had to make to their IP INN MH benefits to become parity compliant are listed below.

Exceptions	Plans (%)
Day limits were removed for Inpatient In-Network RTF services only	0.8%

The following table summarizes the percentage of plans that had to remove various QTLs placed on their IN OON MH benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	6.8%
Percent of plans where visit limits were removed	N/A
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	4.9%

The most common IP OON MH treatment limitation removed was the day limits in a calendar year on inpatient stays (6.8% of the plans).

Other changes that certain plans had to make to their IP OON MH benefits to become parity compliant are listed below.

Exceptions	Plans (%)
Plans where day limits were removed for Inpatient Out-of-Network RTFs only	1.9%
Plans where out-of-network benefits were previously not covered, but were recommended they be added to comply with the cover one, cover all classification requirement	2.9%

For precertification requirements and penalties for lack of precertification, please see section 13.

5. **Inpatient SUD benefits.**

- a. Copay/coinsurance/deductible/OOP maximum levels (quantitative financial requirements).

The table below shows summarized results of the compliance testing of the Inpatient In-Network Substance Use Disorder (IP INN SUD) benefits.

Percent of Plans Covering IP INN SUD Services: 95.2%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible ^{1,2}	93.3%	3.4%	0.0%	0.8%	0.0%	0.8%	0.8%
OOP max ¹	91.6%	7.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay ¹	93.3%	2.5%	0.8%	0.8%	0.0%	1.7%	0.0%
Coinsurance ¹	92.4%	0.0%	0.8%	0.0%	0.0%	5.9%	0.0%
1. Note that some percentages do not add up to 100%. The difference is due to plans where deductible, coinsurance, and OOP max were added to replace a copay or vice versa. These conversions are recorded under the line that represents the original cost-sharing. 2. Indicated exceptions include plans where a partial hospital benefit deductible was removed but could be replaced by a per admit deductible with coinsurance up to OOP max.							

Over 90% of the plans that provided Inpatient IP INN SUD benefits did not have to make any changes to their financial requirements to comply with MHPAEA and the IFR.

About 7.6% of the plans were required to accumulate the member OOP payments for these benefits towards the same OOP maximum that was applicable to medical/surgical benefits.

Nearly 6% of the plans were required to reduce their coinsurance on this benefit to be parity compliant.

The table below shows summarized results of the compliance testing of the Inpatient Out-of-Network Substance Use Disorder (IP OON SUD) benefits.

Percent of Plans Covering IP OON SUD Services: 82.4%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible ^{1,2}	99.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%
OOP max ¹	91.3%	8.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay ¹	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance ¹	94.2%	0.0%	0.0%	0.0%	0.0%	5.8%	0.0%
1. Indicated exceptions include plans where a partial hospital benefit deductible was removed but could be replaced by a per admit deductible with coinsurance up to OOP max.							

Over 90% of the plans that provided IP OON SUD benefits did not have to make any changes to their financial requirements to comply with MHPAEA and the IFR.

About 8.7% of the plans were required to accumulate the member OOP payments for these benefits towards the same OOP maximum that was applicable to medical/surgical benefits.

Nearly 6% of the plans were required to reduce their coinsurance on this benefit to be parity complaint.

b. Quantitative treatment limitations.

The following table summarizes the percentage of plans that had to remove various QTLs placed on their IP INN SUD benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	19.3%
Percent of plans where visit limits were removed	N/A
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	6.7%

The most common IP INN SUD treatment limitation removed was the day limit in a calendar year on inpatient stays (19.3% of plans).

Other changes that certain plans had to make to their IP INN SUD benefits to become parity compliant are listed below.

Exceptions	Plans (%)
Day limits were removed for Inpatient In-Network RTFs only	0.8%
Inpatient Detoxification Days are covered but Inpatient Rehabilitation Days are not covered ¹	2.5%
1. This is a scope of services issue which plans could ignore if they so choose	

The following table summarizes the percentage of plans that had to remove various QTLs placed on their IN OON SUD benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	15.5%
Percent of plans where visit limits were removed	N/A
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	6.8%

The most common out IP OON SUD treatment limitation removed was the day limits in a calendar year on inpatient stays (15.5% of plans).

Other changes that certain plans had to make to their IP OON SUD benefits to become parity compliant are listed below.

Exceptions	Plans (%)
Plans where day limits were removed for Inpatient Out-of-Network RTFs	1.9%
Plans where IN OON SUD benefits were previously not covered but should be under the cover one, cover all classification requirements	2.9%
Inpatient Detoxification Days are covered but Inpatient Rehabilitation Days are not covered ¹	2.9%
1. This is a scope of services issue which plans could ignore if they so choose	

For precertification requirements and penalties for lack of precertification, please see section 13.

About 8% of the plans were tested without making use of the safe harbor provision provided by the IFR. The remaining plans were tested using the safe harbor provision. The safe harbor has implications for how many benefit classifications can be created for parity compliance testing purposes. Prior to the safe harbor provision, there was only one outpatient classification for in-network benefits and a separate one for out-of-network benefits. The safe harbor allows splitting of the outpatient classifications into office visits and outpatient-other sub-classifications. Sections 6 and 7 present the compliance testing results for plans that were tested without the safe harbor. Sections 8 through 11 present the results for plans tested with the safe harbor. Sections 8 and 9 show the results for the Outpatient Office Visit benefit sub-classification, while sections 10 and 11 show the results for the Outpatient Other sub-classification.

6. Outpatient MH benefits.

- a. Copay/coinsurance/deductible/OOP maximum levels (quantitative financial requirements).

The table below shows summarized results of the compliance testing of the Outpatient In-Network Mental Health (OP INN MH) benefits.

Percent of Plans covering OP INN MH Services -- Tested Without Safe Harbor: 8.0%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
OOP max	70.0%	30.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Only 8% of all plans provided OP INN MH benefits and were tested without making use of the safe harbor provision. Most of them were compliant with MHPAEA and the IFR; 30% of these plans required only one notable change to become compliant -- these plans were required to subject the OP INN MH benefits to the predominant medical/surgical OOP maximum.

The table below shows summarized results of the compliance testing of the Outpatient Out-of-Network Mental Health (OP OON MH) benefits.

Percent of Plans Covering OP OON MH Services -- Tested Without Safe Harbor: 17.6%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
OOP max	90.9%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance	90.9%	0.0%	0.0%	0.0%	0.0%	9.1%	0.0%

Only about 18% of all plans provided OP OON MH benefits and were tested without making use of the safe harbor. Nearly all of them were compliant. The only notable changes that needed to be made to a few of the plans to become compliant was subjecting the OP OON MH benefits to the predominant medical/surgical OOP maximum, and reducing the coinsurance applicable to these services to the predominant medical/surgical coinsurance level.

b. Quantitative treatment limitations.

The following table summarizes the percentage of plans tested without the Outpatient safe harbor that had to remove various QTLs placed on their OP INN MH benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	50.0%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	0.0%

The most common OP INN MH treatment limitation removed was the calendar year visit limits on outpatient professional visits (50% of the plans tested without safe harbor).

The following table summarizes the percentage of plans tested without the Outpatient safe harbor that had to remove various QTLs placed on their OP OON MH benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	13.6%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	0.0%

The most common OP OON MH treatment limitation removed was the calendar year visit limits on outpatient professional visits (13.6% of the plans tested without safe harbor).

Other changes that certain plans tested without the Outpatient safe harbor had to make to their OP OON MH benefits to become parity compliant are listed below.

Exceptions	Plans (%)
Plans where OP OON MH benefits were previously not covered but were recommended be covered under the cover one, cover all classification requirement	13.6%

For precertification requirements and penalties for lack of precertification, please see section 13.

7. Outpatient SUD.

- a. Copay/coinsurance/deductible/OOP maximum levels (quantitative financial requirements).

The table below shows summarized results of the compliance testing of the Outpatient In-Network Substance Use Disorder (OP INN SUD) benefits.

Percent of Plans Covering OP INN SUD Services -- Tested Without Safe Harbor: 8.0%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
OOP max	70.0%	30.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Only 8% of all plans provided OP INN SUD benefits and were tested without making use of the safe harbor. Most of them were compliant. The only notable change that was needed to become compliant was subjecting the OP INN SUD benefits to the predominant medical/surgical OOP maximum; 30% of these plans needed this change.

The table below shows summarized results of the compliance testing of the Outpatient Out-of-Network Substance Use Disorder (OP OON SUD) benefits. Approximately 18% of the plans provided this benefit.

Percent of Plans Covering OP OON SUD Services and Were Tested Without Safe Harbor: 17.6%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
OOP max	90.9%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance	90.9%	0.0%	0.0%	0.0%	0.0%	9.1%	0.0%

Only 18% of all plans offered OP OON SUD benefits and were tested without making use of the safe harbor. Nearly all of them were compliant. The only notable changes that were needed to become compliant was subjecting the OP OON SUD benefits to the predominant medical/surgical

OOP maximum, and reducing the coinsurance applicable to these services to the predominant medical/surgical coinsurance level.

b. Quantitative treatment limitations.

The following table summarizes the percentage of plans tested without the safe harbor that had to remove various QTLs placed on their OP INN SUD benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	50.0%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	30.0%

The calendar year professional visit limits for OP INN SUD benefits were removed from 50% of the plans, and calendar year dollar limits were removed for these services from 30% of the plans.

The following table summarizes the percentage of plans tested without the safe harbor that had to remove various QTLs placed on their OP OON SUD benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	63.6%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	9.1%

The most common treatment limitation removed was the calendar year professional visit limits on OP OON SUD visits (64% of the plans). Calendar year dollar limits were removed in 9% of the plans.

Other changes that certain plans had to make to their OP OON SUD benefits to become parity compliant are listed below.

Exceptions	Plans (%)
Plans where OP OON SUD benefits were previously not covered but plans were advised to cover it under the cover one, cover all requirement	13.6%

For precertification requirements and penalties for lack of precertification, please see section 13.

8. **Outpatient office visits for MH disorders.**

- a. Copay/coinsurance/deductible/OOP maximum levels (quantitative financial requirements).

The table below shows summarized results of the compliance testing of the Outpatient Office Visit In-Network Mental Health (OP OV INN MH) benefits.

Percent of Plans Covering OP OV INN MH Benefits -- Tested with Safe Harbor: 88.0%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible ¹	94.5%	0.9%	0.0%	3.6%	0.0%	0.0%	0.0%
OOP max ¹	99.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay ^{1,2,3}	76.4%	0.0%	0.9%	2.7%	0.0%	6.4%	6.4%
Coinsurance ^{1,4}	89.1%	0.0%	7.3%	0.9%	0.0%	0.9%	0.9%
<p>1. Note that some percentages do not add up to 100%. The difference is due to plans where deductible, coinsurance, and OOP max were added to replace a copay or vice versa. These conversions are recorded under the line that represents the original cost-sharing.</p> <p>2. Indicated exceptions include plans that reduced OP OV INN MH copays only for specialist visits.</p> <p>3. Indicated exceptions include plans where plans were advised they could increase the OP OV INN MH copay to the specialist level.</p> <p>4. Indicated exceptions include plans were advised to change coinsurance to copay for "other services in physician office".</p>							

Over 75% of the plans that provided OP OV INN MH benefits did not have to make any changes to their financial requirements to comply with MHPAEA and the IFR.

About 6% of the plans were required to reduce their OP OV INN MH copays.

Over 7% of the plans were required to convert their coinsurance to copays for this benefit category.

The table below shows summarized results of the compliance testing of the Outpatient Office Visit Out-of-Network Mental Health (OP OV OON MH) benefits.

Percent of Plans Covering OP OV OON MH Benefits -- Tested with Safe Harbor: 64.8%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
OOP max	91.4%	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	98.8%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%
Coinsurance	92.6%	0.0%	0.0%	0.0%	0.0%	7.4%	0.0%

Over 90% of the plans that provided OP OV OON MH benefits did not have to make any changes to their financial requirements to comply with MHPAEA and the IFR.

About 9% were required to accumulate the member OOP payments for these OP OV OON MH benefits towards the same OOP maximum that was applicable to medical/surgical benefits.

Over 7% of plans were required to reduce their coinsurance that was application to this benefit category.

b. Quantitative treatment limitations.

The following table summarizes the percentage of plans that were tested with the safe harbor that had to remove various QTLs placed on their OP OV INN MH benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	11.8%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	4.5%

The most common treatment limitation removed was the calendar year professional visit limits on OP OV INN MH benefits (12% of plans). Nearly 5% of these plans had to remove calendar year dollar limits for these benefits.

The following table summarizes the percentage of plans that were tested with the safe harbor that had to remove various QTLs placed on their OP OV OON MH benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	14.8%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	6.2%

The most common treatment limitation removed was the calendar year professional visit limits on OP OV OON MH benefits (15% of plans). Nearly 6% of the plans had to remove calendar year dollar limits.

Other changes that certain plans had to make to their OP OV OON MH benefits to become parity compliant are listed below.

Exceptions	Plans (%)
Plans where OP OV OON MH benefits were previously not covered but were recommended be covered under the cover one, cover all classification requirement	3.7%

For precertification requirements and penalties for lack of precertification, please see section 13.

9. **Outpatient office visits for SUD.**

a. Copay/coinsurance/deductible/OOP maximum levels.

The table below shows summarized results of the compliance testing of the Outpatient Office Visit In-Network Substance Use Disorder (OP OV INN SUD) benefits. Approximately 87% of the plans provided this benefit.

Percent of Plans Covering OP OV INN SUD Benefits -- Tested with Safe Harbor: 87.2%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible ¹	91.7%	0.9%	0.0%	6.4%	0.0%	0.0%	0.0%
OOP max ¹	99.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay ^{1,2,3}	77.1%	0.0%	0.9%	0.9%	0.0%	5.5%	7.3%
Coinsurance ^{1,4}	87.2%	0.0%	8.3%	2.8%	0.0%	0.9%	0.0%
<p>1. Note that some percentages do not add up to 100%. The difference is due to plans where deductible, coinsurance, and OOP max were added to replace a copay or vice versa. These conversions are recorded under the line that represents the original cost-sharing.</p> <p>2. Indicated exceptions include plans that reduced copays only for specialist visits.</p> <p>3. Indicated exceptions include plans where plans were advised they could increase office visit copay to the specialist level.</p> <p>4. Indicated exceptions include plans where plans were advised to change coinsurance to copay for "other services in physician office".</p>							

Over 75% of the plans that provided OP OV INN SUD benefits did not have to make any changes to their financial requirements to comply with MHPAEA and the IFR.

About 6% of the plans were required to remove calendar year deductibles from this benefit category.

About 5.5% of the plans were required to reduce their copays for these benefits. An additional 7% of the plans could increase their OP OV INN SUD copays on specialist services without violating parity, or were required to change from coinsurance to copays for any physician services other than regular outpatient office visits.

Over 8% of the plans were required to convert their coinsurance to copays for these benefits.

The table below shows summarized results of the compliance testing of the Outpatient Office Visit Out-of-Network Substance Use Disorder (OP OV OON SUD) benefits. Approximately 65% of the plans provided this benefit.

Percent of Plans Covering OP OV OON SUD Benefits -- Tested with Safe Harbor: 64.8%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible	98.8%	0.0%	0.0%	1.2%	0.0%	0.0%	0.0%
OOP max	90.1%	9.9%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	98.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance	93.8%	0.0%	1.2%	0.0%	0.0%	4.9%	0.0%

Over 90% of the plans that provided OP OV OON SUD benefits did not have to make any changes to their financial requirements to comply with MHPAEA and the IFR.

About 10% were required to accumulate the member OOP payments for these benefits towards the same OOP maximum that was applicable to medical/surgical benefits.

Nearly 5% of the plans were required to reduce their coinsurance percentage that was application to this benefit category.

b. Quantitative treatment limitations.

The following table summarizes the percentage of plans tested with the safe harbor that had to remove various QTLs placed on their OP OV INN SUD benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	20.2%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	4.6%

The most common in-network treatment limitation removed was the visit limits on OP OV INN SUD benefits (20% of plans). Nearly 5% of these plans had to remove calendar year dollar limits for these benefits.

The following table summarizes the percentage of plans tested with the safe harbor that had to remove various QTLs placed on their OP OV OON SUD benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	14.8%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	6.2%

The most common out-of-network treatment limitation removed was the visit limits on OP OV OON SUD benefits (15% of plans). Nearly 6% of these plans had to remove calendar year dollar limits for these benefits.

Other changes that certain plans had to make to their OP OV OON SUD benefits to become parity compliant are listed below.

Exceptions	Plans (%)
Plans where OP OV OON SUD benefits were previously not covered but were recommended be covered under the cover one, cover all requirement	3.7%

For precertification requirements and penalties for lack of precertification, please see section 13.

10. Outpatient other benefits for MH disorders.

a. Copay/coinsurance/deductible/OOP maximum levels.

The table below shows summarized results of the compliance testing of Outpatient-Other In-Network Mental Health (OP-Other INN MH) benefits.

Percent of Plans Covering OP-Other INN MH Services -- Tested with Safe Harbor: 88.0%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible ¹	74.5%	2.7%	0.0%	8.2%	0.0%	0.0%	0.0%
OOP max ¹	79.1%	3.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	73.6%	0.0%	17.3%	7.3%	0.0%	1.8%	0.0%
Coinsurance ¹	68.2%	0.0%	0.0%	10.0%	0.0%	4.5%	0.0%
1. Note that some percentages do not add up to 100%. The difference is due to plans where deductible, coinsurance, and OOP max were added to replace copays or vice versa. These conversions are recorded under the line that represents the original cost-sharing.							

Nearly 70% of the plans that provided OP-Other INN MH benefits did not have to make any changes to their cost-sharing to comply with MHPAEA and the IFR.

Over 17% of the plans were required to convert their copays to coinsurance for this benefit category, and over 7% had to remove copays completely

10% of the plans were required to remove the coinsurance completely on this benefit, while another 4.5% of the plans were required to reduce the coinsurance level.

The table below shows summarized results of the compliance testing of OP-Other Out-of-Network Mental Health (OP-Other OON MH) benefits.

Percent of Plans Covering OP-Other OON MH Services -- Tested with Safe Harbor: 64.8%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible ¹	95.1%	0.0%	0.0%	3.7%	0.0%	0.0%	0.0%
OOP max	91.4%	8.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	98.8%	0.0%	1.2%	0.0%	0.0%	0.0%	0.0%
Coinsurance ¹	88.9%	0.0%	0.0%	1.2%	0.0%	8.6%	0.0%
1. Note that some percentages do not add up to 100%. The difference is due to plans where deductible, coinsurance, and OOP max were added to replace copays or vice versa. These conversions are recorded under the line that represents the original cost-sharing.							

Over 90% of the plans that provided OP-Other OON MH benefits did not have to make any changes to their cost-sharing to comply with MHPAEA and the IFR.

Nearly 9% were required to accumulate the member payments for these benefits towards the same OOP maximum that was applicable to medical/surgical benefits.

Nearly 9% of the plans were required to reduce their coinsurance that was application to this benefit category.

b. Quantitative treatment limitations.

The following table summarizes the percentage of plans tested with the safe harbor that had to remove various QTLs placed on their OP-Other INN MH benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	8.2%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	4.5%

The most common treatment limitation removed was the visit limits on OP-Other INN MH benefits (8% of plans). Nearly 5% of the plans had to remove dollar limits.

The following table summarizes the percentage of plans tested with the safe harbor that had to remove various QTLs placed on their OP-Other Out-of-Network Mental Health benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	9.9%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	6.2%

The most common treatment limitation removed was the visit limits on OP-Other OON MH benefits (10% of plans). Nearly 6% of the plans had to remove dollar limits.

Other changes that certain plans had to make to their OP-Other OON MH benefits to become parity compliant are listed below.

Exceptions	Plans (%)
Plans where OP-Other OON MH Disorder benefits were previously not covered but were recommended be covered under the cover one, cover all requirement	3.7%

For precertification requirements and penalties for lack of precertification, please see section 13.

11. Outpatient other benefits for SUD.

a. Copay/coinsurance/deductible/OOP maximum levels.

The table below shows summarized results of the compliance testing of the Outpatient-Other In-Network Substance Use Disorder (OP-Other INN SUD) benefits.

Percent of Plans Covering Op-Other INN SUD Services -- Tested with Safe Harbor: 87.2%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible ¹	78.0%	2.8%	0.0%	8.3%	0.0%	0.0%	0.0%
OOP max ¹	82.6%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	77.1%	0.0%	13.8%	7.3%	0.0%	1.8%	0.0%
Coinsurance ¹	70.6%	0.0%	0.0%	8.3%	0.0%	7.3%	0.0%
1. Note that some percentages do not add up to 100%. The difference is due to plans where deductible, coinsurance, and OOP max were added to replace a copay or vice versa. These conversions are recorded under the line that represents the original cost-sharing.							

Over 70% of the plans that provided OP-Other INN SUD benefits did not have to make any changes to their cost-sharing to comply with MHPAEA and the IFR.

About 8% of the plans were required to remove deductibles from this benefit category, while 3% of the plans were not subjecting these benefits to a deductible but could do so without violating parity.

Nearly 14% of the plans were required to convert their copays to coinsurance, and another 7% had to completely remove copays from this benefit.

About 7% of the plans were required to reduce their coinsurance, while another 8% had to completely remove coinsurance from this benefit.

The table below shows summarized results of the compliance testing of the Outpatient-Other Out-of-Network Substance Use Disorder (OP-Other OON SUD) benefits.

Percent of Plans Covering OP-Other OON SUD Services -- Tested with Safe Harbor: 64.8%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible	96.3%	0.0%	0.0%	3.7%	0.0%	0.0%	0.0%
OOP max	90.1%	9.9%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance	92.6%	0.0%	0.0%	1.2%	0.0%	6.2%	0.0%

Over 90% of the plans that provided OP-Other OON SUD benefits did not have to make any changes to their cost-sharing to comply with MHPAEA and the IFR.

About 4% of the plans were required to remove deductibles from OP-Other OON SUD benefits.

Nearly 10% were required to accumulate the member payments for these benefits towards the same OOP maximum that was applicable to the corresponding medical/surgical benefits; over 6% of the plans were required to reduce their coinsurance that was applied to this benefit category.

b. Quantitative treatment limitations.

The following table summarizes the percentage of plans that were tested with the safe harbor that had to remove various QTLs placed on their OP-Other INN SUD benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	16.5%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	4.6%

The most common in-network treatment limitation removed was the visit limits on OP-Other INN SUD benefits (17% of plans). Nearly 5% of the plans had to remove dollar limits on OP-Other INN SUD benefits.

The following table summarizes the percentage of plans that were tested with the safe harbor that had to remove various QTLs placed on their Outpatient-Other Out-of-Network Substance Use Disorder benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where day limits were removed	N/A
Percent of plans where visit limits were removed	9.9%
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	6.2%

The most common treatment limitation removed was the visit limits on OP-Other OON SUD benefits (10% of plans). Nearly 6% of the plans had to remove dollar limits on OP-Other OON SUD benefits.

Other changes that certain plans had to make to their OP-Other OON SUD benefits to become parity compliant are listed below.

Exceptions	Plans (%)
Plans where OP-Other OONSUD benefits were previously not covered but were recommended be covered under the cover one, cover all requirement	3.7%

For precertification requirements and penalties for lack of precertification, please see section 13.

12. **Emergency Care, including true emergency and non-emergent care provided in ERs -- MH and SUD benefits.**

a. Copay/coinsurance/deductible/OOP maximum levels.

The table below shows summarized results of the compliance testing of ER MH/SUD benefits. 100% of the plans provided this benefit.

Percent of Plans Covering ER MH/SUD Services: 100.0%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible ¹	94.4%	2.4%	0.0%	1.6%	0.0%	0.0%	1.6%
OOP max	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay ¹	92.8%	2.4%	0.0%	0.0%	0.0%	0.0%	1.6%
Coinsurance ^{1,2}	80.8%	0.0%	3.2%	1.6%	0.0%	1.6%	12.8%
1. Indicated exceptions include plans where cost-sharing was reduced for ambulance only.							
2. Indicated exceptions include plans where only professional services cost-sharing was reduced.							

Over 80% of the plans that provided ER MH/SUD benefits did not have to make any changes to their cost-sharing to comply with MHPAEA and the IFR.

Over 2% of the plans could subject their ER MH/SUD benefits to a deductible without violating parity but were previously not doing so, while another 2% were required to remove deductibles altogether from these benefits.

Over 2% of the plans could apply a copay to these benefits without violating parity but were previously not doing so.

Over 3% of the plans were required to convert their coinsurance to copays, another 1.6% had to completely remove the coinsurance, and another 1.6% had to reduce the coinsurance levels applicable to this benefit. 13% of the plans were required to reduce their coinsurance on professional services only.

b. Quantitative treatment limitations.

The following table summarizes the percentage of plans that had to remove various QTLs placed on their ER MH/SUD benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where visit limits were removed	0.0%
Percent of plans where (annual) dollar limits were removed	0.0%

As shown above, no treatment limits applied to the ER MH/SUD benefits.

Certain plans were non-compliant with MHPAEA and the IFR in ways other than those described above.

Exceptions	Plans (%)
Percent of plans where non-emergency use of ER had different cost-sharing than for true emergencies	10.4%
Percent of plans where out-of-network ER cost-sharing had to be changed to be the same as in-network ER cost-sharing	28.0%
Percent of plans where members were required to pay the amount above the allowed charge for out-of-network behavioral health emergency services in a non-parity compliant way	0.8%

13. **Rx -- MH and SUD benefits.**

- a. Copay/coinsurance/deductible/OOP maximum levels.

The table below shows summarized results of the compliance testing of MH/SUD Rx benefits; 99% of the plans provided this benefit.

Percent of Plans Covering MH/SUD Rx: 99.2%							
Cost-Sharing	No Change	Added	Converted	Removed	Increased	Decreased	Exception
Deductible	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
OOP max	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Copay	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Coinsurance	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

100% of the plans that provided MH/SUD Rx benefits did not have to make any changes to their cost-sharing to comply with MHPAEA and the IFR.

- b. Quantitative treatment limitations.

The following table summarizes the percentage of plans that had to remove various QTLs placed on their MH/SUD Rx benefits.

Service/Dollar Limitations	Plans (%)
Percent of plans where quantity limits were removed	0.0%
Percent of plans where dollar limits were removed	0.0%

As shown above, no limits applied to the MH/SUD Rx benefits.

Certain plans were non-compliant with MHPAEA and the IFR in ways other than those described above.

Exceptions	Plans (%)
Percent of plans with different cost-sharing for preferred vs. non-preferred pharmacies. Plans were advised to consult with legal counsel.	18.5%
Percent of plans where only 3 smoking cessation drugs are covered.	2.4%
Percent of plans that had a supply limit on smoking cessation drugs/supplies.	21.0%

The IFR does not specify that having different Rx cost-sharing for preferred vs. non-preferred pharmacies is compliant. Therefore, a strict interpretation of only having a single Rx benefit classification implies that this cost-sharing structure for MH and SUD drugs would be non-compliant.

However, Milliman did receive additional informal guidance on this manner that this strict interpretation was not the intent of the sponsoring Departments. The IFR states that “if a plan or issuer applies different levels of financial requirements to different tiers of Rx benefits based on **reasonable factors** (determined in accordance with the NQTL rules) and without regard to whether a drug is generally prescribed for medical/surgical benefits or MH/SUD benefits, then the plan or issuer satisfies the substantially all/predominant test”. Here, if the differences in financial requirements are considered to be based on reasonable factors (discounts for preferred pharmacies), then the tests are satisfied. Therefore, the 18.5% of plans who are reported to be in violation of parity in the table above would not be out of compliance. Hopefully, additional formal guidance will be provided on this issue.

14. **Non-quantitative treatment limitations.**

The following table describes the NQTLs that were found in various plans in the Milliman database. These limitations appear to be non-compliant with MHPAEA and the IFR.

NQTL Description	% of Plans
MH/SUD precertification requirements were more stringent than for medical/surgical benefits.	28.2%
Pre-approval was required starting with the 13th OP OV MH visit.	1.8%
The external/expedited fees charged to appeal a service denial for treatment of a mental condition were higher than for medical/surgical conditions.	4.5%
No MH/SUD benefits were provided outside the state of residence but medical/surgical benefits were.	0.9%
Some smoking cessation benefits were covered in one or more benefit classifications but not in all benefit classifications that covered medical/surgical benefits.	12.7%
Medical necessity was applied to MH/SUD benefits but not to medical/surgical benefits.	8.2%
Out-of-network treatment was covered only if in-network treatment was unavailable. This applied only to MH/SUD benefits.	0.9%
Plans imposed a probationary period only for substance abuse treatment.	0.9%
Smoking cessation drugs were only covered on a mail-order basis.	0.9%
Out-of-network eating disorder treatment was covered only if in-network services were unavailable; no such requirement applied to OON medical/surgical benefits.	0.9%
Plans did not include smoking cessation for dependent children.	2.7%

In addition to the NQTLs listed above, other plan design features which have not been previously mentioned which plans should consider regarding MHPAEA compliance. These changes include removal of QTLs that are not mentioned in the sections above.

Other Treatment Limitations	% of Plans
Plans placed limits on professional counseling for tobacco use/smoking	24.5%
Plans placed a benefit limit on early intervention services which includes psychological counseling.	0.9%
Plans imposed a dollar penalty for not getting pre-approval for inpatient MH/SUD admissions, and no such penalty applied to inpatient medical/surgical benefits.	0.9%
Inpatient SUD services are covered but limited to detoxification. No change was recommended to plan design because this situation is currently allowed under the "scope of services" provision in MHPAEA.	2.7%

APPENDIX B. DETAILED COMPLIANCE TESTING RESULTS: 2011 PLAN YEAR

The Paul Wellstone and Pete Domenici MHPAEA of 2008 (MHPAEA) was enacted on October 3, 2008. Interim final regulations were posted in the *Federal Register* on February 2, 2010, and clarifying guidance was released on July 1, 2010. The MHPAEA prohibits group health plans providing MH/SUD benefits from imposing more restrictive financial requirements or treatment limitations than those provided for medical/surgical benefits. A distinction is made between QTLs (such as day limits, visit limits, etc.) and NQTLs, such as medical management and formulary design.

In 2010, Aon Hewitt worked with a number of clients to provide guidance on the legislation requirements and to evaluate benefit design and program provisions to assess compliance. A summary of the results of the plan design compliance testing and the NQTL compliance review provided in this report.

Plan Design Compliance Testing Results

Background

According to the regulations, a plan must meet two testing requirements within each benefit classification in order to comply with parity requirements:

1. **Substantially all:** A requirement or limitation applies to substantially all if it applies to at least two-thirds of the benefits in that classification. If a benefit type does not apply to at least two-thirds of the medical/surgical benefits in a classification then it cannot be applied to MH/SUD benefits in that classification.
2. **Predominant:** A requirement or limitation is considered predominant if it applies to at least one-half of the benefits in that classification.

Determination of substantially all and predominant is based upon 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.

Plan design compliance must be assessed within the six benefit classifications specified by the regulations. Regulatory guidance also clarified the ability to review compliance in two sub-classifications for outpatient services. The classifications and sub-classifications recognized by the regulations are listed below:

- Inpatient In-Network
- Inpatient Out-of-Network

- Outpatient In-Network
 - Office Visits
 - All Other Outpatient Items and Services
- Outpatient Out-of-Network
 - Office Visits
 - All Other Outpatient Items and Services
- Emergency Care
- Rx

Overview

In order to assess compliance with the MHPAEA regulations, plan designs were analyzed to determine the compliant design for MH/SUD benefits. The plan design review and compliance testing were conducted in 2010 and were based on the plan designs each employer expected to implement in the 2011 plan year.

The plan design review encompassed over 60 employers, ranging in size from 400 to over 300,000 employees and representing 230 plan options. Each plan option represented a single combination of benefits (a combination of medical/surgical and MH/SUD benefits) that is available to employer participants. Of the 230 plan options reviewed, 140 plan options required compliance testing to determine the benefit design that would apply to MH/SUD benefits.

For most employer plans, the benefit type and level within the inpatient in-network and out-of-network, outpatient out-of-network, Rx, and emergency care classifications were consistent for both medical/surgical and MH/SUD and, as a result, demonstrated compliance with the parity regulations. For these benefit classifications, detailed compliance testing was not required.

Benefit design for the outpatient in-network classification, however, required compliance testing most frequently across employer programs. Within this classification, employer programs typically applied a variety of benefit types (copay or coinsurance) and benefit levels (primary care, specialty care, other). Compliance testing was required within this benefit classification to determine the benefit that met the substantially all and predominant requirements for MH/SUD services.

In addition to the compliance testing that was conducted employer plan designs were reviewed to ensure other aspects of the MHPAEA regulations were compliant, such as the elimination of QTLs (e.g., day and visit limitations, dollar maximums, etc.). In our review, we noted several plan options that applied QTLs to MH/SUD benefits and recommended these limitations be removed in order to comply with MHPAEA. It is our understanding that these plan design provisions were eliminated. A summary of the plan provisions that required removal of the quantitative limitations is provided below:

QTLs	Number (%*) of Plan Options	Examples
Inpatient day limitations for MH/SUD	18 (7.8%)	<ul style="list-style-type: none"> • 30-day annual maximum (in-network) • 60-day annual maximum (in-network) • 21-day annual maximum (out-of-network) • 7-day annual maximum for detox (in-network and out-of-network)
Outpatient day limitations for MH/SUD	14 (6.1%)	<ul style="list-style-type: none"> • 30-visit annual maximum (in-network) • 20-visit annual maximum (out-of-network) • 52-visit annual maximum (in-network)
Separate deductible and OOP maximum for MH/SUD	3 (1.3%)	N/A
Penalty for not precertifying care (similar requirement not in place for medical/surgical)	Outpatient: 10 (4.3%) IOP/PHP: 3 (1.3%)	<ul style="list-style-type: none"> • Non-precertification of outpatient visits after the 20th visit: Coverage reduced to 50% • Non-precertification of partial hospitalization and intensive outpatient care: Coverage reduced to 50%
Annual dollar maximum for smoking cessation Rx (similar requirement not in place for other drugs or drug classes)	6 (2.6%)	<ul style="list-style-type: none"> • Smoking cessation drugs covered up to \$200 per year • Smoking cessation drugs covered up to \$500 per year
Supply limits for smoking cessation Rx (similar requirement not in place for other drugs or drug classes)	4 (1.7%)	<ul style="list-style-type: none"> • Smoking cessation drugs covered up to 12 or 24 weeks per year depending on drug (e.g., Chantix)
* Percent of total plan options reviewed (230).		

Testing Process

For each plan option requiring compliance testing, the employer's program administrator (vendor) was asked to submit plan costs associated with each covered service category within the classification or sub-classification included in the testing process.

We first conducted the substantially all test for each plan option to determine which benefit type represents at least two-thirds of the plan costs in the benefit sub-classification. Plan cost data was grouped according to benefit type (e.g., copay, coinsurance, etc.) and evaluated to determine the percentage of the total plan costs represented by each type.

Once the benefit type representing substantially all was determined, we then grouped the plan cost data associated with each benefit level (e.g., \$15, \$20, etc.) within that benefit type to determine the predominant benefit level in that sub-classification.

The benefit type and level determined to represent substantially all and predominant within the sub-classification is the benefit that can be applied to MH/SUD

services in the same benefit sub-classification. This benefit represented the most restrictive benefit permitted within the sub-classification.

Results of the compliance testing process were documented and communicated to the employer for review by their internal legal counsel. It is our understanding that any plan design changes that were identified as a result of the testing process were implemented by the employer in 2011.

Compliance Testing Findings

Results of the compliance testing conducted by Aon Hewitt in 2010 are summarized below:

- A total of 140 plan options were tested.
 - Testing for all 140 plan options was conducted in the outpatient in-network office visit sub-classification.
- Benefit designs for the 140 plan options that were tested included a variety of benefit types:
 - 98 plan options (70%) applied copays to all outpatient services.
 - 77% applied split copays for PCPs and SCPs where higher copays are applied for SCP office visits than for PCP office visits (e.g., \$40 copay for SCPs and \$20 copay for PCPs). Of those applying split copays, 71% (53 plan options) applied the SCP copay level to outpatient MH/SUD services. The remaining 22 plan options applied the PCP copay level to outpatient MH/SUD services.
 - 23% applied the same copay for both medical/surgical and MH/SUD services.
 - 35 plan options (25%) applied coinsurance to all outpatient services.
 - Seven plan options (5%) applied a mix of copay and coinsurance to outpatient services.
- Of the 140 plan options tested, only 33% required benefit changes (benefit type and/or benefit level) in order to comply with MHPAEA regulations. An additional 6% (eight plan options) made benefit design changes that were not required, but maintained compliance.
- Testing results for the 98 plan options that apply copays to all outpatient services determined that the PCP benefit level was predominant for 76 plan options (78%), requiring that the MH/SUD benefit level be no more than the PCP benefit level. For 21 plan options (21%), testing results determined that the SCP benefit

level was predominant. And, for one plan option (1%), the results showed that neither copay nor coinsurance could be applied to MH/SUD outpatient benefits.

- For plan options where the SCP copay is applied to MH/SUD outpatient benefits (53 plan options), the compliance testing results determined that the PCP level was predominant for 36 plan options (68%) and the SCP level was predominant for 17 plan options (32%).
 - For the 36 plan options where the testing results determined PCP to be predominant, the employers modified the MH/SUD outpatient copay from the SCP level to the PCP level.
 - For the 17 plan options where the testing results determined SCP to be predominant, 25% (four plan options) moved to the PCP level to reflect best practices and maintain consistency across benefit options, while the remainder maintained the benefit at the SCP level.
- For the plan options where the PCP copay is applied to MH/SUD outpatient benefits (45 plan options), the compliance testing results determined that the PCP level was predominant for 40 plan options (89%), the SCP level was predominant for four plan options (9%), and neither copay nor coinsurance could be applied to MH/SUD outpatient benefits for one plan option (2%).
 - For the 40 plan options where the testing results determined PCP to be predominant, employers maintained the PCP copay level for outpatient MH/SUD benefits.
 - For the four plan options where the testing results determined SCP to be predominant, employers increased the copay for MH/SUD outpatient benefits from the PCP benefit level to the SCP benefit level.
- Testing results for the 35 plan options that apply coinsurance to all outpatient services determined the following:
 - Four plan options (11%) were required to apply a less restrictive coinsurance level for MH/SUD outpatient benefits.
 - 31 plan options (89%) were compliant at the current coinsurance level and were not required to modify the outpatient MH/SUD benefit.
- Testing results for the seven plan options that applied a mix of copays and coinsurance to outpatient services determined that the majority (72%) were required to apply a copay to MH/SUD outpatient benefits at a less restrictive level than what was currently in place. The remaining two plan options (28%) were not required to make a benefit change to comply.

Non-Quantitative Treatment Limitation Assessment Results

Background

According to the regulations, NQTLs limit the scope or duration of benefits and can include, but are not limited to, plan provisions related to:

- Medical management,
- Rx formulary,
- Provider admission in a network,
- Determination of UCR amounts,
- Step-therapy requirements, and
- Conditioning benefits on completion of a course of treatment.

Any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to medical/surgical benefits. However, these requirements allow variations to the extent that recognized clinically appropriate standards of care may permit a difference.

Overview

In order to assess compliance with the MHPAEA regulations, NQTLs processes in place for MH/SUD and medical/surgical benefits were evaluated. NQTL assessments were conducted for self-insured programs when requested by an employer. In 2010, NQTL assessments were completed for 22 different employers, representing 17 different medical and MH/SUD vendors. All employers were national employers with at least 1,000 employees. The majority of employers (72%) for whom NQTL assessments completed were large employers with 10,000 or more employees.

When the MHPAEA regulations were released, many health plans and behavioral health care organizations assured employers that they would conduct an analysis of their program procedures and, if identified, would implement the necessary changes to ensure compliance with MHPAEA regulations. As NQTL analyses were completed for only 22 employers, we can only assume that most employers relied on the health plans and behavioral health care organizations to conduct the NQTL analysis and make any necessary changes to comply with the regulations.

Employers participating in the analysis review did so for a number of reasons, including:

- Recognized that the employer is ultimately responsible for plan compliance due to the self-insured status of the plan and wanted to engage with an objective third party to conduct the analysis; and/or

- Required written documentation of the assessment process, results, and outcomes.

In the process of conducting the analyses, we evaluated medical/surgical and MH/SUD procedures in place for most of the major medical and behavioral health care organizations in the country. As we communicated our findings to these organizations, issues identified as potential areas of non-compliance could be addressed and our recommendations could be applied across the vendors' book-of-business. As a result, it is likely that the analyses conducted for the 22 employers helped to shape the vendor response to and compliance with the regulations.

Assessment Process

Each vendor that administered an employer's medical and MH/SUD benefit plans was requested to respond to an extensive questionnaire that collected details about the vendor's NQTL processes and procedures in place in 2010. Information was collected on both medical/surgical and MH/SUD procedures. Any differences between the vendor's standard procedures and employer-specific procedures were noted. We also requested each employer's Rx vendor to respond to specific questions regarding NQTLs related to medical and MH/SUD Rx benefits.

Once the questionnaire was completed, we reviewed vendor responses and conducted a detailed comparison of the processes and procedures that were in place for medical/surgical and for MH/SUD. The following areas were reviewed:

- Precertification
 - Procedures and services requiring precertification
 - Responsibility for precertification (provider or member)
 - Documentation required
 - Medical necessity review conducted
 - Guidelines used
- Concurrent Review
 - Levels of care considered for review
 - Source of guidelines
 - Process
 - Frequency of reviews
- Discharge Planning
 - Process
 - Frequency of reviews
 - Follow-up after discharge

- Case Management
 - Case identification process
 - Case management process
- Retrospective Review
 - Process
 - Services included
- UCR Determination
 - Data source
 - Frequency of updates
 - Percentile
- Provider Network Admission
 - Credentialing process and requirements
 - Timing to complete credentialing process
 - Ongoing monitoring
 - Re-credentialing frequency
- Performance Networks
 - Specialties included
 - Criteria
 - Network model
- Reimbursement Rates
 - Source
 - Process
- Experimental and Investigational
 - Definition

Each process and procedure was compared to determine which, if any, were more stringent for MH/SUD than they were for medical/surgical. Any procedures or requirements that could be considered to be more stringent for MH/SUD than medical/surgical were identified as potentially non-compliant with the MHPAEA regulations.

Results of the assessment were communicated to the employer as well as to each vendor involved in the assessment process. Discussions were held between the employer and each vendor to review the findings and determine the appropriate and necessary actions to comply with MHPAEA regulations.

Areas of Potential Non-Compliance

Our initial review identified many areas that were deemed potentially non-compliant. However, after further investigation and follow-up documentation from the vendors, it was determined, in some instances, that the MH/SUD process was not more stringent than medical/surgical.

Additional issues that were identified as potential for non-compliance required modification in order to meet MHPAEA regulation requirements. Modifications to NQTL provisions occurred more frequently when the employer used a carve-out vendor to administer the MH/SUD benefit (i.e., MH/SUD benefit was administered by a specialty behavioral health care organization and not the same vendor as medical/surgical).

The non-compliance issues identified through the NQTL Assessment are listed below along with the outcome as reported by the vendor and/or employer:

NQTL Category	Process/ Procedure	Potential Non-Compliance Issue	Outcome
Medical Management	Outpatient Precertification	Precertification required for all outpatient MH/SUD services. Precertification is not required for all outpatient medical/surgical services.	Precertification requirement removed for all outpatient services, but was maintained for services requiring greater oversight and supported by recognized clinically appropriate standards of care (e.g., psychiatric testing, ECT, etc.).
	Outpatient Medical Necessity Review	All outpatient MH/SUD counseling services are authorized for up to 8-12 visits (varied by vendor). After the 8 th or 12 th visit, a clinical/medical necessity review is conducted. Similar procedure not in place for outpatient medical/surgical services.	Some vendors extended the threshold for conducting medical necessity review on outpatient MH/SUD counseling services to allow for review of cases that represent outliers (e.g., 20 visits).
	Concurrent Review	Concurrent review conducted for all MH/SUD conditions and levels of care, including inpatient, intermediate (i.e., partial hospitalization, intensive outpatient), and outpatient. Concurrent review was conducted only for inpatient medical/surgical cases.	Vendor revised procedures to include only inpatient MH/SUD in concurrent review process to align with medical/surgical process.

NQL Category	Process/ Procedure	Potential Non-Compliance Issue	Outcome
Medical Management (continued)	Concurrent Review	<p>Concurrent review conducted for MH/SUD cases includes a medical necessity review as well as a review for adherence to benefit provisions.</p> <p>Concurrent review conducted for medical/surgical cases includes a review for adherence to benefit provisions; no medical necessity reviews.</p>	Concurrent review conducted for MH/SUD cases will include only a review for adherence to benefit provisions; no medical necessity reviews.
	Retrospective Review	<p>Retrospective review process for MH/SUD included a review for medical necessity, as well as a review for adherence to benefit provisions.</p> <p>Retrospective review process for medical/surgical included a review for adherence to benefit provisions and only when no prior notification was provided.</p>	MH/SUD retrospective review will include a review for adherence to benefit provisions only when no prior notification was provided. No medical necessity review will be conducted.
	Inpatient Medical Necessity Review	<p>All inpatient MH/SUD cases require precertification and a medical necessity review is conducted during the precertification process.</p> <p>For medical/surgical inpatient cases, members notify the vendor; no medical necessity review is conducted.</p>	Notification process implemented for MH/SUD (eliminated medical necessity review requirement). Medical necessity reviews conducted only for cases considered to be outliers based on diagnosis, high-cost and complex cases, and provider outliers.
Provider Network Management	Network Admission Criteria	<p>Specific number of years of experience (e.g., 3 years of experience) required for MH/SUD network providers.</p> <p>Years of experience not required for medical/surgical network providers.</p>	Years of experience requirement eliminated for MH/SUD network providers.
	Network Admission Criteria	<p>Site visits required for some MH/SUD network providers.</p> <p>Site visits not required for medical network providers.</p>	Requirement maintained, as the requirement is essential to ensuring quality and safety of MH/SUD network providers; site visits conducted at facilities and programs that are not accredited.
	Reimbursement Rates	<p>MH/SUD provider reimbursement rates were determined based upon vendor's internal set of data.</p> <p>Medical/surgical provider reimbursement rates were determined using an external database.</p>	MH/SUD provider reimbursement rates were modified to reflect a similar process and data source as medical/surgical provider reimbursement rates.

NQTL Category	Process/ Procedure	Potential Non-Compliance Issue	Outcome
Provider Network Management (continued)	UCR Percentile	Percentile used to determine reimbursement rates for MH/SUD services was set at the 50 th percentile. Medical/surgical services were reimbursed at the 80 th percentile.	Reimbursement percentile rate modified to the 80 th percentile for MH/SUD services.
Rx	Smoking Cessation Drug Requirements	Member is required to participate in a smoking disease management program in order to receive coverage for smoking cessation medication. Similar requirement not in place for any other drug or drug class.	Program revised to eliminate the requirement that members participate in a smoking disease management program in order to receive coverage for smoking cessation medication.
	Smoking Cessation Drug Limits	Smoking cessation drugs limited to 12 or 24 weeks per year depending on brand. Similar limits not imposed on other drugs or drug classes.	Limitation removed for smoking cessation drugs.

Annual Behavioral Health Request for Information Results

Background

Each year, Aon Hewitt requests behavioral health care organizations to respond to a RFI that collects information regarding their administrative, operational, and clinical capabilities. In their 2011 Annual RFI, behavioral health care organizations were asked to respond to several questions regarding the impact of MHPAEA. Responses to the MHPAEA questions were received by seven national behavioral health care organizations, representing all of the major carve-in and carve-out vendors. Vendor responses are summarized below:

RFI Questions	Vendor Response
Percent of employers* that eliminated MH/SUD coverage.	2010: 57% of vendors reported no employers eliminated MH/SUD coverage; 43% of vendors reported 1%. 2011: 43% of vendors reported no employers eliminated MH/SUD coverage; 57% of vendors reported 1%.
Percent of employers* that moved from carve-out to carve-in MH/SUD administration due to federal parity.	18% (range by vendor from 0% to 80%).
Percent of employers* who were required to cover outpatient MH/SUD at 100% due to compliance testing.	2.1% (range by vendor from 0% to 10%).
Percent of employers* required to cover outpatient MH/SUD at the PCP copay level due to compliance testing.	85% (range by vendor from 29% to 100%).

RFI Questions	Vendor Response
Percent of employers* required to cover outpatient MH/SUD at the specialist copay level due to compliance testing	15% (range by vendor from 0% to 100%)
* Within the vendor's book-of-business.	

APPENDIX C. DETAILED PLAN DESIGN DATABASE RESULTS (2009-2011)

Plan Design Database Overview

Aon Hewitt's PDD contains data on 252 employers and 12,384 plan designs. The majority of employers in the database are large national employers (over 10,000 employees). However, the PDD does contain employers that represent small and midsize organizations. The following provides an overview of the employers and plan design options included in the database.

Employer Size

The database consists of employers ranging in size from fewer than 1,000 to over 250,000. The distribution by employer size is reported in the table below.

Range	Percent of Employers	Number of Employers
1 to 1,000	4.8%	12
1,001 to 5,000	20.2%	51
5,001 to 10,000	19.8%	50
10,001 to 20,000	17.9%	45
20,001 to 50,000	15.5%	39
50,001 to 100,000	6.0%	15
100,001 to 250,000	3.2%	8
Over 250,000	0.4%	1
Unavailable	12.3%	31
	100%	252

Employer Industry

The employers included in this analysis represent a broad array of industries.

Industry	Percent of Employers	Number of Employers
Chemicals	1.6%	4
Consumer Products	6.8%	17
Energy Production/Transmission	2.0%	5
Entertainment & Hospitality	6.4%	16
Financial	10.7%	27
Government/Education	7.1%	18
Health Care	4.4%	11
Insurance	6.4%	16
Manufacturing	11.9%	30
Pharmaceuticals	2.4%	6
Printing & Publishing	2.0%	5

Industry	Percent of Employers	Number of Employers
Professional Services	2.0%	5
Retail	6.0%	15
Technology	8.7%	22
Telecommunications	2.8%	7
Transportation	3.6%	9
Utilities (Gas & Electric)	3.2%	8
Unknown	12.3%	31
	100.0%	252

Plan Options

A total of 12,384 plan options were included in our review for each plan year. The actual number of plan options included in the review of each plan design field varies and reflects only the plan options that reported credible data. The number of plan options included in each plan design field review is reported for each comparative analysis.

Plan Type

Plan design data used for this analysis reflected several different types of plans. The types of plans and percent of options with each type is summarized below.

Plan Type	Percent of Plan Options	Number of Plan Options
Consumer Directed Plan (CDP)	2.5%	305
Exclusive Provider Organization (EPO)	2.0%	251
Health Maintenance Organization (HMO)	31.4%	3,894
Indemnity	9.6%	1,184
Point-of-Service (POS)	5.9%	734
Preferred Provider Organization (PPO)	36.2%	4,483
Passive Preferred Provider Organization (PPP)	0.2%	24
Not Available	12.2%	1,509
	100.0%	12,384

Plan Funding

A large portion of plan options included in this analysis are self-insured (i.e., the employer pays an administrative fee to a health plan to administer the benefit and pay claims; the employer is responsible for funding claim payments). The percent of plan options that reflect fully-insured and self-insured funding arrangements is summarized below.

Plan Type	Percent of Plan Options	Number of Plan Options
Fully-Insured	26.7%	3,312
Self-Insured	43.0%	5,319
Not Available	30.3%	3,753
	100.0%	12,384

Summary Observations

The plan design data reviewed in this analysis suggests a significant degree of change in the benefits applied to MH/SUD services after the implementation of MHPAEA. Although some of the changes may have been implemented due to other legislative or employer-specific initiatives, we have observed some notable changes in plan designs between 2009 and 2011. Some of the key trends identified in the data analysis are described below:

- Benefits for inpatient MH/SUD services have remained relatively stable from 2009 to 2011.
 - The vast majority of plan options applied the same benefit design for both inpatient medical/surgical and MH/SUD services in 2009 and the percentage remained relatively stable in 2010 and 2011.
- For plan options where the same copay/coinsurance was applied to PCP and SCP office visits, we noted no significant change in the level of copay/coinsurance applied to outpatient MH/SUD services from 2009 to 2011.
- For plan options that apply a different copay/coinsurance level for PCP and SCP, data showed a movement in the distribution of plan options which aligned the MH/SUD outpatient benefit with PCP and SCP office visit benefits.
 - In 2009, percentage of plan options were equally distributed among those that aligned the outpatient MH benefit with the PCP copay/coinsurance, aligned with the SCP copay/coinsurance, and in between the PCP and SCP copay/coinsurance level. However, in 2011, over half the plan options reported that the outpatient MH benefit was aligned with the PCP benefit level.
- The percentage of plan options that applied quantitative limits (annual day limits and annual visit limits) decreased dramatically from 2009 to 2011.
 - In 2009, approximately half of the plan options reported applying day limits on in-network inpatient MH and SUD benefits. In 2011, the percent of plan designs with annual day limits for in-network inpatient MH services decreased to 7.54% for MH and 8.51% for SUD.
 - In 2009, more than half of the plan options reported applying visit limitations on in-network and out-of-network outpatient MH and SUD benefits. In 2011, the percent of options with visit limits on in-network outpatient MH and SUD benefits dropped to 6.49% for MH and 8.51% for SUD.

Detailed plan design analysis results are reported below.

Inpatient MH/SUD

Inpatient Benefit Design

Our analysis reviewed the benefit design in effect in each plan year for inpatient medical/surgical and MH/SUD services. We compared the benefits applied to inpatient medical/surgical with those for MH/SUD services to determine if the benefit in place for MH/SUD services is the same as, more restrictive, or less restrictive than medical/surgical services.

For purposes of this analysis, we evaluated only the copay and/or coinsurance levels applied for each plan option. This analysis did not consider day, dollar, or confinement limitations. The analysis on quantitative limitations is reported separately. Results are reported in three categories:

- Inpatient benefit is the same for MH/SUD and medical/surgical: This category includes all plan options where the copay and/or coinsurance level for MH/SUD and medical/surgical are the same.
 - Example: Inpatient MH/SUD services are covered at 80% coinsurance after the deductible and inpatient medical/surgical services are covered at 80% coinsurance after the deductible.
- Inpatient benefit is more restrictive for MH/SUD than for medical/surgical: This category includes all plan options where the plan applies a more restrictive benefit for MH/SUD than for medical/surgical.
 - Example #1: Inpatient MH/SUD services are covered at 50% coinsurance after deductible and inpatient medical/surgical services are covered at 80% coinsurance after deductible.
 - Example #2: Inpatient MH/SUD services are subject to a \$250 copay, then are covered at 80% coinsurance and medical/surgical services are covered at 80% coinsurance.
- Inpatient benefit is less restrictive for MH/SUD than for medical/surgical: This category includes all plan options where the plan applies a less restrictive benefit for MH/SUD than for medical/surgical services.
 - Example: MH/SUD services are covered at 80% coinsurance and medical/surgical services are subject to a \$100 copay, then are covered at 80% coinsurance.

Observations

For both in-network and out-of-network inpatient benefit designs in all 3 years of this analysis, the vast majority of plan options apply the same benefit design for both medical/surgical and MH/SUD benefits. The data suggests a slight increase in the percent of plans that aligned the inpatient MH/SUD benefit design with the medical/surgical inpatient benefit design from 2009 to 2010 and a decrease in the

percent of plan options that applied a more restrictive benefit design for MH/SUD than for medical/surgical. However, the distribution among plans that apply a more restrictive, less restrictive or the same benefit design as medical/surgical stayed relatively stable in all 3 years.

There are a number of plan options that report having a less restrictive MH benefit for inpatient MH services than for medical/surgical services, for example, 11.75% in 2011. Some examples of less restrictive MH benefit designs are listed below:

- Example #1: MH/SUD services covered at 80% coinsurance (no deductible); medical/surgical services covered at 80% coinsurance after the deductible.
- Example #2: MH/SUD services covered at 100% after deductible; medical/surgical services covered at 80% coinsurance after deductible.
- Example #3: MH/SUD services covered at 90% coinsurance; medical/surgical services covered at 80% coinsurance.

Of note is the percentage of plan options where the MH and SUD benefit designs are more restrictive than the medical/surgical inpatient benefit design. Although we cannot confirm these designs are non-compliant with federal parity requirements, they do raise concern. We have provided some examples of the more restrictive benefit design for inpatient MH and SUD as recorded in the PDD below:

- Example #1: MH/SUD services covered at 90% coinsurance after hospital copay; medical/surgical services covered at 100% coinsurance after hospital copay.
- Example #2: MH/SUD services covered at 90% coinsurance; medical/surgical services covered at 100%.
- Example #3: MH/SUD services covered at 80% coinsurance; medical/surgical services covered at 90% coinsurance.

In-Network Benefit Design	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Mental Health						
Inpatient benefit is the same for MH and medical/surgical	79.6%	82.8%	83.3%	4,329	3,862	3,871
Inpatient benefit is more restrictive for MH than for medical/surgical	6.5%	4.5%	4.9%	353	210	228
Inpatient benefit is less restrictive for MH than for medical/surgical	13.9%	12.7%	11.8%	758	594	546
Total	100.00%	100.00%	100.00%	5,440	4,665	4,645

In-Network Benefit Design	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Substance Use Disorders						
Inpatient benefit is the same for SUD and medical/surgical	77.2%	79.4%	82.5%	3,548	3,154	3,249
Inpatient benefit is more restrictive for SUD than for medical/surgical	6.4%	5.3%	4.0%	292	211	159
Inpatient benefit is less restrictive for SUD than for medical/surgical	16.5%	15.3%	13.5%	758	606	532
Total	100.0%	100.0%	100.0%	4,598	3,971	3,940

Out-Network Benefit Design	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Mental Health						
Inpatient benefit is the same for MH and medical/surgical	80.5%	77.6%	79.1%	1,376	1,354	1,544
Inpatient benefit is more restrictive for MH than for medical/surgical	9.4%	6.5%	5.6%	160	113	110
Inpatient benefit is less restrictive for MH than for medical/surgical	10.1%	15.9%	15.3%	173	278	298
Total	100.00%	100.00%	100.00%	1,709	1,745	1,952
Substance Use Disorders						
Inpatient benefit is the same for SUD and medical/surgical	76.7%	75.0%	79.8%	1,164	1,133	1,359
Inpatient benefit is more restrictive for SUD than for medical/surgical	11.1%	5.8%	3.8%	168	88	64
Inpatient benefit is less restrictive for SUD than for medical/surgical	12.3%	19.2%	16.4%	186	290	280
Total	100.00%	100.00%	100.00%	1,518	1,511	1,703

Inpatient Quantitative Limitations

As MHPAEA legislation prohibits group health plans providing coverage for medical/surgical and MH/SUD benefits from imposing more restrictive financial requirements or treatment limitations for MH/SUD than those provided for medical/surgical benefits, our analysis included a review of the plan options that applied quantitative limits, including day, dollar, or confinement limitations, to inpatient MH/SUD services.

The limitations included in this analysis are described below:

- Inpatient day limitations are typically plan provisions that limit the number of inpatient days covered under the plan and can be annual or lifetime limits.
 - Example: Inpatient MH/SUD services covered up to 20 days per year.
- Inpatient dollar limitations are plan provisions that limit the amount the plan will pay for inpatient MH/SUD services and is typically an annual or lifetime limit.
 - Example: Inpatient MH/SUD services covered up to \$10,000 per year and/or \$20,000 lifetime.

- Inpatient confinement limitations reflect plan provisions that establish limits regarding each MH/SUD confinement.
 - Example: Inpatient MH/SUD services are limited to one confinement per lifetime.

Observations

The data suggests that most plan options reflected in the PDD have made modifications from 2009 to 2011 to eliminate quantitative limitations on inpatient MH/SUD benefits and are offering the MH/SUD benefits in parity with medical/surgical.

The plan design data shows a drastic reduction in the percent of plan options that applied annual or lifetime day limits to inpatient MH/SUD benefits. For example, in 2009, approximately half of the plan options reported applying annual day limits on in-network inpatient MH and SUD benefits. In 2010, the percent of plan designs that apply annual day limits for in-network inpatient MH services decreased to 12.01% for MH and 13.84% for SUD. A similar trend was observed in out-of-network benefit designs. No significant change was noted in limits in 2011.

Few plan options reported applying annual and lifetime dollar and confinement limitations on inpatient MH/SUD services in 2009. These statistics stayed relatively stable in 2010 and 2011 with no significant change in the percent of plans with dollar or confinement limitations. Although the majority of plan options do not apply these types of quantitative limits to inpatient MH/SUD services, the data does show some options with quantitative limits that are more restrictive for MH/SUD than for medical/surgical.

Quantitative limitations on MH/SUD benefits that are more restrictive than medical/surgical could potentially be non-compliant with MHPAEA requirements. However, we were not able to assess the compliance status of those plans that report such limits on inpatient MH/SUD services.

In-Network Limitations	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Mental Health						
Day limitations (annual)						
Day limits are more restrictive for MH than medical/surgical	54.0%	12.0%	7.5%	3,337	635	393
Day limits are less restrictive for MH than for medical/surgical	0.1%	0.1%	0.1%	8	7	5
Day limits are the same for MH and medical/surgical (no limits in place)	45.9%	87.9%	92.4%	2,839	4,647	4,814
Total	100.0%	100.0%	100.0%	6,184	5,289	5,213

In-Network Limitations	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Day limitations (lifetime)						
Day limits are more restrictive for MH than medical/surgical	13.0%	5.4%	4.0%	803	283	210
Day limits are less restrictive for MH than for medical/surgical	0.0%	0.0%	0.0%	1	2	1
Day limits are the same for MH and medical/surgical (no limits in place)	87.0%	94.6%	96.0%	5,380	5,004	5,002
Total	100.0%	100.0%	100.0%	6,184	5,289	5,213
Dollar limitations (annual)						
Dollar limits are more restrictive for MH than medical/surgical	0.5%	0.2%	0.2%	29	9	10
Dollar limits are less restrictive for MH than for medical/surgical	0.0%	0.0%	0.0%	1	1	0
Dollar limits are the same for MH and medical/surgical (no limits in place)	99.5%	99.8%	99.8%	6,154	5,279	5,203
Total	100.0%	100.0%	100.0%	6,184	5,289	5,213
Dollar limitations (lifetime)						
Dollar limits are more restrictive for MH than medical/surgical	0.0%	0.0%	0.0%	0	0	0
Dollar limits are less restrictive for MH than for medical/surgical	0.3%	0.1%	0.1%	16	6	5
Dollar limits are the same for MH or medical/surgical (no limits in place)	99.5%	99.6%	99.7%	6,155	5,270	5,195
Total	100.0%	100.0%	100.0%	6,171	5,276	5,200
Confinement limitations						
Confinement limits are more restrictive for MH than medical/surgical	1.9%	1.2%	0.8%	116	64	43
Confinement limits are less restrictive for MH than for medical/surgical	0.3%	0.3%	0.3%	21	17	17
Confinement limits are the same for MH or medical/surgical (no limits in place)	97.8%	98.5%	98.8%	6,045	5,208	5,151
Total	100.0%	100.0%	100.0%	6,184	5,289	5,213
Substance Use Disorders						
Day limitations (annual)						
Day limits are more restrictive for SUD than medical/surgical	46.2%	13.8%	8.5%	2,562	656	395
Day limits are less restrictive for SUD than for medical/surgical	0.2%	0.7%	0.2%	12	32	10
Day limits are the same for SUD and medical/surgical (no limits in place)	53.6%	85.5%	91.3%	2,975	4,053	4,236
Total	100.0%	100.0%	100.0%	5,549	4,741	4,641

In-Network Limitations	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Day limitations (lifetime)						
Day limits are more restrictive for SUD than medical/surgical	21.4%	5.4%	4.1%	1,187	285	212
Day limits are less restrictive for SUD than for medical/surgical	0.1%	0.1%	0.1%	3	5	5
Day limits are the same for SUD and medical/surgical (no limits in place)	78.5%	94.5%	95.8%	4,356	4,999	4,996
Total	100.0%	100.0%	100.0%	5,546	5,289	5,213
Dollar limitations (annual)						
Dollar limits are more restrictive for SUD than medical/surgical	0.1%	0.1%	0.0%	3	3	2
Dollar limits are less restrictive for SUD than for medical/surgical	0.0%	0.0%	0.0%	0	0	0
Dollar limits are the same for SUD and medical/surgical (no limits in place)	99.9%	99.9%	99.9%	5,539	4,727	4,628
Total	100.0%	100.0%	100.0%	5,542	4,730	4,630
Dollar limitations (lifetime)						
Dollar limits are more restrictive for SUD than medical/surgical	0.0%	0.0%	0.0%	0	0	0
Dollar limits are less restrictive for SUD than for medical/surgical	5.3%	0.8%	0.7%	293	37	31
Dollar limits are the same for SUD and medical/surgical (no limits in place)	94.7%	99.2%	99.3%	5,258	4,704	4,608
Total	100.0%	100.0%	100.0%	5,551	4,741	4,639
Confinement limitations						
Confinement limits are more restrictive for SUD than medical/surgical	2.5%	1.1%	0.4%	141	50	19
Confinement limits are less restrictive for SUD than for medical/surgical	1.2%	1.0%	0.9%	64	47	42
Confinement limits are the same for SUD or medical/surgical (no limits in place)	96.3%	98.0%	99.0%	5,346	4,645	4,580
Total	100.0%	100.0%	100.0%	5,551	4,742	4,641

Out-Network Limitations	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Mental Health						
Day limitations (annual)						
Day limits are more restrictive for MH than medical/surgical	48.2%	10.5%	5.8%	1,252	249	146
Day limits are less restrictive for MH than for medical/surgical	0.5%	0.5%	0.2%	14	11	4
Day limits are the same for MH or medical/surgical (no limits in place)	51.3%	89.0%	94.1%	1,331	2,110	2,388
Total	100.0%	100.0%	100.0%	2,597	2,370	2,538

Out-Network Limitations	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Day limitations (lifetime)						
Day limits are more restrictive for MH than medical/surgical	8.1%	1.4%	1.1%	210	33	28
Day limits are less restrictive for MH than for medical/surgical	0.0%	0.0%	0.0%	0	0	0
Day limits are the same for MH and medical/surgical (no limits in place)	91.9%	98.6%	98.9%	2,387	2,337	2,510
Total	100.0%	100.0%	100.0%	2,597	2,370	2,538
Dollar limitations (annual)						
Dollar limits are more restrictive for MH than medical/surgical	0.2%	0.2%	0.2%	4	4	5
Dollar limits are less restrictive for MH than for medical/surgical	0.0%	0.0%	0.1%	1	0	3
Dollar limits are the same for MH or medical/surgical (no limits in place)	99.8%	99.8%	99.7%	2,592	2,366	2,530
Total	100.0%	100.0%	100.0%	2,597	2,370	2,538
Dollar limitations (lifetime)						
Dollar limits are more restrictive for MH than medical/surgical	0.0%	0.0%	0.0%	0	0	0
Dollar limits are less restrictive for MH than for medical/surgical	0.1%	0.0%	0.0%	3	0	1
Dollar limits are the same for MH or medical/surgical (no limits in place)	99.6%	99.7%	99.7%	2,587	2,363	2,530
Total	100.0%	100.0%	100.0%	2,590	2,363	2,531
Confinement limitations						
Confinement limits are more restrictive for MH than medical/surgical	0.9%	0.3%	0.1%	24	7	3
Confinement limits are less restrictive for MH than for medical/surgical	0.0%	0.0%	0.4%	0	0	11
Confinement limits are the same for MH or medical/surgical (no limits in place)	99.1%	99.7%	99.9%	2,573	2,363	2,535
Total	100.0%	100.0%	100.0%	2,597	2,370	2,538
Substance Use Disorders						
Day limitations (annual)						
Day limits are more restrictive for SUD than medical/surgical	40.4%	12.7%	7.6%	924	266	174
Day limits are less restrictive for SUD than for medical/surgical	0.5%	0.6%	0.3%	12	12	6
Day limits are the same for SUD or medical/surgical (no limits in place)	59.0%	86.8%	92.1%	1,349	1,824	2,099
Total	100.0%	100.0%	100.0%	2,285	2,102	2,279

Out-Network Limitations	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Day limitations (lifetime)						
Day limits are more restrictive for SUD than medical/surgical	8.1%	1.4%	1.1%	210	33	28
Day limits are less restrictive for SUD than for medical/surgical	0.0%	0.0%	0.0%	0	0	0
Day limits are the same for SUD or medical/surgical (no limits in place)	91.9%	98.6%	98.9%	2,387	2,337	2,510
Total	100.0%	100.0%	100.0%	2,597	2,370	2,538
Dollar limitations (annual)						
Dollar limits are more restrictive for SUD than medical/surgical	0.1%	0.1%	0.1%	3	3	2
Dollar limits are less restrictive for SUD than for medical/surgical	0.0%	0.0%	0.0%	0	0	0
Dollar limits are the same for SUD or medical/surgical (no limits in place)	99.9%	99.9%	99.9%	2,275	2,092	2,270
Total	100.0%	100.0%	100.0%	2,278	2,095	2,272
Dollar limitations (lifetime)						
Dollar limits are more restrictive for SUD than medical/surgical	0.0%	0.0%	0.0%	0	0	0
Dollar limits are less restrictive for SUD than for medical/surgical	7.3%	1.1%	0.8%	166	22	18
Dollar limits are the same for SUD and medical/surgical (no limits in place)	92.7%	99.0%	99.2%	2,119	2,080	2,261
Total	100.0%	100.0%	100.0%	2,285	2,102	2,279
Confinement limitations						
Confinement limits are more restrictive for SUD than medical/surgical	1.7%	1.1%	0.7%	39	22	16
Confinement limits are less restrictive for SUD than for medical/surgical	0.0%	0.0%	0.0%	0	0	0
Confinement limits are the same for SUD and medical/surgical (no limits in place)	98.3%	99.0%	99.3%	2,246	2,080	2,263
Total	100.0%	100.0%	100.0%	2,285	2,102	2,279

Outpatient MH/SUD

Outpatient Benefit Design

Our analysis reviewed the benefit design in effect in each plan year for outpatient medical/surgical and MH/SUD services. Specifically, our review focused on routine outpatient MH/SUD services compared to the benefit design for medical/surgical office visits for PCP and SCP services.

We recognize that there may be other outpatient services that may fall into the outpatient office visit classification. However, our review is focused on comparing

routine outpatient MH/SUD services to medical/surgical office visits, as we felt this comparison to be most relevant to the assessment of how MHPAEA has impacted employer plan designs since implementation. Office visit services for medical/surgical services are the closest in terms of scope to typical outpatient MH/SUD visits, and PCP and SCP office visit benefits are often the point of comparison when determining how outpatient MH/SUD benefits are handled relative to medical/surgical.

Historically, many employers have considered MH/SUD professionals to be specialists and therefore applied a coinsurance or copay that was in alignment with the benefit for SCPs. With MHPAEA, there is recognition that the parity compliant benefit for outpatient MH/SUD services should be determined based on an evaluation of substantially all and predominant. As such, aligning the MH/SUD outpatient benefit to the SCP benefit may or may not be compliant, depending upon the outcome of compliance testing. As we do not have access to employer compliance testing results for the employers represented in the PDD, our analysis focuses on the benefits that are documented on the PDD and the comparison between benefits for routine MH/SUD outpatient services and PCP and SCP office visit services. We are unable to assess the compliance status of the plan options included in this analysis.

The results of our analysis show how outpatient MH/SUD benefits compare to the benefits for PCP and SCP office visit services. This comparison did not consider visit or dollar limits, as these plan provisions were evaluated separately.

Some plan options apply the same level of copay or coinsurance to both PCPs and SCPs. Other plan options apply differing copays or coinsurance for PCPs and SCPs, where the PCP copay or coinsurance is often lower than the SCP copay or coinsurance (referred to as Split Copay/Coinsurance Plans). So that the analysis is clear and results are not skewed, we are reporting the results for each group of plan designs separately.

Comparative results are reported as described below:

Plan Options with Same Copay/Coinsurance for PCPs/SCPs

- Outpatient MH/SUD benefit is the same as PCP/SCP: This category includes all plan options where the MH/SUD benefit and the benefit for PCPs and SCPs are the same.
 - Example #1: MH/SUD benefit is 80% after deductible; PCP and SCP benefit is 80% after deductible.
 - Example #2: MH/SUD benefit is \$30 copay; PCP and SCP benefit is \$30 copay.
- Outpatient MH/SUD benefit is more restrictive than PCP/SCP.
 - Example #1: MH/SUD benefit is 50% after deductible; PCP and SCP benefit is 80% after deductible.
 - Example #2: MH/SUD benefit is \$50 copay; PCP and SCP benefit is \$30 copay.

- Outpatient MH/SUD benefit is less restrictive than PCP/SCP.
 - Example #1: MH/SUD benefit is 90% after deductible; PCP and SCP benefit is 80% after deductible.
 - Example #2: MH/SUD benefit is \$20 copay; PCP and SCP benefit is \$30 copay.

Plan Options with Split Copay/Coinsurance for PCPs/SCPs (copay/coinsurance varies for PCPs and SCPs)

- Outpatient MH/SUD benefit is the same as PCP: This category includes all plan options where the outpatient MH/SUD benefit and the PCP benefit are the same.
 - Example #1: MH/SUD copay is \$20; PCP copay is \$20.
 - Example #2: MH/SUD coinsurance is 80%; PCP coinsurance is 80%.
- Outpatient MH/SUD benefit is the same as SCP: This category includes all plan options where the outpatient MH/SUD benefit and the SCP benefit are the same.
 - Example #1: MH/SUD copay is \$40; SCP copay is \$40.
 - Example #2: MH/SUD coinsurance is 70%; SCP coinsurance is 70%.
- Outpatient MH/SUD benefit is less restrictive than PCP: This category includes all plan options where the MH/SUD benefit is less restrictive than the PCP benefit.
 - Example #1: MH/SUD copay is \$10; PCP copay is \$20.
 - Example #2: MH/SUD coinsurance is 90%; PCP coinsurance is 80%.
- Outpatient MH/SUD benefit is more restrictive than SCP: This category includes all plan options where the MH/SUD benefit is more restrictive than the SCP benefit.
 - Example #1: MH/SUD copay is \$50; SCP copay is \$40.
 - Example #2: MH/SUD coinsurance is 60%; SCP coinsurance is 70%.
- Outpatient MH/SUD benefit is more restrictive than PCP but less restrictive than SCP: This category includes all plan options where the MH/SUD benefit falls between the PCP and SCP benefit level.
 - Example #1: MH/SUD copay is \$25; PCP copay is \$20; SCP copay is \$30.
 - Example #2: MH/SUD coinsurance is 75%; PCP coinsurance is 80%; SCP coinsurance is 70%.

Observations

Plan Options with Same Copay/Coinsurance for PCPs/SCPs

The vast majority of plan options in each plan year utilized the same copay/coinsurance for in-network outpatient MH as the PCP/SCP benefit. However, the

data shows a decrease in the percent of plan options with a MH benefit design that is more restrictive than the PCP/SCP benefit level. For example, in 2009, 12.87% of plan options applied a more restrictive in-network benefit for MH than for PCP/SCP services. This percentage decreased to 1.99% in 2011. A similar trend was observed for outpatient SUD and out-of-network MH and SUD benefits.

Plan Options with Split Copay/Coinsurance for PCPs/SCPs

In 2009, approximately one-third of plan options aligned the outpatient MH benefit with PCP, one-third with SCP, and one-third more or less restrictive than PCP or SCP. In 2010, a distinct change occurred in the benefit for MH services. Almost two-thirds of plan options aligned the MH outpatient benefit with the SCP copay level. In 2011, plan designs changed once again. Over half of plan options reported that the outpatient MH benefit aligned with the PCP benefit.

The changes observed across plan options suggest that employers responded to the parity legislation. In 2010, after the enactment of MHPAEA, many employers aligned the outpatient MH benefit with the SCP level, suggesting that employers made the interpretation that treating a MH provider as a specialist would be compliant under the legislation. The interim final regulations were released in early 2010 (implemented in 2011 for most plans) and clarified that design compliance is governed by a review of the benefit design that represents substantially all and predominant. Plan design information reported for 2011 suggests employers evaluated plan designs once again and made adjustments to comply with the interim final regulations. As a result, more plan options were adjusted to align the outpatient MH benefit design with the PCP benefit level.

The plan design data shows that over half of the plan options aligned the outpatient SUD benefit with the PCP benefit level in all 3 years (2009, 2010, and 2011). In 2009 and 2010, approximately 27% of plan options applied a benefit for outpatient SUD services that was either more restrictive than the SCP benefit level or in between the PCP and SCP benefit level. This changed in 2011 when we observed movement away from this approach and more plan options aligned the outpatient SUD benefit with the SCP benefit level.

In-Network Benefit Design	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Mental Health						
<i>Plan Options With Same Copay/Coinsurance for PCPs/SCPs</i>						
Outpatient MH benefit is the same as PCP/SCP	84.9%	89.8%	93.9%	2,059	2,451	2,357
Outpatient MH benefit is more restrictive than PCP/SCP	12.9%	5.3%	2.0%	312	144	50
Outpatient MH benefit is less restrictive than PCP/SCP	2.2%	5.0%	4.0%	54	135	102
Total	100.0%	100.0%	100.0%	2,425	2,730	2,509

In-Network Benefit Design	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Plan Options with Split Copay/Coinsurance for PCPs/SCPs						
Outpatient MH benefit is the same as PCP	33.7%	25.8%	55.8%	778	424	1,093
Outpatient MH benefit is the same as SCP	32.0%	61.2%	25.2%	739	1,005	494
Outpatient MH benefit is less restrictive than PCP	6.2%	4.3%	14.1%	144	71	277
Outpatient MH benefit is more restrictive than SCP	20.4%	3.5%	3.7%	472	58	73
Outpatient MH benefit is more restrictive than PCP but less restrictive than SCP	7.7%	5.1%	1.2%	179	83	23
Total	100.0%	100.0%	100.0%	2,312	1,641	1,960
Substance Use Disorder						
Plan Options With Same Copay/Coinsurance for PCPs/SCPs						
Outpatient SUD benefit is the same as PCP/SCP	73.8%	76.1%	97.6%	535	325	2,007
Outpatient SUD benefit is more restrictive than PCP/SCP	24.3%	20.8%	1.3%	176	89	26
Outpatient SUD benefit is less restrictive than PCP/SCP	1.9%	3.0%	1.2%	14	13	24
Total	100.0%	100.0%	100.0%	725	427	2,057
Plan Options with Split Copay/Coinsurance for PCPs/SCPs						
Outpatient SUD benefit is the same as PCP	54.8%	55.0%	52.6%	897	631	657
Outpatient SUD benefit is the same as SCP	15.1%	13.3%	39.7%	248	152	496
Outpatient SUD benefit is less restrictive than PCP	2.9%	3.9%	3.1%	48	45	39
Outpatient SUD benefit is more restrictive than SCP	16.8%	17.4%	2.6%	275	200	32
Outpatient SUD benefit is more restrictive than PCP but less restrictive than SCP	10.4%	10.4%	1.9%	170	119	24
Total	100.0%	100.0%	100.0%	1,638	1,147	1,248
Mental Health						
Plan Options With Same Copay/Coinsurance for PCPs/SCPs						
Outpatient MH benefit is the same as PCP/SCP	72.0%	88.2%	89.3%	1,304	1,518	1,713
Outpatient MH benefit is more restrictive than PCP/SCP	24.5%	7.5%	8.3%	444	129	160
Outpatient MH benefit is less restrictive than PCP/SCP	3.4%	4.4%	2.4%	62	75	46
Total	100.0%	100.0%	100.0%	1,810	1,722	1,919
Plan Options with Split Copay/Coinsurance for PCPs/SCPs						
Outpatient MH benefit is the same as PCP	20.7%	48.8%	37.5%	17	20	18
Outpatient MH benefit is the same as SCP	70.7%	39.0%	27.1%	58	16	13
Outpatient MH benefit is less restrictive than PCP	2.4%	2.4%	33.3%	2	1	16
Outpatient MH benefit is more restrictive than SCP	4.9%	7.3%	2.1%	4	3	1
Outpatient MH benefit is more restrictive than PCP but less restrictive than SCP	1.2%	2.4%	0.0%	1	1	0
Total	100.0%	100.0%	100.0%	82	41	48

In-Network Benefit Design	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Substance Use Disorder						
Plan Options With Same Copay/Coinsurance for PCPs/SCPs						
Outpatient SUD benefit is the same as PCP/SCP	74.2%	89.1%	89.4%	1,161	1,332	1,527
Outpatient SUD benefit is more restrictive than PCP/SCP	22.3%	6.8%	7.4%	349	101	126
Outpatient SUD benefit is less restrictive than PCP/SCP	3.5%	4.2%	3.2%	55	62	55
Total	100.0%	100.0%	100.0%	1,565	1,495	1,708
Plan Options with Split Copay/Coinsurance for PCPs/SCPs						
Outpatient SUD benefit is the same as PCP	Data set too small to report credible results					
Outpatient SUD benefit is the same as SCP						
Outpatient SUD benefit is less restrictive than PCP						
Outpatient SUD benefit is more restrictive than SCP						
Outpatient SUD benefit is more restrictive than PCP but less restrictive than SCP						

Outpatient Quantitative Limitations

As MHPAEA legislation prohibits group health plans providing coverage for medical/surgical and MH/SUD benefits from imposing more restrictive financial requirements or treatment limitations for MH/SUD than those provided for medical/surgical benefits, our analysis included a review of the plan options that applied some type of visit or dollar limitation to outpatient MH/SUD services.

The limitations included in this analysis are described below:

- Outpatient visit limitations are typically plan provisions that limit the number of outpatient visits covered under the plan and can be annual or lifetime limits.
 - Example #1: Outpatient MH/SUD services covered up to 30 visits per year.
 - Example #2: Outpatient MH/SUD services covered up to 100 visits lifetime.
- Outpatient dollar limitations are plan provisions that limit the amount the plan will pay for outpatient MH/SUD services and is typically an annual or lifetime limit.
 - Example: Outpatient MH/SUD services covered up to \$5,000 per year and/or \$10,000 lifetime.

Observations

Similar to the results reflected for inpatient MH/SUD benefits, outpatient data shows a decrease in the percent of plan options with visit and dollar limits for outpatient MH/SUD benefits from 2009 to 2011 and the majority of plan options are offering the MH/SUD benefit in parity with medical/surgical.

The plan design data reported shows a drastic reduction in the percent of plan options that apply visit limitations to outpatient MH and SUD services. In 2009, more than half of the plan options reported applying visit limitations on in-network and out-of-network MH and SUD benefits. In 2010, the percent of plan options that apply visit limitations for in-network and out-of-network MH and SUD benefits decreased to approximately 11% and was further reduced to approximately 6% in 2011.

Few plan options (less than 0.1%) reported applying annual dollar limitations on outpatient MH services, while almost 10% of plan options applied annual dollar limitations to outpatient SUD services in 2009. The percentage of plan options with annual dollar limitations on outpatient MH services remained relatively stable, while the percent of plan options with annual dollar limitations on outpatient SUD services decreased from 2009 to 2010. No significant changes were noted in 2011.

Although the majority of plan options do not apply visit or dollar limitations to outpatient MH and SUD services, in 2011, several plan options continue to report that these limits are in place. Examples of the types of limits in place in 2011 are noted below:

- Outpatient MH/SUD services covered up to 20 visits per year.
- Outpatient MH/SUD services covered up to 60 visits lifetime.
- Outpatient MH/SUD services covered up to \$2,000 per year and/or \$5,000 lifetime.

Limitations on MH/SUD benefits that are more restrictive than medical/surgical could potentially be non-compliant with MHPAEA requirements. However we were not able to assess the compliance status of those plans that report quantitative limits on outpatient MH/SUD services.

In-Network Limitations	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Mental Health						
Visit Limitations						
Visit limitations apply to MH services	56.1%	11.1%	6.5%	3,649	617	359
No MH visit limitations	43.9%	88.9%	93.5%	2,854	4,939	5,173
Total	100.0%	100.0%	100.0%	6,503	5,556	5,532
Dollar Limitations (Annual)						
Dollar limitations apply to MH services (annual)	0.8%	0.6%	0.7%	52	32	38
No MH dollar limitations	99.2%	99.4%	99.3%	6,451	5,524	5,494
Total	100.0%	100.0%	100.0%	6,503	5,556	5,532
Substance Use Disorders						
Visit limitations apply to SUD services						
Visit limitations apply to SUD services	51.1%	12.7%	8.5%	3,038	639	417
No SUD visit limitations	48.9%	87.3%	91.5%	2,907	4,378	4,482
Total	100.0%	100.0%	100.0%	5,945	5,017	4,899
Dollar limitations (Annual)						
Dollar limitations apply to SUD services (annual)	9.4%	1.5%	1.0%	561	73	51
No SUD dollar limitations	90.6%	98.5%	99.0%	5,384	4,944	4,848
Total	100.0%	100.0%	100.0%	5,945	5,017	4,899

Out-Network Limitations	Percent of Plan Options			Number of Plan Options		
	2009	2010	2011	2009	2010	2011
Mental Health						
Visit Limitations						
Visit limitations apply to MH services	59.6%	11.0%	6.4%	1,672	281	171
No MH visit limitations	40.4%	89.0%	93.6%	1,135	2,279	2,512
Total	100.0%	100.0%	100.0%	2,807	2,560	2,683
Dollar Limitations (Annual)						
Dollar limitations apply to MH services (annual)	0.5%	0.3%	0.2%	14	7	6
No MH dollar limitations	99.5%	99.7%	99.8%	2,793	2,553	2,677
Total	100.0%	100.0%	100.0%	2,807	2,560	2,683
Substance Use Disorders						
Visit limitations apply to SUD services						
Visit limitations apply to SUD services	53.2%	14.0%	9.0%	1,339	320	216
No SUD visit limitations	46.8%	86.0%	91.0%	1,178	1,959	2,179
Total	100.0%	100.0%	100.0%	2,517	2,279	2,395
Dollar limitations (Annual)						
Dollar limitations apply to SUD services (annual)	9.8%	2.9%	1.3%	246	65	31
No SUD dollar limitations	90.2%	97.2%	98.7%	2,271	2,214	2,364
Total	100.0%	100.0%	100.0%	2,517	2,279	2,395

Considerations

Some of the results contained in this report suggest that some employer plan designs may not be compliant with MHPAEA. For example, the copay or coinsurance for MH/SUD is more restrictive than medical/surgical or the plan reports quantitative limits in effect for MH and SUD benefits. Although some plan options may not seem to align with MHPAEA compliance requirements, it is important to consider the following:

- Employer reviewed their plan design based on the substantially all and predominant tests and the benefit reported in the PDD is compliant with parity requirements.
- Some plan designs could reflect plan options offered to union groups and have not yet been updated to reflect MHPAEA requirements. For collective bargaining agreements ratified before the date of enactment of the MHPAEA, MHPAEA applies to plan years beginning after the later of July 1, 2010 or the date that the last collective bargaining agreement terminates.
- We assume all data (except those data points that have been excluded from the analysis) to be accurate. It is possible that some data fields may not have been updated by the employer.

APPENDIX D. DETAILED ANALYSIS OF YEAR-BY-YEAR CHANGES IN COST-SHARING BY MIDSIZED EMPLOYERS, 2009-2011

	Pre-Parity (2008) Percent of Plans (n = 86)	Post-Parity (2009 Only) Percent of Plans (n = 78)	Post-Parity (2010 Only) Percent of Plans (n = 40)	Post-Parity (2011 Only) Percent of Plans (n = 36)
Cost-Sharing				
Inpatient care: cost-sharing for in-network MH/SUD treatment higher than inpatient medical/surgical care	9%	12%	0%	0%
Inpatient care: cost-sharing for out-of-network MH/SUD treatment higher than inpatient medical/surgical care	16%	89%	10%	6%
Outpatient care: cost-sharing for in-network MH/SUD office visits higher than medical/surgical PCP visits	56%	40%	28%	32%
Outpatient care: cost-sharing for in-network MH/SUD office visits higher than medical/surgical specialist office visits	29%	15%	9%	8%
Outpatient care: cost-sharing for out-of-network MH/SUD treatment higher than outpatient medical/surgical treatment	30%	25%	13%	0%
Treatment Limitations				
Inpatient: day limitations for MH/SUD treatment more restrictive than medical/surgical care	84%	64%	22%	13%
Outpatient: visit limitations for MH/SUD treatment more restrictive than for medical/surgical care	81%	75%	23%	13%
SOURCE: Author's analysis of SPDs of midsized employers.				
NOTE: Detailed information on employer size was unavailable from BLS. Instead, establishment size was used to identify midsized employers (establishment sizes of 51-500).				
NOTE: Analyses should be interpreted with caution due to small sample sizes.				

APPENDIX E. DETAILED INTERVIEW RESPONSES BY TOPIC

The responses from the seven participating companies are listed below. These responses have been de-identified, and within each section they are randomly sorted and given the name of Company A, B, C, D, E, F, or G.

Medical Necessity Criteria

- Company A uses McKesson's InterQual criteria for all behavioral health services. Many behavioral health facilities use these criteria internally, which allows for better coordination with Company A. InterQual criteria are updated regularly. The updates are added to Company A's electronic system for review of claims and requests for services. The system enables Company A's staff to explain a denial to providers over the telephone. Upon request, Company A will send the InterQual criteria on paper to a provider or member.

In some cases, Company A has developed criteria of its own. For example, within the area of residential treatment programs Company A has decided that it will not cover wilderness residential programs.

- Nearly all of the various health plans with which Company B works use medical necessity criteria for behavioral health services. Some health plans had moved away from medical necessity criteria for medical care in the late 1990s and early 2000s, but in 2008-2009 the plans started moving back to using them. After passage of MHPAEA, the utilization of medical necessity criteria for behavioral health plans dropped to the point that it equaled the use of such criteria in medical plans. Having achieved that equilibrium, any future changes in medical necessity criteria will affect behavioral health and medical benefits equally.
- Company C uses its own medical necessity criteria that were developed in combination with other available criteria and expert opinion. Company C uses McKesson InterQual criteria for a couple of accounts. For the public sector, it uses state-specific criteria. It uses ASAM criteria for substance abuse services. Company C's criteria are updated each year.

The PPACA has had a greater effect on medical necessity criteria than the MHPAEA, because the PPACA requires that health plans provide the criteria to their members. There is some worry about copyright restrictions on sharing this information.

- There are several sets of medical necessity criteria. In general, Company D uses guidelines from McKesson InterQual for specialized psychiatric treatment and

MH services. It also generally uses ASAM criteria for the substance abuse services. States may require a specific set of medical necessity criteria for certain services, such as community-based services. One state with which Company D works is an exception to the norm of using InterQual and ASAM criteria, in that it requires the use of its own internally created medical necessity criteria. Sister health plans also use McKesson InterQual as well Milliman Care Guidelines. None of these practices have changed because of the parity law.

- Company E has home-grown medical necessity criteria that are updated yearly. Each year they give the professional community the opportunity to comment on them. In 2010, Company E redesigned their medical necessity criteria. Before 2010 the criteria were called *level of care guidelines*. The parity law has not changed Company E's medical necessity criteria, but it has changed the circumstance in which the criteria are applied. For example, if an account does not provide utilization management services for medical inpatients, then Company E is unable to provide utilization management services for behavioral health at this level of care.

Medical necessity criteria are shared with individuals upon request. They are also made available to the public on Company E's website.

- Under health plan contracts, Company F is obligated to use the medical necessity criteria specific to the member's health plan. Some health plans use McKesson's InterQual criteria, whereas others have developed their own. If a health plan lacks medical necessity criteria for behavioral health, Company F may use its own. Medical necessity criteria have not changed with the implementation of the parity law.
- Company G develops behavioral health medical necessity criteria in a manner similar to that used by health plans to develop criteria for medical/surgical criteria. Company G likewise reviews new technologies on a similar schedule and with similar criteria. This has not changed since the parity law (MHPAEA) went into effect. Some of Company G's senior clinical leaders were with full service health plans previously, so the organization had already adopted clinical practices aligned with those of medical care.

Company G has developed its own medical necessity criteria that incorporates feedback from outside consultants (e.g., physicians, psychologists), and these criteria are reviewed and updated annually. Some states, however, require Company G to use the ASAM criteria or medical necessity criteria that were created by the state.

Informing About Claim Denials

- Company A's patients are notified of claim denials through EOB statements and adverse determination letters. DOL rules and state law dictate the content and

timing of the letters. The letters state the reason(s) for denial. The letters were affected by PPACA but not by MHPAEA. The rules apply equally to behavioral health services and medical services.

Denial rates have always been low; less than 1% of outpatient claims were denied even before MHPAEA. Denying care does not manage a person's treatment. The goal is to shape treatment rather than deny it.

- If the claim is denied, Company B sends a letter explaining the reason for denial to the provider and to the member. The process has not changed since implementation of the parity law.
- There are two major types of claim denials: administrative denials (e.g., a denial for a service that is not covered or that is not filed in time) and a medical necessity denial.

Company C has not seen changes in the claim denial process since the implementation of the parity law. What is influencing this process is the PPACA, which is changing the regulations on what is contained in the EOBs and denial letters, how quickly the company must respond, and the beneficiary's options in such a situation.

It is standard protocol to give the patient a written letter of denial.

- If a provider submits a claim and the claim is denied then Company D will send a written notice to the provider as well as the member receiving treatment. If the claim is submitted by the member directly, and the claim is denied, then the denial would be communicated just to the member. These denials would take place after a claim is submitted. Denials can be sent in advance of services being rendered where an authorization requirement applies and the request is submitted for authorization in advance of the services. If the request is urgent and comes prior to the service, the explanation of will be verbal followed by a letter. If it occurs after the service has been offered, notification happens through an EOB form. Parity has not changed this process.
- If a claim or treatment request has been denied, a notice in writing is provided to the practitioner with a copy to the member. The content of the letters and timeline for when they are distributed are dictated by the states in which Company E operates. There is some variance on the required response timeline based on level of care and whether the treatment is life threatening or urgent. In general, the letters must contain both a reason for denial and the criteria that were used for deciding that the treatment request was denied.

Separately, seven of Company E's markets require distribution of an EOB be sent to both the practitioners and members once the claim for services rendered to the member is adjudicated. Company E also started a process to help identify

fraud; it sends EOBs to a random sample of members to see if the members call back to confirm that the treatment did not take place. In addition, Company E routinely calls individuals to discuss claims that it suspects are fraudulent as a means of confirming whether the services billed were actually provided.

- Company F is delegated by some plans to carry out the denial process. It provides letters to members and providers. First level appeals always go through the health plan. Clinical denials also have to go through the medical director for his or her review. Once the medical director has reviewed the denial and agreed that it should take place, the process switches to helping the member understand the right to appeal. Company F shares with their members how the claims denial process works. Company F also assists with complaints and grievances.

Parity has not changed the claims denial process. The PPACA has had a greater effect on this process because it has required changes in the language of the denial letters and the timeframe for appeals of the denials.

- An ABD letter is sent out immediately once a benefit denial is issued when a treatment request does not meet medical necessity criteria. EOBs are sent out when a claim has been submitted. If the request for services was not authorized due to a Medical necessity denial, this will be documented on the EOB as a reason for non-payment. The timeframe and language of these letters are determined primarily by DOL regulations established in 2000. Further changes to this process may come from the PPACA regulations. For Company G, no changes have occurred to this process as a result of the MHPAEA, as all the requirements in MHPAEA were already met by adopting the DOL standards.

Utilization Management Techniques

- For Company A, medical management depends on the plan with which it is working.

The definition of *prior authorization* varies. In some cases it is merely notification for the sake of patient registration. In other cases it involves free determination of clinical necessity. Retrospective review occurs when prior review was not possible. *Outlier management* is when plans start to manage after the 20th session of outpatient counseling because at that point the patient becomes an outlier from the norm (the norm is only about eight sessions). Concurrent review is often used for behavioral health services, but it is rarely used for medical outpatient care. Examples of outpatient medical care that would have concurrent review include physical therapy, speech therapy, occupational therapy, home health services, and skilled nursing services.

Company A has seen that most behavioral health plans apply some form of concurrent review, particularly for inpatient services and in some form for outpatient services. Since MHPAEA, Company A has had to look closely at what

happens on the medical side. Inpatient medical services are managed and paid quite differently from behavioral health services. Typical medical inpatient stays are paid via DRGs, so payment does not depend on length of stay. With behavioral health services, however, there is much broader variability and DRG methods are not used. Based on a subjective determination of necessity, a decision will be made about allowable length of stays. Company A has had to study medical processes and try to align with behavioral health processes and services. Company A is moving in the direction of retrospective review to meet parity. *Retrospective review* occurs after treatment is completed but before the provider is reimbursed. Company A sees a downside -- less certainty for patient and provider about funding. Prior authorization does not exist as often on the medical side, so Company A has moved away from it for behavioral health services. They stated that this “seems perverse” but they do not see an option.

For outpatient medical care the situation is even worse, because very few routine outpatient services require prior authorization. With routine behavioral health services they now typically cannot require preauthorization for outpatient care because it is not used for medical services. This was removed because of MHPAEA. Only non-routine outpatient, specialized services require preauthorization, such as ECT and psychological testing. This is similar to non-routine outpatient medical services such as ambulatory surgery.

Before parity, there was a single standard within each carrier, mostly, for prior authorization. The parity law requires that behavioral health match the particular medical plan to which the patient belongs. Thus, rules about prior authorization will vary by patient within the same carrier if two patients belong to different plans with different rules for prior authorization of medical care. This adds complexity to administration for the providers.

- Previous to the parity law health plans often wanted to precertify all behavioral health outpatient services. In response to MHPAEA, there is no requirement for precertification for outpatient in Company B. Physicians and other medication prescribers are never required to precertify and are not subjected to any review concurrently. For other behavioral health professionals who provide psychotherapy services, there are periodic quality checks, designed to insure that medications are being used when indicated, and communication with other professionals and family members are maintained. Company B periodically requests this quality information from professionals to identify enrollees that are not receiving treatment according to best practice clinical guidelines.

As a provider seeks recertification for treating a patient, he or she must fill out a form and report on some quality indicators. For example, if the patient is an adolescent then the provider will need to report whether they are working with the parents of the patient. The provider must give an explanation if he or she has not done this. Similarly, if an individual has anorexia the provider may be asked if he or she has coordinated with the patient’s medical provider. Company B works

with the providers to established coordinated care for patients. In the contract that network physicians sign there is a clause that states that they will cooperate with Company B on issues of quality. If a provider does not cooperate, for example with coordinating with other providers that treat the same patient, then the provider may not be reauthorized to provide services for the patient. If this happens, Company B will attempt to contact the member to arrange further care.

Prior to the parity law, Company B spent much time managing the initiation of treatment for its enrollees. This is no longer the case. Some treatments, however, are still managed from the very beginning. For example, applied behavioral analysis (ABA) is managed closely from the beginning, as the state mandates intensive treatment (up to 40 treatment hours each week) to be approved in blocks of 6-12 months. Health plans manage speech therapy and physical therapy for those with autism, but Company B manages ABA. Before starting ABA, Company B verifies that the member has autism, that the member has been evaluated appropriately for the functional disabilities related to autism, and that the treatment the member is seeking falls within ABA guidelines that are usually set by the state. The mandates from the states usually specify whether autism should be is considered a behavioral health or medical condition.

Since most accounts manage medical inpatient care, Company B also manages behavioral health inpatient care for those plans. In one large plan, Company B does not manage inpatient behavioral health because the plan does not manage inpatient medical services. For this account Company B still conducts quality reviews of the inpatient services; however, it does not do any other utilization review (e.g., concurrent review). Parity has had no other major effects on utilization management of inpatient services.

- Company C uses the standard non-qualitative treatment limitations (NQTLs) of prior authorization, concurrent and retrospective review, and case management. States generally set the quantitative limits but do not impose requirements for prior authorization and the use of other NQTLs. These have not changed since the parity law was enacted.

Company C worked with Milliman to conduct a review of several markets and to examine how parity regulations from the CMS might change its work. Milliman determined that Company B met the parity test with regard to NQTLs across two sample markets.

- The largest changes stemming from the parity law have been in management of outpatient services. Since implementation of the law, Company D has developed an open-access registration model for outpatient services. Company D assists members with access and referral to services. For example, if an individual calls before receiving a service, Company D will check the person's eligibility and may conduct clinical triage. However, Company D no longer engages in utilization

management for routine services. It manages a few psychological outpatient services, but they are not routine or typical.

In place of utilization management for outpatient services, since 2010 Company D has focused on operational review and quality management. It looks for claims that fall outside of normal practice: outliers, multiple visits per week, and other potential patterns of fraud, waste, or abuse. For example, if an individual is receiving treatment for longer than normal given his or her diagnosis, Company D will contact the provider. If the care falls outside of good clinical practice or does not meet medical necessity criteria and the provider continues to offer the treatment, Company D will prospectively deny claims from that provider for treatment of the individual. Because Company D tries to speak with the provider first, there have been relatively few cases where it has prospectively denied claims.

For outpatient care, Company D has replaced most preauthorization with quality management. Before the parity law was implemented, an extensive amount of time was spent reviewing requests for outpatient treatment. Now, almost all time is spent on intensive follow-up reviews of the process and quality of services being provided.

Company D does not conduct concurrent review or retrospective review for routine outpatient services. *Concurrent review* refers to the practice of checking whether medical necessity criteria continue to be met as the member receives a service. For inpatient services, a concurrent review typically takes place every 2-3 days; for outpatient services it will take place every eight sessions or every 15-20 sessions, depending on the plan. Retrospective review is also conducted. With both concurrent and retrospective review, the claim is paid only if it passes the review. Under quality management, however, Company D will pay a claim as long as the services are covered under the member's benefit package. The review process can be performed even after a claim has been processed. If an outlier is identified, Company D tries to resolve it prospectively with the provider so that treatment will not continue if deemed inappropriate.

Company D requires preauthorization for inpatient services but not for emergency department services. For inpatient care it conducts utilization review of several kinds, including preauthorization, concurrent reviews, and some retrospective reviews. Company D may conduct a *peer review* if an individual does not appear to be making progress with treatment based on information gathered during a concurrent review. In this case, the medical director of Company D speaks with the attending physician about the patient. Peer review has reduced the number of denials because Company D is able to get more complete information about the individual. This process has not changed with implementation of the parity law.

- Prior to the parity law there were varying session limits for different types of treatment. These limits were eliminated in response to the parity law, and use of these services has increased slightly since then. Company E anticipated this result. To offset the cost of more encounters, Company E began to manage practice patterns rather than the treatment of individual members. In the earlier system, a provider obtained authorization prior to starting treatment and reauthorization after every 8-10 sessions. Among providers that serve enough of its members, Company E now looks only at the average length of treatment for its members. If the average meets a certain standard, Company E takes a hands-off approach -- eliminating the requirement for reauthorization. If providers do not meet the standard or have patients with extremely long lengths of treatment, Company E may move these providers to a lower tier within their network. Providers in the lower tier do not receive referrals from Company E.

In conjunction with parity, but not necessarily as a result of it, Company E has also established a similar program with facilities. Facilities that meet certain standards -- such as no member complaints and good member follow-up -- still need prior authorization, but they are exempt from concurrent review. This incentivizes facilities to have good outcomes and to partner with Company E.

Company E has reduced its use of authorization and concurrent review through this process, leaving it similar to its associated medical plans. Although Company E has seen a slight increase in utilization because of the parity law, it has been able to reduce costs associated with authorizations through this new approach.

- The impact of MHPAEA on care management practices has varied by plan. Company F is moving away from requiring precertification (preauthorization) for all outpatient procedures. Company F instead tries to steer these services toward outlier management. Precertification may be retained for certain disorders or procedures, such as ECT for major depression. Company F has proprietary algorithms for identifying outliers. The program involves outreach calls, primarily to the provider, in an attempt to shape the treatment. If treatment is not progressing appropriately, a utilization management program may be implemented on case-by-case basis to ensure medical necessity; this would happen at around 20 sessions of treatment. (Note that the average outpatient case resolves during 6-8 sessions.) Similarly, health plans with which Company F works typically manage outliers rather than require precertification for medical services that are reoccurring and may continue for long periods (e.g., physical therapy, radiology, or skilled nursing). The health plans also manage some of these services with visit limits, but this is not an option that Company F can utilize because of parity.

Under-utilization can also be a problem because it increases the likelihood of an inpatient stay. For example, if an individual with a severe mental illness like schizophrenia is receiving outpatient visits but no medication management, Company F may call their provider to encourage use of medications.

Precertification is typically required for both behavioral health and medical non-emergent inpatient care. Other care management techniques include concurrent and retrospective reviews. Concurrent review is used only for inpatient care. Retrospective review mostly applies to inpatient care and to out-of-network outpatient care. Inpatient behavioral health providers have an incentive to keep patients longer because they are paid a per-diem rate. These types of reviews are less needed for medical stays because the DRG payment system does not offer more money for an extra day of stay. In most plans, inpatient behavioral health services and inpatient medical services -- at least those not reimbursed through DRGs -- are reviewed with the same frequency through a concurrent review process. DRGs cover most but not all medical/surgical conditions.

- For Company G, the parity law has changed how they use preauthorization, concurrent review, and retroactive review.

Before the law almost everything required preauthorization, but parity has stripped behavioral health plans from preauthorization. There are still some services that require preauthorization, but these are generally more specialized services.

For the medical side there has been no change in preauthorization. A challenge is with mental or behavioral disorders that require both physical and behavioral health treatment (e.g., anorexia). The medical field can do more preauthorization *and* utilization management if needed, but the behavioral health organizations are responsible for these individuals and are limited by the parity law to do more utilization management.

Company G now uses an outlier process where the preauthorization begins after a certain number of visits. Parity allows for clinical exceptions where there is a clinically appropriate reason to try a different treatment.

Company G stated that one challenge with parity is that it does not *require* behavioral health services to be covered. At times behavioral health services may be excluded for other add-ons. Parity is now a big part of plan design and in considering how plans will incorporate utilization management.

Managing Out-of-Network Care

- Company A does not manage out-of-network benefits. If it needed a provider outside of its network, it would negotiate a single-case agreement to purchase the necessary services for the member.
- Management of out-of-network care has changed with the implementation of parity. Prior to the law, Company B had several commercial accounts that offered out-of-network options that were not managed. With the implementation of parity,

more commercial accounts have needed to offer more out-of-network care to be comparable to physical health benefits. Many more commercial accounts are now managing their out-of-network accounts. Company B uses processes for managing out-of-network care that are similar to those used for in-network care, such as notification, concurrent review, and retrospective review. Retrospective review is most frequently used for out-of-network care. No level of care now requires prior authorization, so Company B instead uses notification.

- For Company C certain types of out-of-network providers are problematic, such as wilderness programs and resort-like substance abuse treatment facilities. There is little incentive for these out-of-network providers to cooperate, and they often do not cooperate with retrospective review. Prior to parity, many plans limited behavioral health services to credentialed in-network facilities.
- Company D is obligated to meet *minimum network access* standards, meaning that at least a certain percentage of patients using behavioral health services through Medicaid must use contracted (*par*) providers. The percentage threshold varies by market. Some states set a threshold and require monitoring of claims received from non-par providers. Company D tries to redirect members to access par providers. In some cases it establishes *single-case agreements* with a non-par provider, essentially making it a par provider for the sake of one plan member.

Enrollees may access non-par providers directly and may self-refer to care. However, once the provider conducts an initial assessment, the patient would need authorization by Company D to be reimbursed for any further services. Single-case agreements are established if they promote continuity of care. For example, if a new member has been working with a non-par provider, Company D will establish a single-case agreement to maintain continuity of care. Prior authorization is required if an individual seeks treatment outside of the state where he or she has public health insurance.

Company D conducts an ongoing analysis of the need to expand provider options for its members.

- Company E was not asked about managing out-of-network services.
- Previous to parity, Company F had day limits on out-of-network services. These limits have now been removed. The strategy of most plans is to provide incentives for individuals to receive in-network rather than out-of-network care. They do this by having lower copayments and cost-sharing for in-network care.

With regard to non-quantitative services, health plans have had to move away from prior authorization for out-of-network care. As a result more retrospective review is used instead of prior authorization. This has been a challenge for

providers because they want prior authorization to ensure that they will be paid for the services they provide.

Company F conducts a targeted retrospective review of claims for out-of-network services. They examine practice patterns of providers. For example, they may look to see if a certain diagnosis was needed before a treatment was provided to an individual. If Company F finds a procedure that is not acceptable, it typically works with the provider to change things prospectively rather than retrospectively.

There has been more change for outpatient rather than inpatient NQTLs for out-of-network care because of the removal of prior authorization for outpatient services. Many behavioral health inpatient services still maintain prior authorization, because this is comparable to the procedures for physical health services.

- The same utilization management techniques for in-network services are used for out-of-network services. The difference is that some contracts do not cover out-of-network benefits. In these cases Company G will inform the provider if he or she calls in with a treatment request.

There may have been a slight increase in the use of out-of-network services; however, Company G did not have any statistics to share.

Demand for Residential or Intensive Outpatient Substance Abuse Care

- Company A has not seen an increase in utilization or demand for residential services. With the establishment of parity, customers actually wanted to exclude residential care. They asked Company A if they were mandated to include it or not, and Company A informed them that from a legal perspective they could exclude it if they were including other inpatient services. However, Company A explained to them that it would not be cost effective to exclude residential care. Company A explained that by excluding residential services the customers would be removing part of a continuum of care, and some individuals might need that specific level of care to prevent them from multiple acute inpatient visits that over time cost more than residential services. Company A explained to their customers that it would be unwise to exclude residential services. Customers did some analyses and came to the same conclusion.

Parity has impacted the day limitations with residential services. Residential services were categorized as inpatient services that do not have any day limits. Some customers wanted to compare residential services to SNFs, because SNFs have day limits; however, they could make this comparison based on the parity law because a SNF is not one of the six categories of services that are the basis for comparison between MH and physical health services. Customers needed to classify these services as inpatient services.

Intensive outpatient (IOP) care is slightly different from residential care. It is an intermediate level of care; some customers classified IOP care as an inpatient service and others classified it as an outpatient service. Customers are responsible for disclosing how they are categorizing IOP care so that parity between mental and physical health services can be established.

Company A has not seen an increase in demand or utilization with IOP. For those that treat IOP as an inpatient service, the day limits are excluded. It is a greater struggle to meet the parity requirements when IOP is classified as an outpatient service, because IOP is not a standard outpatient therapy. For example, it is unclear how to establish parity with copayments for IOP programs because individuals will be attending the program 3-5 days per week. It would be costly to patients if they were required to pay a \$25 copayment for these visits. Company A's recommendation has been that individuals should be required to pay a copayment for the course of treatment or, if copayment is paid by the visit, the individuals should be required to pay a smaller copayment (e.g., \$5 per visit).

There has possibly been a modest increase in the length of stay or number of days these services are provided; however, Company A did not know at the time of the interview how much these figures have changed, if at all.

- Company B was not asked about residential treatment and IOPs.
- Company C has had no significant increase in the request for residential treatment services.

Especially for out-of-network care, but also to some extent for in-network residential care, individuals making calls to check the coverage of a residential service speak with a clinician to ensure that the client meets medical necessity criteria and the residential service of interest is covered under the member's benefit package. This is to avoid the problem of parents sending their youths to an outdoor leadership residential program (e.g., Outward Bound), and then calling the company and finding out that the residential service is not covered.

Company C has not seen an increase in the utilization of structured outpatient services for substance abuse. It has, however, seen an expansion in the length of treatment. Previously clinicians were seeing individuals 3 days per week, but now they are seeing them 5-7 days per week. Previously structured outpatient programs lasted a total of 10-12 days, but now they are lasting 20-25 days. This increase has persisted even with reviews to ensure that the enrollees meet medical necessity criteria.

- Some states have recently expanded the scope of their benefit package to include more behavioral health services. One of Company D's markets recently added substance abuse services, such as intensive outpatient services, to its

benefit package in order to more fully comply with the parity law. Another market expanded its CHIP benefits to include more behavioral health services.

Other than the states that have recently started to cover intensive outpatient services and other behavioral health services, Company D has not seen any significant change in the demand for or utilization of residential and intensive outpatient services among public insurance plans.

- Company E has seen an increase in the number of 21-26 year olds being admitted to chemical dependency programs. This is due to the PPACA regulation that allows young adults up to the age of 26 to be covered under their parents' insurance plans.

There has not been a significant change in the utilization of residential treatment services. Most plans that Company E works with do not cover residential services. Some plans have tried to compare RTFs to SNFs; however, SNFs are not one of the six areas of coverage defined by HHS. Coverage of residential treatment services has not changed with the implementation of the parity law.

Most plans cover IOP services and did so even before the parity law. Company E has not noticed more people using IOP services. Even with the removal of QTLs the length of IOP programs has not increased significantly to this time. It has, however, allowed for individuals who have a relapse after finishing the program to go through the program again.

An FEHBP that Company E works with is currently experimenting with not managing partial hospitalization and IOPs. In the next couple of years the health plan will evaluate this experimental program.

- With Company F, the utilization of residential treatment and intensive outpatient services has not changed since MHPAEA went into effect; however, now more patients seek to use out-of-network facilities. The day limitations for residential treatment have not changed significantly, because even before the implementation of the parity law most plans did not set day limitations for residential treatment.
- Recently, Company G has seen more requests for residential treatment. In particular, more individuals are requesting to initiate treatment at the residential level. Company G noted that there have been more licensed and available residential facilities in the state where it works in recent years. The length of stay has not changed notably.

Company G has also seen growth in partial hospitalization IOP services in recent years. In the public sector IOP services are commonly considered outpatient services, whereas in the commercial sector they are frequently classified as inpatient services. IOP is often billed as a daily facility charge or a bundled

payment. IOP services are an important part of the treatment continuum, especially for those with chemical dependency.

Management of Prescriptions

- Company A does not manage prescriptions for commercial accounts; however, it does manage prescriptions for some public accounts. Nothing has changed in Company A's management of prescriptions for public accounts because public Medicaid accounts do not yet fall under the parity law.
- Company B does not manage prescriptions.
- Company C does not manage prescriptions. Its associated health plans contract with a pharmacy benefit manager. The manager administers the contract, pays pharmacy claims, establishes networks, and manages prior authorizations. Company C directs providers to the manager when they have issues about access to pharmacies or use of specific drugs.

The states establish formularies for publicly funded plans. If a state has not established a formulary, the health plan will establish a formulary to use.

The health plans with which Company C works have examined the parity of the pharmacy benefits it manages. It found that *step-therapy* -- covering a medication only after one or more alternatives have been tried without success -- was applied consistently across all drug categories. The health plans also found parity in the pharmacy benefits for psychiatric drugs relative to other drugs.

- Company D does not manage prescriptions and has not tried to ensure parity in medication coverage. That task would fall to any PBM firm hired by the plan. Most behavioral health medications are prescribed by primary care providers, who are not within the behavioral health carve-out; thus, Company D would not be well placed to manage their prescribing. Moreover, there might be little gain from managing behavioral health medications -- most health plans cover them in the belief that they are less expensive than counseling.
- Company E is not involved with prescription management in any way.
- Company F does not typically manage Rx. The responsibility to manage Rx usually remains with the manager for the plan. In the case where Company F is an internal client to a health plan, it has been able to talk with the manager and ensure that the formulary and tiers do not discriminate or are not more restrictive for psychiatric drugs. As a carve-out vendor, Company F provides information to their customers regarding not discriminating in formularies; however, they cannot do more than this.

Before parity, there was a movement to try to limit psychiatric drugs prescribed by primary care providers. With the advent of parity, there is no way to legally enforce these limitations; thus, the movement has ended.

- Company G was not asked about managing prescriptions.

Additional Comments About Parity

- The overall utilization of services has not increased as significantly as Company A was expecting with the implementation of the parity law.
- States dictate the benefit package and limitations of services for public insurance plans. Company B has no say in establishing or changing the benefits it is responsible to cover under public programs.

Company B has noticed that states have been so preoccupied with health reform that parity has not been as emphasized. If the parity law had been established a few years earlier, the results and speed of change would have likely been very different.

With one exception, states are not asking Company B if they meet parity requirements. States appear to be preoccupied with lowering the cost of their share of Medicaid programs and addressing health reform. Rather than ask about parity, states are interested in innovative and more effective ways to manage care and reduce costs.

In one state, Company B is working to improve the managed care system by providing behavioral health homes to those with serious mental illness (SMI). This is different than the normal health homes in that the primary line of service is related to behavioral health and the secondary line of service is related to physical health.

- Company C has seen an increase in cost of care for behavioral health services. It is unclear if this increase in cost has come from the changes in benefit design (e.g., cost-sharing and copayments), or the limitations on what utilization management techniques can be used.

As a result of the parity law, psychiatrists can be reimbursed at the same rate as an obstetrics and gynecology physician for using an E&M code. Company C has seen an increase in the use of E&M codes for psychiatric services, possibly because psychiatrists can be reimbursed at a slightly higher rate by using these codes. This has caused some complaints by health plan providers.

- A challenge working with health plans, especially the smaller commercial plans, is in keeping up to date on the shared accumulators, members' deductibles and lifetime maximums. Prior to the parity law, Company D had lifetime maximums

that applied solely to behavioral health benefits. Now, Company D must use a unified set of maximums, called *shared accumulators*, in conjunction with members' medical health plans. This has increased the administrative burden of determining whether a claim should be denied based on exceeding a limit.

Company D works with McKesson continually to improve the InterQual criteria. Clinical areas on which they have collaborated include residential services, psychological testing, and ABA for people with autism, among others.

Company D conducts internal reviews to ensure compliance with parity regulations. They are evaluated externally by state agencies such as a state's Department of Managed Care.

- Company E has seen an increase in the length of stay and in the number of admissions. There has also been an increasing number of outpatient visits. Most people are receiving fewer than eight sessions of outpatient therapy, and the distribution of the length of treatment is getting wider. In general, Company E noticed that it takes longer for the outpatient community to make benefit changes than the inpatient community.

It is a challenge to figure out what the regulations mean. Many providers disagree on the various interpretations of the law.

Parity still does not cover everyone. It does not apply to small groups and individual policies. Some providers have misunderstood parity, thinking that it gives everyone unlimited behavioral health services. This is not the case.

There are a small number of plans that decided to drop all behavioral health services because of the parity regulations. Other plans have experimented with excluding certain diagnoses from the diseases they cover.

Company E has had ample discussion on NQTLs, yet some questions still remain. It is unclear whether it is necessary to totally harmonize MBHO and medical contracts with facilities and providers. Some advocates have also suggested that parity has not yet been established between the level of network access within the field of behavioral health and the level of network access within the rest of the medical field. Company E uses the exact same standards for access to facilities, professionals, and other programs that the medical part of the health plan uses. This strategy should insure similar access to behavioral health and medical professionals. It is also unclear how to reconcile different payment strategies for inpatient services, where payment is based on DRGs for medical services and per-diem rates for behavioral health services. Even though the parity law was designed to establish parity across behavioral health and medical insurance benefits, providers have also tried to use the law to establish parity in how much they are reimbursed, which did not appear to be the original intent of the law.

- Company F has seen an overall increase in the utilization of behavioral health services in the last few years, although the level has begun to plateau. In addition to changes in limitations and management of behavioral health services, more plans in Company F's state where Company F works started to cover substance abuse services because of the parity law.

The PPACA has also caused increases in the utilization of behavioral health care. By eliminating preexisting condition clauses and extending coverage to more adolescents and young adults, it has increased demand for all services. Use of certain services has risen dramatically, such as treatment for chemical dependence among adolescents and young adults.

Company F has not received any complaints that the behavioral health services it offers are not comparable to the physical health benefits of its members. They do receive requests from members regarding the behavioral health medical necessity criteria.

There appears to be more advocacy regarding parity within the last 6 months than during the whole year after the parity law was passed. A small minority of providers has begun to see members multiple times per week with no clear treatment plan or goals. This pattern of practice was more frequent prior to care management. Company F advises providers that open-access to care does not eliminate the need to monitor its quality. Treatment goals and progress are still required for continued payment.

- Self-funded employer plans have multiple medical vendors, some of which are not forthcoming with information to allow parity analysis. Some of those vendors also have their own behavioral health business line and may be attempting to steer the customer to their own services. In cases where information has not been shared, Company G assumes a typical benefit package when helping the self-funded plan to ensure that the parity regulations are met.

"Apples-to-apples" comparisons between behavioral health and medical services are sometimes difficult. For example, there is no medical/surgical equivalent to intensive outpatient services or partial hospitalization.

Autism presents special difficulties for several reasons. There is no agreement on whether to treat it as a behavioral health condition, a birth defect, or a typical medical condition. It has no analogs in medical care, making parity comparisons difficult.

States have been active in regulating insurance coverage for autism. Most states with mandates have annual dollar limits. In order to avoid contravening MHPAEA, some of the states designate autism as a medical condition or a birth defect. Others seem to have paid no attention to MHPAEA at all, and it is unclear

if MHPAEA was contemplated. Most of the states have the autism applied behavior analysis mandates as standalone mandates. Notably, these rules do assign autism to the same category as SMI or biologically based mental illness; instead, they issue a standalone mandate. Dollar caps, when they exist, are relatively high (e.g., \$36,000, \$50,000, \$70,000). The laws passed are usually based on the Autism Speaks model. New Jersey is the only state that precludes a dollar limit for any plan that covers autism treatment if the plan is subject to federal parity; for plans not subject to federal parity, the plans may enforce the dollar cap.

Soon after the regulations implementing MHPAEA were released, Company G worked with customer plans to check their compliance with the law. This process took many hours of work for each customer. Now, a few years later, the issue of parity rarely surfaces except with respect to autism.

The parity analyses were not conducted for each plan that Company G works with. A single large customer can have more than 300 separate plans (certificates). Analyzing parity for each one was not possible. The typical approach was to use the customer's largest or most typical plan. The result would apply broadly, because most plans from a particular customer had similar characteristics.

EVALUATION OF COMPLIANCE WITH THE WELLSTONE-DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Reports Available

Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Executive Summary <http://aspe.hhs.gov/daltcp/reports/2013/mhpaeActes.shtml>
HTML <http://aspe.hhs.gov/daltcp/reports/2013/mhpaeAct.shtml>
PDF <http://aspe.hhs.gov/daltcp/reports/2013/mhpaeAct.pdf>

Substantial Improvements to Mental Health and Substance Use Disorder Coverage in Response to the Mental Health Parity and Addiction Equity Act of 2008: Research Brief

HTML <http://aspe.hhs.gov/daltcp/reports/2013/mhsudRB.shtml>
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APPENDIX D
NQTL/SOS Study



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy



SHORT-TERM ANALYSIS TO SUPPORT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION

February 2012

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract #HHSP23320095649WC between HHS's ASPE/DALTCP and the RAND Corporation. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, John Drabek, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. His e-mail address is: John.Drabek@hhs.gov.

SHORT-TERM ANALYSIS TO SUPPORT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION

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The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services, the contractor or any other funding organization.

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PREFACE

The Interim Final Rules (IFR) implementing the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 went into effect on July 1, 2010. This report describes the findings from short-term studies commissioned by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services (HHS) and undertaken by the RAND Corporation. These studies were focused on two issues in the IFR, where HHS felt that further research would be useful in informing the implementation of the MHPAEA. The two issues are the use of “non-quantitative treatment limitations” (NQTLs) by self-insured employers, insurers, health plans and managed behavioral health organizations and the identification of a “scope of services” in behavioral health to which parity applies.

The findings reported here on NQTLs are based on interviews with managed behavioral health industry experts, deliberations of an Expert Panel convened by the HHS Substance Abuse and Mental Health Services Administration, consultations between ASPE and RAND staff, and a discussion with state regulators in Oregon, which is the only state that has adopted a statute with NQTL provisions similar to the MHPAEA.

The findings on “scope of services” reported here are based on descriptive analyses of linked plan and utilization data from the MarketScan Health Benefits Database for the year 2008. The original purpose of analyzing these data was to generate a model of annualized per member per month (PMPM) total cost so that the model could be used to assess the extent to which these costs were sensitive to alternative scenarios for coverage of three types of “intermediate” behavioral health services (i.e., intensive outpatient visits, partial hospitalization, and residential treatment). Careful scrutiny of the data, however, revealed there was insufficient variation in spending on these key services across health plans in the MarketScan database, which would be necessary in order for us to build a reliable model. However, the linked data provide insights into the provision of these intermediate services by health insurance plans prior to the implementation of the MHPAEA. The findings are helpful in considering the effect of applying a parity requirement to the scope of services that health plans cover.

EXECUTIVE SUMMARY

This paper describes analyses commissioned by the U.S. Department of Health and Human Services (HHS) to inform the implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. This law generally requires that mental health and substance use disorder (MH/SUD) insurance benefits be comparable to the benefits for medical and surgical care. Coverage of MH/SUD services has often been more limited than most other health services with, for example, more restrictions on the number of outpatient visits or inpatient days covered and higher co-pay requirements.

The MHPAEA requires group health plans and group health insurance issuers to ensure that financial requirements (e.g., co-payments, deductibles) and treatment limitations (e.g., visit limits) applicable to MH/SUD benefits are no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical-surgical benefits. The Interim Final Rules (IFR) implementing the MHPAEA clarified that there are other types of treatment limits, beyond those listed as examples in the statute, to which the principles of parity should apply. These other types of treatment limits are referred to in the IFR as “non-quantitative treatment limitations” (NQTLs) and are defined as limits that are not expressed numerically but otherwise limit the scope or duration of benefits. NQTLs are further described as including the broad array of health care management policies and practices designed to contain costs of health care, including: medical necessity definitions and criteria (claims not covered unless care is deemed medically necessary); utilization management (UM) practices (preauthorization, concurrent review, retrospective review to determine medical necessity); formulary design in the pharmacy benefit (tiers of medications with differing co-pays/maximum days filled); and provider network management (credentialing and inclusion/exclusion of providers from networks, establishing fees for in-network providers, setting “usual, customary and reasonable” fees for out-of-network providers).

To better understand how health plans and issuers use these NQTLs to manage access to care, HHS commissioned a study to gather information from health plans and practitioners. This paper summarizes interviews with managed behavioral health industry experts and the discussion by a panel comprised of well-known researchers and practitioners with clinical expertise in MH/SUD treatment as well as general medical treatment, experience in developing evidence-based practice guidelines, and knowledge of how plans use NQTLs.

The information provided by managed behavioral health industry experts and the deliberations of the Technical Expert Panel were focused on how NQTLs are used by plans and insurers to manage MH/SUD benefits and any clinical justifications for variations in how NQTLs apply to MH/SUD benefits compared to medical benefits. The Expert Panel discussed three main categories of NQTLs: medical necessity definitions and criteria, UM practices, and provider network management. The panel discussed a number of processes, strategies, and evidentiary standards that they considered justifiable considerations for plans and insurers to use in establishing NQTLs for

MH/SUD and medical-surgical benefits. The justifiable considerations identified by the panel included evidence of clinical efficacy, diagnostic uncertainties, unexplained rising costs, availability of alternative treatments with different costs, variation in provider qualifications and credentialing standards, high utilization relative to benchmarks, high practice variation, inconsistent adherence to practice guidelines, whether care is experimental or investigational, and geographic variation in availability of providers. The panel also discussed how the standard in the IFR requires that these considerations be applied in a comparable way to MH/SUD benefits and medical-surgical benefits in determining how a plan or insurer will apply an NQTL. Furthermore, the panel discussed situations in which the outcome of applying these considerations in a comparable way may justifiably result in a different application of an NQTL to MH/SUD benefits compared to medical-surgical benefits.

Another issue identified by HHS as meriting additional research was the implications of the MHPAEA for the scope of services that health plans must offer. The IFR requested public comment on this question. To inform policy-making on this topic, HHS commissioned research into current coverage of intermediate level services for MH/SUD by health plans. In behavioral health care, as in general medical care, there is a continuum of services that lie between inpatient and outpatient care that have been shown to effectively treat some MH/SUD, and in some cases do so more cost-effectively than inpatient care. Examples of such intermediate forms of behavioral health care include non-hospital residential services, partial hospitalization services, and intensive outpatient services including case management and some forms of psychosocial rehabilitation. Although such services are provided in employer plans, there has been little quantitative information available on the extent to which these services are covered and utilized.

This paper includes an analysis of the Thomson Reuters MarketScan data that offers several insights into the extent to which employer plans included coverage for these services prior to the implementation of the MHPAEA and at what cost. Descriptive analyses showed that the average cost per member per month (PMPM) for all plan-provided health care was found to be \$268. Almost all of these costs are for medical-surgical services and related prescription drugs. Behavioral health services accounted for \$12, or 4.6% of total PMPM costs. Furthermore, the vast majority of the cost for behavioral health was for behavioral health prescriptions (\$7.46).

Intermediate behavioral health services -- those that lie between inpatient and outpatient care -- were provided by employer plans in 2008, although the results differed greatly for each service. Examples of such intermediate services are non-hospital residential treatment, partial hospitalization, and intensive outpatient treatment. Almost all of the employer-based plans had claims for intensive outpatient treatment (98%), most had claims for partial hospitalization (59%), but few had claims for non-hospital residential treatment (18%). Together the additional cost of providing these three services represented a very small fraction of the average total plan cost in 2008 (\$2.40 PMPM or 0.9%).

These findings on current levels of coverage of these intermediate services are helpful in considering the effect of applying a parity requirement to the scope of services that plans cover. They indicate that these types of services are already covered to some degree. However, in order to estimate the effect of imposing a parity requirement further research is needed to estimate the degree to which these current coverage levels of intermediate services may change to meet a parity standard.

1. INTRODUCTION

In general, parity requires that mental health and substance use disorder (MH/SUD) insurance benefits be comparable to and no more restrictive than the benefits for medical-surgical care. Coverage of MH/SUD services has been more limited than most other health services. Restrictions have included annual or lifetime limits on the number of provider visits or inpatient days, annual or lifetime caps on spending for MH/SUD services, or differential co-pay requirements for MH/SUD services. The net effect of these limitations has been generally less coverage and greater patient financial risk for care of these illnesses.

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

The 2008 enactment of the MHPAEA represents a new era for coverage of behavioral health conditions. While the law has some exclusions, it is substantially more comprehensive than the previous federal parity law¹ and considerably stronger than most state parity laws. The Act requires that financial requirements and treatment limitations for group health plans, including out-of-network provider coverage for treatment for mental and substance use disorders, be no more restrictive than those for medical-surgical services. The new federal law does not pre-empt more restrictive state parity requirements but does extend parity to self-insured plans that are exempt from state regulation. It also extends parity beyond benefits for treating mental health disorders, to include benefits for treating substance use disorders.

The Interim Final Rules (IFR)

On February 2, 2010 the Departments of Labor, Treasury and Health and Human Services published Interim Final Rules (IFR) in the *Federal Register*.² The IFR and the accompanying guidance were meant to help consumers, self-insured employers, insurers, health plans and managed behavioral health organizations (MBHOs) (among other stakeholders) understand the provisions of the MHPAEA and to guide the implementation.

Non-Quantitative Treatment Limitations

The IFR forbid self-insured employers and health plans from employing more restrictive “quantitative treatment limitations” (such as visit limitations for treatment of mental and substance use disorders) and also required that the use of “non-quantitative limitations” (including differential formulary design, standards for admitting providers to

¹ Mental Health Parity Act, PL 104-204 (1996).

² 26 CFR Part 54 (Treasury-IRS); 29 CFR Part 2590 (Labor-EBSA) and 45 CFR Part 146 (HHS-CMS).

the network, or differential medical necessity criteria) be no more stringent in limiting the scope or duration of benefits for behavioral health treatment relative to medical treatment.

Non-quantitative treatment limitations (NQTLs) refer to the broad array of health care management policies and practices designed to contain costs of health care, including medical necessity definitions and criteria (claims not covered unless care is deemed medically necessary); utilization management (UM) practices (preauthorization, concurrent review, retrospective review to determine medical necessity), formulary design in the pharmacy benefit (tiers of medications with differing co-pays/maximum days filled), and provider network management (credentialing and inclusion/exclusion of providers from networks; establishing fees for in-network providers; setting usual, customary, and reasonable fees for out-of-network providers).

The IFR specifically requires that the “processes, strategies, evidentiary standards and other factors used to apply NQTLs to MH/SUD benefits in a classification have to be comparable to and applied no more stringently than the processes, strategies, evidentiary standards and other factors used to apply to medical-surgical benefits in the same classification.” The regulations also acknowledge that there may be different clinical standards used in making these determinations -- including evidence-based practice guidelines. The regulations do not necessarily require equivalence in results when applying parity requirements to NQTLs, only comparable processes, strategies, and standards in determining application of NQTSs.

After publication of the IFR questions remain regarding application of the NQTL provisions and also how the MHPAEA applies to scope of services.

Scope of Services

In behavioral health -- like other areas of medical care -- there is a continuum of services that lie between inpatient and outpatient care that have been shown to effectively treat some MH/SUDs, and in some cases do so more cost-effectively than inpatient care. Examples of such intermediate forms of behavioral health care include non-hospital residential services, partial hospitalization services, and intensive outpatient services including case management and some forms of psychosocial rehabilitation. The “scope of services” issue concerns the extent to which the MHPAEA requires a full *range* of MH/SUD services (i.e., a continuum of care). The IFR did not specify requirements regarding application of parity to these intermediate services.

Given the unanswered questions in the IFR with regard to NQTLs and scope of services, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) sought a contractor to perform short-term studies in order to better understand the likely impact of regulation.

ASPE asked RAND to design and conduct studies to address the following policy questions:

1. What should be the criteria for parity in NQTLs?
2. What is the impact of applying parity to the scope of services covered by health plans and insurers, focusing on various levels of coverage of intermediate services?

The purpose of this Project Memorandum is to summarize the findings from these two studies.

2. NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTLs)

In the original scope of work, RAND was asked to provide background materials, attend, and write up a summary of the deliberations of an Expert Panel on NQTLs to be convened by the Substance Abuse and Mental Health Services Administration (SAMHSA). However, at ASPE's request, we revised the scope of work to develop a strategy that would enable the Expert Panel convened for this project to focus on clarifying issues related to the implementation of parity in NQTLs. In the revised scope of work, we expanded the NQTL study to encompass three areas of activity: (1) consulting with industry representatives on their experiences with implementation of the IFR to date; (2) working with the Expert Panel to create additional specific examples that could be included in future guidance with regard to NQTLs; and (3) understanding the experience of Oregon regulators who had to address NQTLs in the implementation of the Oregon parity law -- the only state law in the country that specifically addresses NQTLs.

Consultations with Industry Representatives

RAND interviewed several industry representatives, and in this section we summarize their perceptions of the parity legislation and regulations, including their concerns. Industry representatives reported that implementation of parity regulations may have challenging and far-reaching business consequences for the MBHO industry. Some sectors of the industry report that they are facing much more complicated implementation issues than others. The implementation of parity regulations is seen as fairly straightforward for organizations that are integrated medical and behavioral health managed care plans.

Our interviews identified special issues that may confront the MBHO carve-out business. Comparisons with general medical plan features can become very complex, because hundreds of different general medical plans can be involved. The MBHO can employ a strategy that makes comparisons and adjustments on a plan-by-plan basis, which imposes greater complexity of management (and increases administrative costs). A key concern is that if the MBHO adopts a more centralized management strategy, carve-out clients (the clients in this case are the self-insured employer or the major medical plan) may find their behavioral health benefit management misaligned with its corresponding major medical plan. Because the behavioral health carve-out is often not the "at-risk" plan, but instead is a provider of administrative services only, it can make recommendations, but the client ultimately determines key features of NQTLs. Some MBHOs, through an era of mergers and acquisitions, have become very large organizations with a multiple and diverse book of business; consequently, according to some industry representatives, implementation of the IFR is a complex undertaking, which begins with investment of considerable time and resources to collect the

information needed to evaluate compliance, let alone respond. In addition to these general observations, these industry representatives offered the following specific observations on types of NQTLs.

Medical Necessity Definitions and Criteria

Medical necessity definitions provide a broad framework for guiding the more specific standards, guidelines, or decision support protocols that these organizations use to make coverage decisions. In October 2000, the Board of the Trustees of the American Psychiatric Association (APA) endorsed the statement of the American Medical Association (AMA), which defined medical necessity as “services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider.”³ The medical necessity definitions used by the organizations with whom we spoke were identical or closely corresponded to this definition, but sometimes had an additional cost-related consideration (e.g., “not more costly than alternative services and at least as likely to produce equivalent therapeutic or diagnostic results...”). The NQTL regulations stimulated these organizations to undertake efforts to document and compare their behavioral health and general medical benefit definitions, but they reported that this resulted in no or little change in those definitions.

To translate the definitions into tools that can guide decisions to authorize or deny care, these organizations invariably use a committee structure, composed of both in-house and external clinical experts, to review existing guidelines, research evidence and benchmarks, and to develop specific coverage recommendations and criteria, which are updated on an annual basis, and approved at the top levels of the organization. These criteria are used by care managers in making coverage decisions as part of the UM processes (e.g., to preauthorize care, or approve care for reimbursement as part of concurrent or retrospective review.) Several organizations mentioned that, while care managers can approve care, a supervising physician must review all denials of care. Several organizations mentioned testing consistency of application of criteria among care managers. Some organizations also described use of information systems to scan for potential problem areas (e.g., high geographic or facility variation in utilization patterns for certain diagnoses or treatments, with those areas then becoming a topic for committee review.) Leaders from each organization with whom we spoke had reviewed and determined that their processes of developing medical necessity criteria were comparable to the processes used for general medical care.

Specific decision tools and algorithms used to apply medical necessity criteria on a case-by-case basis have traditionally been considered proprietary and they were not shared with us. We note, though, that these may not stay protected for long. The

³ American Medical Association Policy Statement, H-320.953 -- Definitions of "Screening" and "Medical Necessity" (CMS Rep. 13, I-98; Modified: Res. 703, A-03).

statute and the IFR require that the criteria used for medical necessity determinations for behavioral health benefits be provided to participants, beneficiaries, or contracting providers upon request. One organization has decided to go a step beyond the requirements -- it has begun routinely providing the relevant criteria to participants and providers when care is denied or partially denied. This industry leader said that, so far, this information about specific reasons for denial seems to be well received.

These organizations are not yet seeing appeals of medical necessity decisions specifically related to MHPAEA parity, although they are watching broader trends carefully. They have had some inquiries from providers who are under the impression that any use of NQTLs is prohibited under the IFR.

A few examples were given of services that are not covered because they are not considered medically necessary: (1) “wilderness” programs for youth -- because of no evidence of effectiveness and the lack of clinically credentialed staff; and (2) Applied Behavioral Analysis (ABA) for autism, because it is considered educational rather than medical. In addition, industry leaders mentioned limited coverage for psychological testing, because while it is clinically appropriate to rule out certain diagnoses, it is also a service that is subject to abuse. Some industry representatives suggested that these services may serve useful social functions but are not evidence-based behavioral health treatments.

One industry leader discussed the challenges of managing the quality and costs of outpatient psychotherapy, which composes the bulk of outpatient care. This respondent argued that outpatient psychotherapy does not have a parallel in medical care because: (1) existing guidelines are not specific; (2) clinician training and standards, especially for masters-level therapists, are diverse, so therapists may not have appropriate skills; and (3) there is no way to know what goes on in psychotherapy (e.g., what specific therapeutic approaches and techniques are used).

Utilization Management (UM) Practices

UM refers to the policies and protocols that define when and for what types of services preauthorization, concurrent review, and retrospective review are utilized. The review provides the opportunity for medical necessity criteria to be applied. Thus, the review may result in denial of coverage for all or some portion of care, or authorize coverage for an alternative to the requested care. In addition, preauthorization and concurrent review may delay care -- if participants and providers wait on the outcome of the review -- or discourage care due to the “hassle” factor.⁴

The industry leaders we interviewed reported that their organizations review and update UM practices in the same manner as updating of medical necessity criteria, and use the same or similar committee process. UM practices are also updated in response to federal and state regulatory requirements. Industry representatives said that the

⁴ Koike A, Klap R, Unutzer J (2000). “Utilization management in a large managed behavioral health organization.” *Psychiatric Services*, 51: 621-626.

factors they use to drive the nature of review processes were intended to prevent “overuse” and “misuse” of services. For example, one organization cited Wennberg’s⁵ four factors: (1) regional variation; (2) underuse of effective care; (3) misuse of preference-sensitive care; and (4) overuse of supply-sensitive care. Another mentioned practice variation, above benchmark use, and evidence of inconsistent adherence to evidence-based guidelines. Cost containment is also relevant, as reflected in comments that they attend to: unexplainable rise in costs of a service, and patterns of use of high cost services relative to commonly available alternatives.

Comparison of behavioral health UM practices to those in general medical care required these organizations to develop a cross-walk between classes of services, and make a comparison. Some organizations were still in the process of collecting information and making changes on a plan-by-plan basis. One organization mentioned that they have sometimes changed from UM to a limit in benefit design, to be consistent with the medical plan.

The industry representatives told us that a few issues stood out as being particularly ambiguous with respect to comparison across behavioral health and general medical UM practice:

1. According to the industry, outpatient behavioral health care has some unique features and does not cross-walk well with outpatient medical care. The potential for misuse and overuse is perceived to be high relative to, for example, visits with a primary medical care provider or a cardiologist. One industry leader suggested that psychotherapy was probably more like occupational, physical, and speech therapy, in its potential for misuse and overuse.
2. They also said that intermediate levels of care (e.g., intensive outpatient and partial hospitalization) are also challenging to cross-walk, and plans have made different decisions about whether to place these alongside outpatient or inpatient medical care. Industry leaders reported that as a result behavioral health UM practices have become more varied across plans than prior to the IFR. Some industry leaders noted that guidance from the government that would allow a more uniform approach to behavioral health UM practice would be welcome.
3. For inpatient care, some medical plans rely on DRG-based standards, for example, applying retrospective review or capping the benefit when DRG amounts are exceeded. Behavioral health inpatient care is not subject to Medicare DRG payments (too variable within diagnostic groups), so no equivalent method exists.

⁵ Wennberg JE, Fisher ES, Skinner JS (2002). “Geography and the debate over Medicare reform.” *Health Affairs*, published ahead of print February 13, 2002, doi:10.1377/hlthaff.w2.96. [Available at <http://content.healthaffairs.org/content/early/2002/02/13/hlthaff.w2.96/suppl/DC1>]

The IFR has already led to UM practice changes for these organizations. For outpatient behavioral health care, several industry leaders told us that the pass-through number (that is, the number of visits that are allowed prior to review) has changed from a somewhat arbitrary number (e.g., 2, 8, 10, or 20), to a number based on the statistical distribution of visits (e.g., 1 or 2 standard deviations above mean visits, sometimes calculated within diagnosis). This has had the effect of making the pass-through number larger, and also preserving a more unified approach across medical plans served by a particular MBHO.

Some organization representatives told us that pre-certification of outpatient care, and preauthorization of inpatient care has been, or is in the process of being, phased out. One organization is replacing inpatient preauthorization with “pre-notification.” Another is replacing inpatient prior authorization with intensive concurrent review.

Provider Network Management

Provider network management refers to processes for credentialing and including/excluding providers from networks, the establishment of fees for in-network providers, and setting usual, customary and reasonable (UCR) fees for out-of-network providers.

These organizations reported using standard credentialing checks to decide which providers to include in their networks. Some leaders mentioned excluding certain subspecialties (for example, specialty providers of ABA for autism), and reported doing ongoing evaluations of network providers. One industry leader noted that a problem for all organizations is a shortage of psychiatrists in many geographic regions (especially in rural and frontier areas), and that they work hard to credential and include as many psychiatrists as apply. Another noted that exclusion of individual providers was done only on the basis of “egregious” quality issues. All have reviewed their provider network management practices in response to the IFR, and a number of issues have emerged.

1. Some organizations report having special requirements for masters-level therapists to have post-degree supervised clinical experience (2 or 3 years), because many masters programs do not offer this training and state licensing requirements vary widely for masters-level clinicians. There is no parallel with general medical network providers and they do not require this for psychiatrists or PhD-level psychologists, whose licensing does require supervised clinical experience.
2. Some organizations discussed challenges related to setting and/or negotiating in-network provider fees using similar approaches to medical plans. For example, some medical plans may use Medicare fee standards (some multiple of Medicare fees), but not all do. Providers sometimes have expectations that their fees should be increased to be equivalent to medical providers, or should be automatically adjusted along with those of medical providers. The industry perspective is that these providers fail to recognize, in the words of one respondent, that “the markets are different.”

3. According to the industry representatives, establishing UCR fees for out-of-network providers is another challenging issue. Medical plans rely on data obtained from companies that collect and analyze large numbers of claims from multiple payers, but information on psychotherapy is not available from these companies. One organization uses their own in-network data to establish UCR fees; another mentioned less systematic collection of information about UCR fees in local markets.

In response to the IFR, one organization has dropped their provider network inclusion requirement of supervised experience for some clinical subspecialties, while two others have not (on the basis that the requirement is defensible).

Expert Panel

On March 3, 2011, SAMHSA convened a panel of experts to provide substantive and technical input on issues related to the use of NQTLs. The Expert Panel members represented a broad range of knowledge and expertise including clinical expertise in MH/SUD treatment, experience in developing evidence-based practice guidelines, and experience use of NQTLs in their practice. In attendance at the meeting were the Expert Panelists, the moderators (Howard Goldman and Audrey Burnam), and SAMHSA, ASPE, and National Institute of Mental Health staff. In addition, a number of federal agency staff participated in all or parts of the meeting (see Appendix 1). RAND provided a background paper for panelists that included some of the observations made by industry representatives.

Over the course of the meeting, we first solicited feedback from the panelists about how to evaluate parity in medical necessity definitions and processes for establishing specific clinical guidelines and criteria. We then asked the panelists to discuss parity in UM practices. Finally, the panelists weighed in on parity in processes used in provider network management. That discussion is summarized in bullet points below:

Medical Necessity Definitions and Criteria

- Medical necessity definitions are broad, and plans may adopt APA/AMA definitions, which are comparable across behavioral health and general medical care. Plans may also include in their definitions a consideration of costs (e.g., to provide efficient or cost-effective care). The panel view was that, broadly, medical necessity definitions that included cost-effectiveness considerations could be clinically appropriate.
- Specific guidelines and criteria that plans adopt to guide medical necessity determinations are based on processes of expert review of existing guidelines, empirical literature, and other information. The panel discussed the types of information that might be relevant to the adoption of specific criteria: clinical

efficacy, uncertainty, high potential costs, provider qualifications, practice variation. It could be reasonable to treat behavioral health conditions differently with respect to medical necessity determinations when the evidence base supports differences. The panel discussed specific examples, including fail-first and step-care requirements, and some types of procedures/services that are often considered unnecessary, to illustrate situations in which medical necessity determinations would or would not be clinically appropriate and meet parity requirements.

Utilization Management Practices

- Some of the possible rationales discussed by the panel that plans use to justify differential management include the following: utilization above national benchmarks, costly relative to commonly used alternative services or levels of care; unexplained practice variation in the use of services or levels of care; unexplained rising cost trend (e.g., Suboxone), evidence of inconsistent adherence to established practice guidelines, identified gaps in care (e.g., low rates of post-hospital follow-up care); and possible experimental or investigational procedures (e.g., rapid opiate detox).
- Some panelists suggested that, especially in substance abuse treatment, the potential high variation in practice (in treatments received for those with similar substance abuse problems) that is not solely determined by provider training or qualifications suggests that differential management may be appropriate.
- Differential concurrent review may be appropriate when you have a provider type that is not licensed by the state -- this should be the same across the behavioral health and general medical benefit -- although the effect will be felt more on substance abuse providers.

Provider Network Management Practices

- The panel discussed how behavioral health providers (in particular some types of substance abuse treatment counselors and psychotherapists) do not have consistent training or credentialing standards across subfields, and there is also considerable variation in licensing standards for these types of providers across states. This discussion suggested that it may be clinically appropriate for plans to have additional criteria (such as experience requirements) for inclusion in networks.
- The panel did not feel qualified to offer specific opinions on data sources for setting network fees and UCR fees for out-of-network providers, but generally agreed with the principle that use of market data to set fees should be similar across behavioral health and other medical providers (for example, basing fees on a multiple of Medicare fees).

- The relationship between fees and network adequacy is an important parity consideration.
 - Network adequacy is routinely reported by plans using indicators such as access, waiting times, availability of certain specialty care (and others). The panel recognized that network adequacy is influenced by availability (e.g., rural areas may have limited availability of certain kinds of specialists).
 - If fees offered for behavioral health providers are so low that network adequacy is poor, relative to medical network adequacy, then this would raise an issue of parity.
- There was considerable discussion about exclusion of primary care providers in behavioral health networks, because primary care providers often treat behavioral health conditions, and there is growing evidence of effectiveness of some primary care based treatment models. ASPE staff noted that they recognized the importance of this issue, but suggested that the complexity of reimbursement issues were beyond the scope of the panel's charge.

The Expert Panel agreed on the following examples for regulators use in providing additional guidance to the field -- but also raised a number of questions.

Medical Necessity Determinations

- Stepped care requirements can be in violation of parity if these are applied in ways that are not clinically appropriate for behavioral health conditions. Routinely requiring outpatient treatment before covering inpatient or residential treatment for behavioral health conditions (for example, for treatment of substance use disorders) would be inequitable, since such requirements are not routinely applied for general medical conditions. But stepped care requirements can be clinically appropriate for some patients (e.g., with uncomplicated and less severe substance use disorder) when stepped care is consistent with accepted clinical guidelines.
 - There is an analogue in general medical care -- treating pneumonia in a frail, elderly person who lives alone. Treatment for pneumonia can often be ambulatory, but not in every case. The question would be, is the inpatient admission clinically justified? A "blanket rule" against behavioral health inpatient admissions should not be allowed.
- Medical necessity determinations are guided by specific clinical guidelines and/or criteria that plans adopt and update based on processes of review and evaluation of clinical evidence, and on other information such as costs, practice variation, etc. If these processes and criteria hold behavioral health services to higher clinical evidence standards than general medical services, then medical necessity determinations are not equitable and do not meet parity requirements.

- Cost and efficiency considerations, per se, do not violate parity. For example, medical necessity criteria may result in reimbursement for the less costly but denial of the more costly of two alternative treatments that are equally effective and safe. If such cost and efficiency considerations apply to behavioral health medical necessity determinations, however, they must also apply for general medical determinations by the medical plan.
- Routinely reimbursing for self-management and educational services for chronic general medical conditions (such as diabetes) but denying these kinds of services for severe and persistent mental illness is inequitable and does not meet parity requirements.
 - Clinical evidence supports use of certain kinds of self-management and educational services in both cases. If clinical evidence were similarly evaluated, and patient education and self-management services were differentially reimbursed based on level of evidence of clinical appropriateness, then different medical necessity determinations would be justified.
- “Fail-first” requirements may be clinically appropriate. For example, medical necessity determinations may deny reimbursement for a brand name antidepressant medication until the patient first tries and fails a generic antidepressant medication. If fail-first requirements such as these are applied in the behavioral health benefit, however, they must also be applied in a comparable fashion in the medical benefit.
 - There are some instances in which different fail-first requirements would be clinically appropriate. For example, if there is a laboratory test that can be administered to help determine which of several alternative medications to use for a particular medical condition -- and there is no such test to help decide which antidepressant to use -- that could be a reasonable basis on which to require a “fail-first” policy for generic antidepressants but not for medications for the medical condition, because the laboratory findings would determine the choice of medication in the latter case.
 - A fail-first requirement for oral antipsychotic medication before reimbursement of injectable medication may not be clinically appropriate for some patients, because of adherence challenges with oral antipsychotic medications. Parity requirements imply that there should not be fail-first requirements such as these on the behavioral health side (e.g., fail-first requirements that disregard preferred medication choices based on adherence considerations) unless there are also such limits on the general medical side.

Utilization Management

- Outpatient psychotherapy is often subject to plan review after a certain number of visits, to authorize reimbursement for further visits. According to some panelists, psychotherapy is an example within the behavioral health field where there is a high degree of uncertainty about the nature of the problem (diagnosis), about what treatment will work, about what type of provider is required, and with high variability in quality and duration of treatment. These considerations suggest that different UM practices for outpatient psychotherapy may be justified relative to outpatient visits for many general medical conditions.
 - The panel noted that psychotherapy is a specific procedure (not a class of benefits like outpatient services) and so comparability of UM should be evaluated at the level of the procedure, not the benefit level. Panelists pointed out that there are comparable procedures in medical care that are characterized by clinical uncertainty and practice variability, for example, physical therapy. Parity requirements imply that if psychotherapy is subject to a particular UM practice, similar procedures (e.g., physical therapy) in the medical benefit should not have a less intense level of UM.
 - Panelists pointed out that diagnostic uncertainties and high variability in treatment/provider choices exist for some behavioral health conditions, but are also found for other general medical conditions (e.g., lower back pain). If certain behavioral health diagnoses (e.g., adjustment disorders, substance abuse) are selected for differential and more aggressive UM practice than others, such differences would be justified under parity regulations only if these were comparable to or less restrictive than UM practices for comparable general medical conditions.
- Requiring prior authorization for all outpatient behavioral health services is not clinically appropriate, as this may unnecessarily delay clinically appropriate services, and inhibit access to appropriate clinical services. Such prior authorization practices for behavioral health care would meet parity requirements only if similar prior authorization is required for all medical outpatient care.
 - Plans may require prior authorization or conduct concurrent review of targeted behavioral health services or procedures, for example, psychological testing. This may be justified on the basis of clinical appropriateness, but in order to meet parity requirements, similar considerations should result in similar UM management practices for medical services.
- Plans may utilize concurrent review for inpatient psychiatric hospitalizations that are reimbursed on a fee-for-service basis, and retrospective review for general medical hospitalizations that are reimbursed as a total fee based on DRGs. Differences in UM practice in this case are justified because DRG-based fees are

not established for psychiatric hospitalizations. DRG-based reimbursement creates incentives for the hospital to actively manage utilization, but in the absence of incentives for the hospital to control costs, concurrent UM by plans is clinically appropriate.

- For general medical hospitalizations that are not reimbursed based on DRGs, parity would require similar or no more stringent UM practices for behavioral health inpatient care than for these types of general medical inpatient care.
- Plans may require prior authorization for medications like Suboxone (used to treat opiate addiction), if this practice is justified by clinical appropriateness considerations, such as risk for abuse, that are similarly applied to other medications (e.g., Oxycontin). If psychiatric or addiction medications like Suboxone require prior authorization based on different standards than other medications, then parity requirements would not be met.

Network Management

- According to the panelists, the number of different kinds of behavioral health providers with hugely different levels and types of training -- which is both more confusing and less regulated than in the general medical arena -- suggests that differential management may be permissible.
 - But panelists noted that there are areas of general medical care where there is similar variability in provider training -- such as in foot care (surgeons and podiatrists), pain management (anesthesia nurses, anesthesiologists, acupuncturists) and physical medicine (physiatrists, physical therapists and occupational therapists).
- Plans may have network admission criteria that include experience requirements (e.g., 2-3 years of post-degree supervised clinical experience) for certain types of behavioral health providers. These can be justified when training and licensing requirements are highly variable across states and do not consistently require relevant and appropriate supervised clinical experience.
 - Experience requirements should be clinically reasonable given the type of clinical practice the provider engages in, and no more stringent for behavioral health providers than the experience requirements included in licensure for general medical providers.
- Similar network adequacy metrics should apply to both behavioral provider networks and general medical networks.
 - It would not be equitable, for instance, if there were egregious variations in access rates, wait times, availability of specialists, etc.

- Differences across geographic regions and urban/rural areas in network adequacy are also expected because of differential availability of providers.
- Fee standards should be arrived at using the same type of process but the result does not have to be the same (i.e., fees for providers may be under-market for both behavioral health and general medical providers).
 - It would be inequitable to have general medical fees tied to Medicare but not tie behavioral health fees to Medicare. If Medicare-based fee standards are not available for some types of behavioral health providers/services, then parity implies that, whatever market standards are used, behavioral health providers/services are not differentially and more dramatically underpriced relative to their market than general medical providers/services.

Consultation with Oregon Regulators

Oregon is the only state that has adopted a statute with NQTL provisions similar to the MHPAEA.⁶ The Oregon Insurance Division (OID) is the office with responsibility for regulating health plans. We contacted staff at the OID and arranged for an interview about their experience in regulating NQTLs -- providing them with questions in advance.

After some initial “back and forth” with health plans and a few informal enforcement actions when the Oregon parity statute was first being implemented (for example, denying an attempt by one plan to require a treatment plan after eight outpatient visits), one of the health plans “threatened to take [OID] to a hearing” on the NQTL section of their statute. An internal review of the statutory language forestalled any further enforcement actions.

The OID staff reported the following with regard to their interpretation of NQTLs:

1. If the application of a differential policy seems reasonable -- with regard to the number and type of services to which it applies -- they would allow it.
2. They would allow differences (for example, in cost sharing and UM) for psychiatrists -- as long as all specialists were treated the same by the health plan.

They also mentioned that they had begun deferring to the federal IFR and guidance (that is, deeming health plans compliant with the Oregon rules if they are in compliance with the IFR).

⁶ McConnell JK, Gast SHN, Ridgely MS, Wallace N, Jacuzzi N, Rieckmann T, McFarland BH, McCarty D (2012). “Behavioral health insurance parity: Does Oregon’s experience presage the national experience with the Mental Health Parity and Addiction Equity Act?” *American Journal of Psychiatry*, 169: 31-38.

Summary and Discussion

Here we summarize and discuss the work we conducted to assist ASPE in clarifying implementation of the IFR with regard to the requirement that NQTLs be applied no more stringently for behavioral health care relative to medical care. In particular, we note that the IRF requires that the “processes, strategies, evidentiary standards, and other factors used to apply NQTLs to MH/SUD benefits in a classification have to be comparable to and applied no more stringently than the processes, strategies, evidentiary standards and other factors used to apply to medical-surgical benefits in the same classification.”

Consultations with MBHO industry leaders provided insight into processes the industry uses to establish and apply NQTLs, and into industry views on challenges and uncertainties that arise in implementation of NQTL parity regulations. In the area of *medical necessity definitions* and *formulary design*, industry representatives did not raise significant concerns or challenges related to implementation. In the area of *UM practices*, however, industry representatives provided examples of lack of clarity in how to cross-walk and make comparisons between behavioral health and medical care in both outpatient and inpatient benefit classifications, as well as lack of clarity in how to consider intermediate levels of care in behavioral health (such as intensive outpatient and partial hospitalization). In the area of *provider network management*, some representatives expressed lack of clarity about whether supervised clinical experience qualifications for certain types of behavioral health providers to be included in networks were allowable under NQTL regulations, and representatives consistently raised the issue of not being able to use the same methods in setting fees for behavioral health providers as medical providers, because comparable data are not available to do so. In addition to the issues above, industry leaders whose MBHO included a significant carve-out business raised a broader implementation issue. From the perspective of these industry leaders, the task of coordinating with numerous medical plans to evaluate and implement parity was highly challenging.

Based on our discussions with industry leaders, we conclude that providing further examples that clarify NQTL regulatory guidance, particularly in the areas of UM practices, and provider network management, could facilitate understanding of and compliance with the regulations. Further clarifying examples are unlikely, however, to alleviate the concerns of carve-out MBHOs that arise from the burden of coordination with numerous medical plans managed by other organizations.

The panel of clinical experts convened by SAMHSA discussed processes, strategies and evidentiary standards relevant to evaluating parity in NQTLs, and provided examples of situations in which, in the view of the panel, NQTLs would and would not be in accordance with parity regulations. The discussion consistently reflected panelists’ views of NQTLs as a means to promote both clinically appropriate and cost efficient care. The panel discussed a number of processes, strategies and

evidentiary standards -- related to both of these goals -- that were justifiable considerations for establishing medical necessity criteria, UM practices, formulary design, and network management practices. Considerations mentioned by the panel included: evidence for clinical efficacy, diagnostic uncertainties, unexplained rising costs, the availability of alternative treatments with different costs, variation in provider qualifications and credentialing standards, high utilization relative to benchmarks, high practice variation, inconsistent adherence to practice guidelines, identified gaps in care, whether care is experimental or investigational, and geographic variation in availability of providers.

Examples offered by the panel were drawn to show parallels between the kinds of clinical appropriateness and cost efficiency considerations used in management of both behavioral health and general medical care. If such considerations are applied consistently across management of behavioral health and general medical care, in the panel's view, then the application of NQTLs meets parity regulations. While the panel focused on a number of examples in which the potential "uniqueness" of behavioral health care might make the comparison of behavioral health and other medical care NQTLs problematic, the discussion ultimately resulted in the identification of similar NQTL situations in medical care where comparisons could be drawn.

In conclusion, the Expert Panel meeting supported the view that parity of behavioral health care NQTLs with medical care NQTLs can be evaluated by comparing the processes, strategies, and evidentiary standards that are used to establish and apply the NQTLs. The specific examples provided by the panel should serve useful for clarifying the implementation of the NQTL regulations.

3. SCOPE OF SERVICES

As mentioned earlier, there are “intermediate” behavioral health services -- those that lie between inpatient and outpatient care. Examples of such intermediate services are non-hospital residential treatment, partial hospitalization, and intensive outpatient treatment. However, the IFR did not specify requirements regarding application of parity to these intermediate services. RAND was initially asked to construct an actuarial model of health insurance premiums that could be used to evaluate the impact of alternative levels of inclusion of these specific intermediate behavioral health services on health care costs.

A good actuarial model requires information on health plan characteristics (such as benefits and UM techniques) and enrollee population characteristics and therefore requires linked plan-utilization data. In consultation with ASPE, we chose to use the 2008 MarketScan database available through Thomson Reuters. Using these data we set out to build an actuarial model that could be used by ASPE to understand the impact of alternative levels of inclusion of intermediate behavioral health services on average total plan costs and premiums. However, as we began constructing indicators of intermediate service care utilization, and examining them as well as costs in statistical models, it became evident that an analysis employing a single year of data was insufficient for constructing a reliable model for two reasons: (1) the statistical model estimating average per member per month (PMPM) total plan costs was very sensitive to how utilization of intermediate services, particularly residential treatment, was represented in the model due to the sparseness of these data; and (2) with only a single year of data, we could not adequately control for unobserved factors influencing general health care utilization within each health plan. Nevertheless, descriptive analyses (reported below) provide a picture of the number of health plans providing these intermediate services prior to the implementation of the MHPAEA and the level of utilization of these services within these plans -- which is helpful in considering the effect of applying a parity requirement to the scope of services that health plans cover.

MarketScan Health Benefits Database

The MarketScan database provides linked claims data on over 5 million enrollees from 52 employers and 80 different health insurance carriers. The data include individuals with private insurance from across the United States. The data, obtained directly from large employers, include comprehensive claims information (inpatient, outpatient, pharmaceutical and behavioral carve-out information) on all employees who work for a firm, regardless of health plan or whether medical benefits are received from the same carrier as behavioral health benefits. MarketScan includes plans offering very generous health benefits (e.g., large employers and union health and benefit plans), as well as more traditional plans and consumer-directed health plans. Thus the database provides us with a population of enrollees with unlimited access to behavioral health services and those with very limited access.

For a small subset (10%) of the claims and encounters databases (110 health plans in 2008), Thomson Reuters has added benefit plan design information, which they have created from plan booklets obtained from the employers providing the data. The booklets range in their level of detail and depth, so Thomson Reuters codes as much information as possible. Due to the variability in the quality and specificity of information, however, the health plan benefit data are not always complete; nor is it guaranteed that the same specific constructs are being measured precisely across plans. Despite these limitations, we believed useful information could be obtained with respect to general cost sharing requirements (deductibles, co-payments, co-insurance rates), limits, exclusions, and other plan aspects important for understanding the average cost of providing coverage for a plan.

We used the 2008 linked benefits claims and encounters databases to generate a plan-level database for conducting descriptive analyses of current coverage of behavioral health spending and assess the feasibility for estimating an econometric model of the average medical cost (PMPM cost), which would form the backbone of an actuarial model. Although the 2008 database listed identifiers for 110 plans, two plans in the benefits database had no actual enrollees, four plans consistently reported missing information for all plan benefit design measures, and another lacked information on key benefit variables (co-payment and deductibles) relevant for examining PMPM costs (which when combined with an administrative loading factor determine premiums). Thus our starting analytic sample consisted of general plan benefit information for 103 plans.

Limited project resources and the high cost of the data precluded us from obtaining additional years of data to augment the sample. Because it is known that medical costs and medical practices vary substantially across geographic regions, additional information regarding cost of providing particular services can be gleaned by disaggregating the 103 plans down to the region level. Four principal regions are specified in the data (Northeast, Southeast, Midwest and West), but a “national” option was also provided, generating five possible values for this region indicator and a maximum of 432 plan-by-region observations (before missing values are considered). This relatively large number of plan-by-region observations emerges because the overwhelming majority of the 103 original plans (87.4%, n= 90) operated in more than one region.⁷

A problem with disaggregating plans, however, is that it can artificially generate “small” plans out of what are actually large plans. By that we mean that a relatively small share of a plan’s enrollee’s might be serviced in one region, while the bulk of the plan’s enrollees are covered in one or two other regions and yet calculations of average cost are based on the number of enrollees in a given region and not the overall plan. If an intermediate service used infrequently, such as residential treatment, is used by an enrollee in the artificially-generated “small” plan, then it would give the appearance of a

⁷ Seven of the 13 plans operating in one region operated only in the West, four operated in the Midwest, and two operated in the South. None of the plans indicating only one region listed that region as national.

much higher impact on total spending than what was truly experienced by the health plan. To ensure our analysis was not affected by the disaggregation of plans across regions, we used as our final analytic sample a version of the data that removed plans that had fewer than 50 people in one region if 85% or more of the enrollees were located in another region. This sample had 290 region plans represented in the data. Although some person-level data were not used in creating the analytic sample, all 103 plans are represented.

Variable Construction and Descriptive Statistics

We are interested in understanding whether parity requirements with respect to specific intermediate services could generate excessive costs to the health plan, indicated by higher average PMPM medical costs. To understand this, we need to consider and account for a variety of variables that can also influence average PMPM medical costs, including plan and enrollee characteristics, plan benefit design, and general utilization. A description of the construction of each of these measures and some simple descriptive statistics based on the total sample and final analysis sample is provided below.

Enrollee and Health Plan Characteristics. The main demographic variables we could construct from enrollee information (aggregated up to the region level) were the following: percent male, percent children (i.e., <18 years of age versus 19-65 population), and the Charlson-Deyo Index, which is a weighted index of 17 chronic illnesses (identified through ICD-9 codes) that are likely to generate inpatient hospitalization within the coming year (based on Deyo et al., 1992).⁸

The MarketScan database did not include public insurers or Medigap plans. Additional plan characteristics we could construct from the data included the size of the plan (measured by enrollees within the region), and the type of the plan (e.g., HMO, PPO, POS, consumer-directed health plan, etc.). Descriptive statistics for these variables for the full 432 plans and our final analytic sample of 290 plans are provided in Table 1.

The most noticeable consequence of moving from the full sample to the analysis sample is the sizeable decrease in the percent of small plans, from 38.4% to 8.3%. The reductions in small plans show up in other statistics as well. Differences in means and maximum values between the full sample (n=432) and the final analytic sample (n=290) shows that there is an important reduction in variance within our analytic sample in the Charlson-Deyo index. The maximum value falls from 0.667 from the full sample to just 0.166 in the analytic sample (n=290). By construction the maximum score possible for this index is 33, based on the weighting of the 17 diagnoses represented. In our encounter (individual level) data, we do observe some fairly high patient values.

⁸ Deyo R, Cherkin D, Ciol M (1992). "Adapting a clinical comorbidity index for use with ICD-9-CM administrative databases." *Journal of Clinical Epidemiology*, 45: 613-619.

However, when these values are averaged over total plan enrollment, the typical value for the plan is much closer to the mean value observed across all individual encounters of care (0.023). One consequence is that the variance in this index across plans is extremely limited, and not likely to capture the plan heterogeneity in chronicity of patients that we had hoped it would. *This reduced variance in the index across plans is an indication that we may not have adequately captured important differences in general health care utilization across plans.*⁹

TABLE 1. Enrollee and Plan Characteristics for the Full Sample (Panel A) and Final Analytic Sample (Panel B)				
	N	Mean	Min	Max
PANEL A -- Full Sample				
Enrollee Characteristics				
% Male	432	47.9%	0	100%
% Children (Age <18)	432	22.3%	0	62.5%
Charlson-Deyo Index	432	0.023	0	0.667
Plan Characteristics				
Small Plan (<100 full-year enrollees in region)	432	38.4%	0	100%
Medium Plan (100 - 4,999 full-year enrollees in region)	432	38.3%	0	100%
Large Plan (5,000 or more full-year enrollees in region)	432	23.4%	0	100%
% HMO	432	14.8%	0	100%
% PPO (capitated and non-capitated)	432	55.1%	0	100%
% Exclusive Provider Org or Point of Service Plan	432	9.3%	0	100%
% Consumer-Directed or Comprehensive Plans	432	16.4%	0	100%
PANEL B -- Analysis Sample				
Enrollee Characteristics				
% Male	290	48.7%	19.7%	75.0%
% Children (Age <18)	290	24.9%	0	39.2%
Charlson-Deyo Index	290	0.024	0	0.166
Plan Characteristics				
Small Plan (<100 full-year enrollees in region)	290	8.3%	0	100%
Medium Plan (100 - 4,999 full-year enrollees in region)	290	56.9%	0	100%
Large Plan (5,000 or more full-year enrollees in region)	290	34.8%	0	100%
% HMO	290	10.7%	0	100%
% PPO (capitated and non-capitated)	290	61.0%	0	100%
% Exclusive Provider Org or Point of Service Plan	290	7.6%	0	100%
% Consumer-Directed or Comprehensive Plans	290	16.9%	0	100%

Plan benefit design can influence utilization of health care services by influencing the relative cost of the services to patients (through co-payments, deductibles and management techniques). Plan characteristics can proxy both the extent to which care is managed in order to control costs as well as the likely risk pool. In addition to the obvious types of measures (type of plan, region of operation, plan size), we were able to consider several benefit measures available through the benefit plan database. However, many of the potentially important benefit measures for parity were missing data or lacked clarity in terms of what benefit applied. Appendix Table A1 in Appendix 2 lists the plan benefits we had hoped to consider and the number of plans in our linked data set (out of 103) that actually contained this information. As the table highlights,

⁹ We also considered capturing variance in general health care utilization through indicators representing the fraction of plan enrollees who were either: (a) current or past smokers, or (b) obese. However, given the high correlation of these behaviors with behavioral health care utilization, measurement of these values in the same year as behavioral health care utilization would result in significant colinearity.

very few of the actual benefits are systematically recorded for most plans, making the plan information far less useful than we originally anticipated. Thus, the only measures we were able to consider for analysis were the following: family deductible; medical co-insurance rate for outpatient visit; constructed measure of equality in inpatient co-insurance rates; constructed measure of equality in outpatient co-insurance rates; number of NQTLs; and behavioral health carve-out indicator. We obtained the first two plan measures directly from the benefit database. We constructed the remaining four measures using various reported plan benefit information, as described in Appendix 2. Table 2 provides descriptive statistics of these variables for the full sample and our reduced analytic sample.

TABLE 2. Descriptive Statistics for Plan Benefit Characteristics and Measures				
	N	Mean	Min	Max
PANEL A -- Full Sample				
Average Family Deductible	432	\$735.17	0	\$4,000
Co-insurance -- outpatient visit (amount paid by plan)	381	87.68%	70%	100%
Proportion of plans with equal co-insurance - inpatient	413	40.8%	0	100%
Proportion of plans with equal co-insurance - outpatient	413	70.0%	0	100%
Number of health plan NQTLs	432	2.75	0	4
Proportion of plans with behavioral health carve-out	432	66.4%	0	100%
PANEL B -- Analysis Sample				
Average Family Deductible	290	\$843.22	0	\$4,000
Co-insurance -- outpatient visit (amount paid by plan)	261	86.6%	70%	100%
Proportion of plans with equal co-insurance - inpatient	279	82.8%	0	100%
Proportion of plans with equal co-insurance - outpatient	279	76.0%	0	100%
Number of health plan NQTLs	290	2.78	0	4
Proportion of plans with behavioral health carve-out	290	85.2%	0	100%

Behavioral Health Service Setting Variables. There are a number of different indicators that can be used to identify a behavioral health claim occurring in one of the three intermediate care settings of interest, and no one indicator is consistently used by all the plans. We therefore applied rules across a multitude of indicators when we tried to identify residential treatment episodes (and length of stay), partial hospitalization and intensive outpatient visits (IOV) across plans.

Residential Treatment. Identification of individuals receiving treatment in a residential treatment setting involved a multi-step process. First, in the inpatient data we identified anyone receiving care in: (a) a residential substance abuse facility (STDPLAC = 55); (b) a psychiatric residential treatment center (STDPLAC = 56); or (c) general residential treatment center (STDPROV = 35). We removed from these claims those that also indicated that the service setting was an inpatient hospital setting (STDPLAC = 21 or 51 -- meaning general inpatient hospital or psychiatric inpatient hospital) unless the revenue code and procedure codes indicated that the care was non-hospital residential treatment.¹⁰ Second, in the outpatient claims data we identified cases where additional outpatient type services were attached to an inpatient hospitalization, but these had not been flagged and aggregated with the inpatient claims

¹⁰ As revenue and procedure codes are used for reimbursement purposes, we have more confidence in these measures for indication of the type of care received than in the variable identifying the setting. This only affected six claims so even if they are improperly identified, it would not affect our results.

by Thomson Reuters. These were identified in one of two ways: (a) the outpatient claim included an H-code indicating hospital or residential based treatment (H0017, H0018, or H0019); and (b) CPT codes indicated hospital based interactive psychotherapy (CPT codes in the range 90823-90829).

Applying these rules we identified approximately 2,050 residential treatment episodes in the data. While this represents a non-trivial number of residential treatment episodes, analytically what matters for our assessment of the effect on health plan costs is the distribution of these episodes across plans. Table 3 shows that fewer than 15% of the health plans in the full sample (n=52 out of 432) had any episodes involving residential treatment, and the mean number of episodes was very small (n=1). And while the proportion of plans with residential treatment claims is higher in our analytic sample (nearly 18%), this is due to our disproportionately dropping plans with zero claims. The mean number of residential treatment claims rises to just two in the analytic sample.

TABLE 3. Proportion of Plans Experiencing a Residential Treatment, Partial Hospitalization Visit or Intensive Outpatient Claim			
	N	Mean	Mean # of Claims
PANEL A -- Full Sample			
Proportion of Plans with Residential Treatment Claim	432	12.5%	1
Proportion of Plans with Partial Hospitalization Claim	432	39.1%	14
Proportion of Plans with Intensive Outpatient Claim	432	77.8%	2,911
PANEL B -- Analysis Sample			
Proportion of Plans with Residential Treatment Claim	290	17.9%	2
Proportion of Plans with Partial Hospitalization Claim	290	56.9%	21
Proportion of Plans with Intensive Outpatient Claim	290	98.3%	4,333

Table 4 shows the distribution of claims across plans more explicitly. Thirteen of the 52 plans in our final analytic sample had just one residential treatment claim in 2008, and another 18 plans had five or fewer claims. Only 4.5% of all plans (n=13) had more than ten claims processed for residential treatment.

TABLE 4. Distribution of Plans by Number of Visits for Intermediate Services (n=290)								
Intermediate Service Claims	Number of Plans with Claims							
	0	1	2 - 5	6 - 10	11 - 20	21 - 50	51 - 75	75+
Residential Treatment	238	13	18	8	6	6	0	1
Partial Hospitalization	125	27	28	23	24	50	11	18
Intensive Outpatient Therapy	5	1	8	2	4	23	11	236

As is clear from these tables, a claim for residential treatment is a rare event in MarketScan's 2008 data. The relatively low number of claims coupled with the bunching of positive values at very low levels of visits across health plans will make identification of the effects of covering these services highly imprecise and possibly biased.

Partial Hospitalization Visits. There were relatively few cases of partial hospitalization in the inpatient claims data, but a few did exist and were easily identified through either a CPT code (90816-90822) or hospital revenue code (REVCODE = 912). Most of the claims involving partial hospitalization were in the outpatient data. These

claims were identified again through procedure codes (CPT codes of 90816-90822) and H-codes (H0035).

Combined, we identified over 3,700 claims related to partial hospitalization in the inpatient and outpatient data. This is nearly twice the number of claims identified for residential treatment, and far more plans experienced at least one claim for partial hospitalization (as indicated in Table 3 and Table 4). Several plans experienced multiple claims for partial hospitalization and with longer episode length, increasing the variability in number of visits across plans.

Intensive Outpatient Visits (IOV). Identification of IOV was based solely on information provided in the outpatient claims data. Identification of these cases was based on procedure codes (CPT-codes in the range of 90804-90815 or an H-code of H0015). Nearly 178,000 intensive outpatient claims were identified in the MarketScan data for 2008, with over 85% of health plans in our analytic database experiencing at least one claim. As shown in Table 3 (by the mean number of claims) and Table 4 (in terms of the distribution of number of visits), there are a large number of health plans that experienced multiple claims for intensive outpatient treatment. This is a far more common service being utilized across the health plans represented in MarketScan's 2008 data.

Average Spending Overall and By Service. The construction of annualized PMPM total health care costs is based on all payments made by the plan (or a plan subcontractor in the case of behavioral health carve-outs) for general medical care, behavioral health services, and pharmaceutical claims incurred for enrollees. We calculated PMPM annual costs by summing up all health-related costs to the person level, then aggregating persons within the plan to generate a total cost per plan. Average costs are constructed by dividing the total cost per plan by the total number of member months observed in the data (as not all individuals are enrolled over the entire year), which generates a monthly estimate that can be annualized by multiplying by 12.

Table 5 shows some descriptive statistics on the average health care costs across plans, as indicated by average PMPM costs in total, and broken out for selective health categories (medical, behavioral health, pharmaceutical) for our 432 plans (Panel A) and then for the 290 plans in our final analytic sample (Panel B). Again, in looking at changes in mean and maximum values across Panel A and B it is easy to see to how the removal of artificially created "small" plans impacts PMPM costs. Interestingly, the removal of these "small" plans reduces our average PMPM cost for behavioral health services overall, and in the case of residential treatment and partial hospitalization, the reduction in average PMPM costs is fairly substantial. However, the average total PMPM cost, PMPM medical cost, and non-behavioral health prescription costs are all higher in the analytic sample.

TABLE 5. Descriptive Statistics and Sample Sizes for PMPM Cost Estimates								
Variable	PANEL A: 432 Plans				PANEL B: 290 Plans			
	Mean	Std. Dev.	Max	Plans with Non-Zero Obs	Mean	Std. Dev.	Max	Plans with Non-Zero Obs
Total PMPM Cost	\$251.63	\$203.30	\$1,659.81	381	\$268.49	\$125.70	\$734.70	290
General Medical Center								
PMPM Medical	\$186.15	\$160.79	\$1,570.91	381	\$200.90	\$84.27	\$518.98	290
PMPM non-MH/SUD Prescription	\$52.53	\$70.84	\$715.45	379	\$55.37	\$49.15	\$411.24	290
Behavioral Health Care								
PMPM Total MH/SUD	\$14.64	\$22.89	\$232.01	365	\$12.22	\$10.54	\$113.84	290
PMPM IOV	\$2.00	\$2.84	\$24.54	327	\$1.84	\$1.78	\$13.09	282
PMPM Resid Treat	\$0.32	\$5.58	\$108.97	54	\$0.04	\$0.20	\$2.66	52
PMPM Part Hosp	\$0.96	\$7.23	\$100.63	165	\$0.52	\$1.66	\$80.40	161
PMPM MH/SUD Prescription	\$8.03	\$13.69	\$144.94	361	\$7.46	\$6.51	\$49.52	290

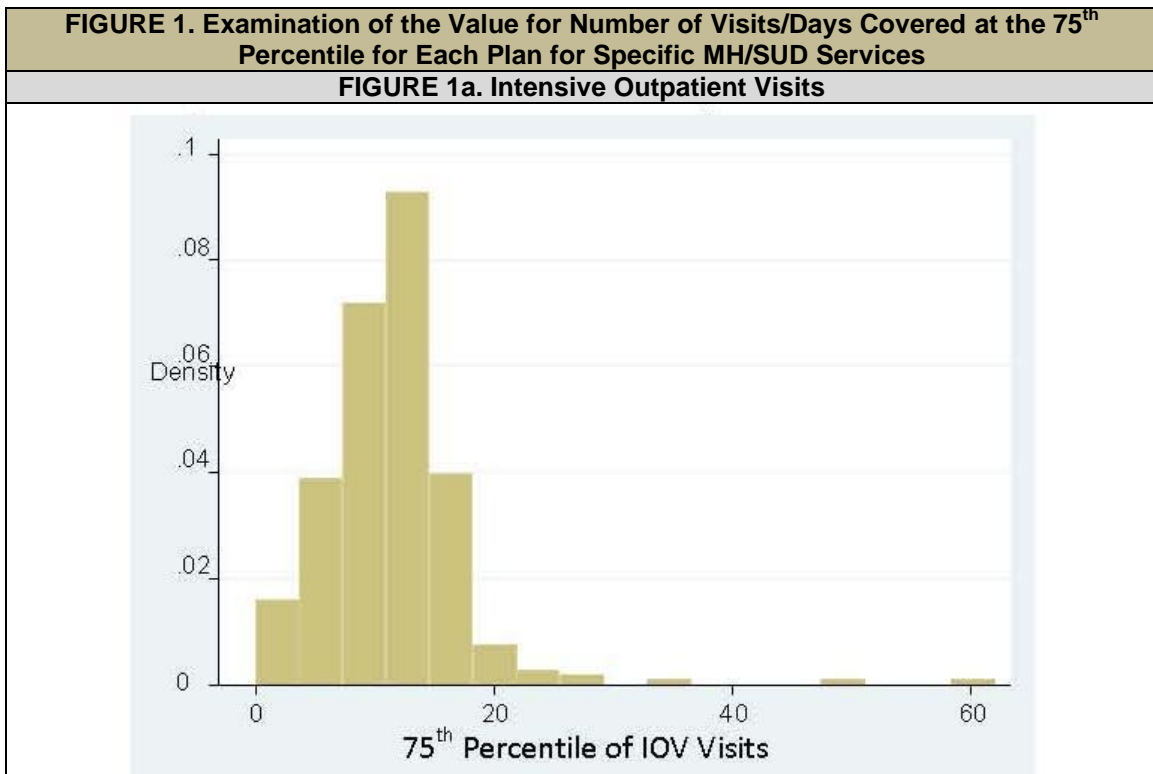
Focusing on values for the analytic sample (Panel B), the total average cost paid per enrollee across health plans represented in the data was \$268.49, of which 4.6% (\$12.22) was total PMPM for behavioral health services. The vast majority of the cost for behavioral health was for behavioral health prescriptions (\$7.46) and not utilization of intermediate care services. Residential treatment, partial hospitalization and IOV combined represent only 19.6% (\$2.40) of the total behavioral health costs to the health plan.¹¹ *Behavioral health prescription drugs represent the biggest share of total PMPM spending on behavioral health and are therefore likely to be a bigger driver of costs than intermediate services of any kind.*

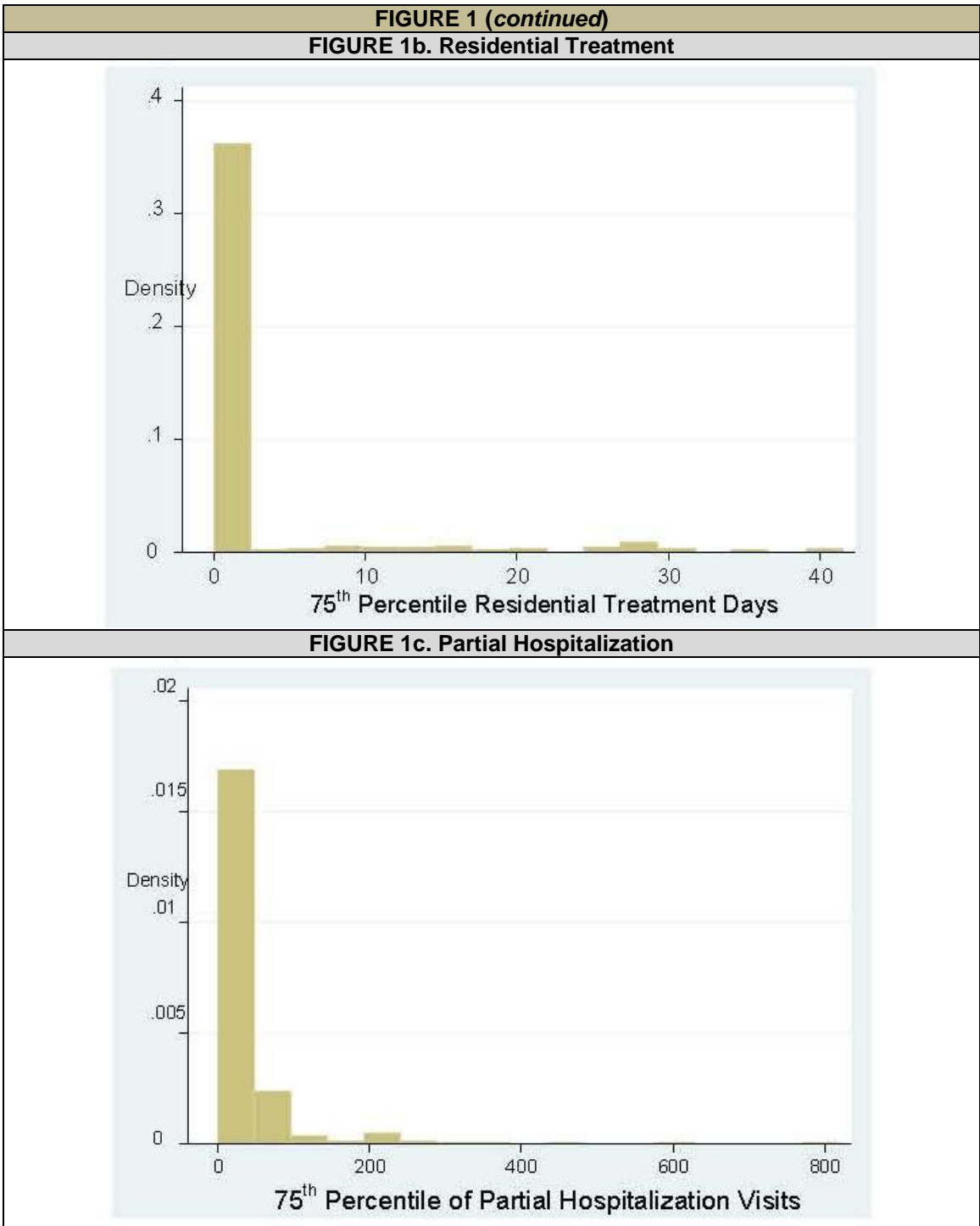
The last column of Table 5 provides some important insights regarding the number of plans for which we have information on utilization of intermediate behavioral health services. As indicated above, very few plans have claims for residential treatment and only about half of the plans have claims for partial hospitalization. Thus, even if these services were expensive, they represent a very small fraction of the average total plan cost. *Residential treatment in particular represents less than one one-thousandths of a percent of total PMPM costs on average. Partial hospitalization represents only 0.2% of total PMPM cost on average. And although IOV are far more common across health plans, this category too represents less than 1% of total PMPM cost.*

The fact that relatively few plans in our sample have claims reported for two of three intermediate services should not be surprising given that the utilization of these services is determined by events that are relatively rare in the general population and many plans do not provide coverage for these services. However, it does complicate our ability to model the impact of providing these services, as we are trying to model something that represents a tiny fraction of our dependent variable (total average plan medical costs). Although the MarketScan sample included some health plans with generous behavioral health coverage, utilization of two of the three intermediate services even within these generous plans was relatively limited.

¹¹ Omitted from this table is the “other non-prescription MH/SUD spending,” which on average is \$2.37 across plans.

The highly skewed nature of the utilization data can be seen in Figure 1, which shows the distribution of the 75th percentile value for IOV (Figure 1a), residential treatment (Figure 1b) and partial hospitalization (Figure 1c). These figures represent the average length of stay or number of visits in a single episode for each plan rather than the number of claims. They show the distribution of these 75th percentile values across plans (demonstrating on the y-axis the proportion of plans with the same value). Even when we look at the 75th percentile value across health plans we see that for two of the intermediate services, plan-utilization appears to be highly restrained. For IOV, the vast majority of health plans have claims involving episodes of 20 visits or fewer. In the case of residential treatment, the bulk of the health plans have zero episodes. The relatively few plans that do have claims, have 75th percentile values for length of stay that are still generally quite low (although uniformly spread out between 1 and 40 days). Partial hospitalization is the only service where we see a fairly large spread in the 75th percentile value for episode length, but this seems to be driven basically by outliers, as the bulk of the plans have episode lengths well under 100 days.





Implications of Limited Data for Understanding Effects on Medical Costs

Typically the best way to resolve the question of whether higher utilization of intermediate services generates higher overall total plan costs given variability in plan benefits and utilization would be to estimate a statistical model that accounts for the other factors plausibly related to total costs. We tried such an approach with these

data, but the results of models tested yielded estimates of the effect of residential treatment on total PMPM costs that seemed implausible in light of residential treatment utilization being a rare event and a tiny proportion of average total costs.

TABLE 6. Comparing Cost in Plans with Residential Treatment Claims to Cost in all Plans								
PANEL A								
	Final Analytic Sample (n=290 plans)				Number of Residential Treatment Claims >0 (n=52)			
	Mean	Std. Dev.	Min	Max	Mean	Std. Dev.	Min	Max
Charlson-Deyo Index of Chronic Conditions	0.02	0.02	0.00	0.17	0.02	0.01	0.00	0.04
Total Average PMPM	\$268.49	\$125.70	\$50.33	\$734.70	\$271.93	\$82.06	\$118.13	\$431.74
Average Medical PMPM	\$200.90	\$84.27	\$34.45	\$518.98	\$207.07	\$60.92	\$90.73	\$341.92
Average MH/SUD PMPM	\$12.22	\$10.54	\$0.08	\$113.84	\$12.65	\$5.75	\$3.39	\$37.00
Average MH/SUD Prescription PMPM	\$7.46	\$6.51	\$0.08	\$49.52	\$7.18	\$3.10	\$2.70	\$17.22
PANEL B								
	Final Analytic Sample (n=290 plans)				Number of Residential Treatment Claims >10 (n=13)			
	Mean	Std. Dev.	Min	Max	Mean	Std. Dev.	Min	Max
Charlson-Deyo Index of Chronic Conditions	0.02	0.02	0.00	0.17	0.02	0.01	0.01	0.03
Total Average PMPM	\$268.49	\$125.70	\$50.33	\$734.70	\$329.19	\$77.72	\$158.69	\$431.74
Average Medical PMPM	\$200.90	\$84.27	\$34.45	\$518.98	\$244.64	\$48.78	\$129.54	\$312.71
Average MH/SUD PMPM	\$12.22	\$10.54	\$0.08	\$113.84	\$17.15	\$7.40	\$4.84	\$37.00
Average MH/SUD Prescription PMPM	\$7.46	\$6.51	\$0.08	\$49.52	\$9.93	\$3.98	\$2.71	\$17.22

To gauge the potential impact of increased utilization of residential treatment services on total plan costs, we compared average PMPM costs for our small subsample of plans that experienced a residential claim with the overall sample. These findings are reported in Table 6. In Panel A we compare plans for which there is a claim for residential treatment and in Panel B we subset this sample further to plans with more than 10 residential treatment claims. It appears in Panel A that by selecting on plans that had a residential treatment claim in 2008, average behavioral health care spending across plans increases by about \$0.43 (from \$12.22 for all plans to \$12.65 for plans with a residential treatment claim). Importantly, the mean difference in average medical spending and total PMPM costs across these groups rises *by more than* what is observed for behavioral health care spending. Although the plans likely differ on many dimensions, it is difficult to imagine how a \$0.43 difference in residential treatment could influence a \$6.17 difference in average medical costs and a \$3.44 difference in average total plan costs. (Note that behavioral health prescription costs fall a bit on average as we move to this sample, which may be part of the reason why total plan costs rise by less than medical costs alone. Omitted from the table is non-MH/SUD prescription drug costs, which is the other factor causing total plan costs to rise by less than medical costs). The Charlson-Deyo Index, which we presumed would capture the general health of the plan population by indicating presence of expensive chronic illnesses,

does not suggest any differential severity in health across these two groups and indeed the variance in this value is reduced in the plans that cover residential treatment.

When we make the comparison more selective and consider only those plans that had more than ten residential treatment claims (Panel B), we still do not see differences in average severity of illness among enrollees (using the Charlson-Deyo Index), and yet we see even larger differences in average medical costs and total costs than those observed for behavioral health (MH/SUD). Plans providing more generous coverage for these intermediate services appear to provide more generous coverage for medical services as well. However, we cannot rule out other potential explanations for the positive association, including unobserved case mix differences in plan populations (that are not adequately accounted for by the Charlson-Deyo Index).

Table 7 shows that the results presented for partial hospitalization are similar to those found for residential treatment, even though these visits are more common across plans. Panel A shows that health plans that paid claims for partial hospitalization visits in 2008 exhibit a far greater rise in average medical costs (\$200.90 to \$207.11) than average behavioral health costs (\$12.22-\$12.90). The differences between all plans and plans covering partial hospitalization visits get even more pronounced when we focus on plans with more than 20 claims for partial hospitalization (Panel B).

TABLE 7. Comparing Cost in Plans with Partial Hospitalization Claims to Cost in all Plans								
PANEL A								
	Final Analytic Sample (n=290 plans)				Number of Partial Hospitalization Claims >0 (n=165)			
	Mean	Std. Dev.	Min	Max	Mean	Std. Dev.	Min	Max
Charlson-Deyo Index of Chronic Conditions	0.02	0.02	0.00	0.17	0.02	0.02	0.00	0.17
Total Average PMPM	\$268.49	\$125.70	\$50.33	\$734.70	\$277.01	\$110.87	\$92.97	\$734.70
Average Medical PMPM	\$200.90	\$84.27	\$34.45	\$518.98	\$207.11	\$73.37	\$73.68	\$420.40
Average MH/SUD PMPM	\$12.22	\$10.54	\$0.08	\$113.84	\$12.90	\$8.43	\$2.47	\$54.08
Average MH/SUD Prescription PMPM	\$7.46	\$6.51	\$0.08	\$49.52	\$7.72	\$5.66	\$0.75	\$41.71
PANEL B								
	Final Analytic Sample (n=290 plans)				Number of Partial Hospitalization Claims >20 (n=63)			
	Mean	Std. Dev.	Min	Max	Mean	Std. Dev.	Min	Max
Charlson-Deyo Index of Chronic Conditions	0.02	0.02	0.00	0.17	0.02	0.02	0.01	0.16
Total Average PMPM	\$268.49	\$125.70	\$50.33	\$734.70	\$292.17	\$90.78	\$106.20	\$713.09
Average Medical PMPM	\$200.90	\$84.27	\$34.45	\$518.98	\$220.93	\$58.85	\$87.57	\$407.61
Average MH/SUD PMPM	\$12.22	\$10.54	\$0.08	\$113.84	\$13.54	\$7.54	\$3.46	\$54.08
Average MH/SUD Prescription PMPM	\$7.46	\$6.51	\$0.08	\$49.52	\$8.15	\$5.13	\$1.51	\$41.71

This evidence reinforces the interpretation that plans providing more generous coverage for these intermediate services provide more generous coverage for medical

services as well.¹² However, such an interpretation can only be verified through the construction of a statistical model using multiple years of data so that unobserved plan characteristics, including case mix of enrollees, are fully accounted for.

Summary and Discussion

Although this report does not provide estimates of the impact of the MHPAEA on private-sector health insurance plans, it does provide information on the extent of spending on behavioral health services by plans prior to the enactment of the MHPAEA. The MarketScan data provide several insights into how behavioral health services were provided by relatively generous employer-sponsored private health insurance plans in 2008. As indicated Table 6, the average cost PMPM is \$268, but there is considerable variance in PMPM cost across plans. Almost all of these costs are for medical-surgical services and related prescription drugs. Behavioral health services accounted for \$12, or 4.6% of total PMPM costs.

The vast majority of the cost for behavioral health was for behavioral health prescriptions (\$7.46). *Behavioral health prescription drugs represent the biggest share of total PMPM spending on behavioral health, and are therefore likely to be a bigger driver of costs than intermediate services of any kind.*

We found that “intermediate” behavioral health services -- those that lie between inpatient and outpatient care -- were provided by employer plans in 2008, although the results differed greatly for each service. Examples of such intermediate services are non-hospital residential treatment, partial hospitalization, and intensive outpatient treatment. Almost all plans had claims for intensive outpatient treatment (98%), most had claims for partial hospitalization (59%), but few had claims for residential treatment (18%). These services represented a very small fraction of the average total plan cost in 2008 (\$2.40 or 0.9%).

These findings on current levels of coverage of these intermediate services are helpful in considering the effect of applying a parity requirement to the scope of services that plans cover. They indicate that these types of services are already covered to some degree. However, in order to estimate the effect of imposing a parity requirement further research is needed to estimate the degree to which these current coverage levels of intermediate services may change to meet a parity standard.

¹² Similar analyses are not presented for IOV because the vast majority of plans have claims, and hence there is no statistical difference in means for plans with positive claims. Because the average number of visits across plans are generally below 20, we also do not find significant difference in means for plans with episode lengths within the 75th percentile.

This descriptive analysis shows that the majority of spending on behavioral health services by health plans is on prescription drugs (61%). Intermediate services represent a far smaller share of total behavioral health spending (20%). Even if plans have high intermediate service utilization, these costs represent a relatively small percent of the total PMPM costs because the same plans also have high utilization of prescription drugs and medical-surgical services. A critical question for future work is why this is the case.

APPENDIX 1: NQTLs EXPERT PANEL MEMBERS

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APPENDIX 2: PLAN BENEFIT DETAIL AND CONSTRUCTION OF MEASURES

Appendix Table A1 (next page) provides a complete listing of available benefit information in the MarketScan data and the number of plans for which these data were available in 2008. The rest of this Appendix describes the construction of specific variables related to benefit design or management of care that were also examined.

We defined a plan as having equal inpatient co-insurance rates (value = 1) if the plan had the same co-insurance rate for general inpatient services as that listed for inpatient psychiatric visits and inpatient substance abuse visits, and neither were “missing”. If any of the co-insurance rates were not equal, then the plan was deemed not to have equal co-insurance parity (value = 0). Similarly, equality in outpatient co-insurance rates was determined if the co-insurance rate for general outpatient office visits was equal to that for outpatient psychiatric visits and outpatient substance abuse visits, and neither was missing. If no values were missing and all values were the same, then we deemed the plan to have equal outpatient co-insurance rates.

The data provide no specific information about the degree to which plans attempt to control costs through managing care but they do include a range of management techniques. We used the information regarding use of specific health management strategies to construct a composite indicator of the number of techniques required by the plan either generally or for specified diagnoses. The specific health management tools captured in our composite indicator (called “Num NQTLs,”) are: case management, pre-certification, utilization review, step therapy required for certain drugs, and use of a prescription drug formulary. None of these management techniques is used exclusively for behavioral health, and indeed it is not clear from the reported information contained in the benefits database whether the management techniques apply to just physical health, behavioral health, or both. Nonetheless, it is reasonable to assume that a plan that reports using more of these techniques is generally more aggressive at managing care and containing costs than a plan that applies fewer of them. The average value for our NQTL variable (which ranges from 0 to 5) is 3.5 (median = mean in this case).

The Thomson Reuter data have their own measure of whether a plan carves out behavioral health care (“pscarve”). The measure is based on Thomson Reuter’s reading of benefit plan pamphlets provided to them by the plans; they believe the information in the pamphlets is not very reliable. Indeed, the measure contained in the database shows very little variation: 91% of the plans in our plan-by-region data set showed a behavioral health carve-out -- far higher than conventional wisdom. We therefore decided to construct our own measure of a behavioral health carve-out, using information in the data about how financial claims were paid. In those cases where the data show an “encounter” with a single payment for the entire package of behavioral health services, we assume the service was carved out. Based on this assumption, we

estimate that approximately 75% of the large insurance plans in our plan-by-region dataset carved out behavioral health services, a percentage far more consistent with conventional wisdom.

TABLE A1. MarketScan Benefit Information				
Specified Benefits	Variable Name	# of Plans	Range	Notes
Outpatient (OP)				
Co-payment individual primary care	copaypc	65	\$5-\$30	37 plans where copaypc is missing have non-zero co-insurance rate (coins in range of 70-100%). So 102 plans have either co-pay or co-insurance for general medical. 2 plans with neither are plantyp="comprehensive".
Co-payment individual -- specialist	copaysp	56	\$5-\$50	All 56 plans also have non-zero copaypc.
Co-payment individual psych SA: paid by patient	copayps	38	\$5-\$50	Generally plans have copayps OR copays copaypc. In one case, plan has both copaypc (\$100) and copayps (\$20).
Co-pay individual OP SA: paid by patient	copays	8	\$5 - \$20	
Co-pay individual OP psych: paid by patient	copayp	9	\$5 - \$100	
Co-insurance flag: indicates "whether the same in network co-insurance applies to all service types captured in the benefit plan design database"	coinflg	103	1 = no; 2 = yes	2 = yes, 96 plans said yes; 7 said no.
Co-insurance: "% of medical costs that a plan pays for most medical services after med deductible is met"	coins	96	70% - 100%	These 96 plans are the firms that said yes to coinflg; 6 plans with missing coins report co-payment for primary care (copaypc of \$10-\$20).
Co-insurance office visit: percent plan pays	coinsov	103	70% - 100%	
Co-insurance other outpatient: percent plan pays	coinsop	101	70% - 100%	
Co-insurance individual OP psych: percent plan pays after deductible met	coinpso	75	0 - 100%	1 plan says 0, 2 plans say 50%, and all others say 70% or more. Only 20 plans (26% cover 100%.
Co-insurance individual OP SA: percent plan pays	coinso	23	0 - 100%	2 plans (8.7%) say 0, otherwise all other plans are 75% or higher. 11 plans (47%) report 100% coverage.
Annual max visits individ OP SA	iamxso	15	20 - 60	
Annual max visits individual OP psych	ialpo	0		None exist probably due to previous MH parity law.
Annual limit individual OP SA	ialso	0		None of these plans have annual limits (per previous mental health parity law).
Annual limit individual psych	ialpo	0		
Annual limit individual OP psych	ialpo	0		
Inpatient (IP)				
Co-insurance IP, amt paid by plan after deductible is met	coinsip	103	70% - 100%	
Co-insurance individual IP psych, amt paid by plan after deductible met	coinpi	23	75% - 100%	Note, when coinpi has a value, 60% of the time coinsip = 100%, 17% it is 90%.
Co-insurance individual IP SA, amt paid by plan after deductible met	coinsi	21	0 - 100%	Note, when coinsi has a value, coinsip = 80%, 90%, or 100%.
Co-insurance individual IP psych SA, amt paid by plan after deductible met	coinpsi	75	70% - 100%	
Annual max days individ IP SA	iamxsi	8	20 - 60 days	
Annual limit individual IP psych SA	ailpsi	0		
Annual limit individual IP SA	ialsi	3	\$2,00 - \$12,000	
General Benefit Info				
Type of plan	plantyp	103	1 = Basic/Major medical (0); 2 = Comprehensive (7); 3 = EPO (4); 4 = HMO (18); 5 = Non-capitated PPO (6); 6 = PPO (57); 7 = POS (1); 8 = CDHP (11).	

TABLE A1 (continued)				
Specified Benefits	Variable Name	# of Plans	Range	Notes
Preventive care coverage indicator	prev	103	0 = unknown (10); 1 = covered (63); 2 = not covered (1); 3 = covered in	
Case management of high cost diagnoses and procedures	cm	103	0 = unknown (51); 1 = required (51); 3 = required OON only (2).	
Utilization review of inpatient stays	ur	103	0 = unknown (65); 1 = required (39).	
Pre-certification for surgery	precr	103	0 = unknown (39); 1 = required (65).	
Step therapy for certain drugs	steprx	96	0 = unknown (0); 1 = yes (48); 2 = no (48).	
Formulary indicator	rxform	96	0 = unknown (0); 1 = yes (87); 2 = no (7).	
Psychiatric and SA carve-out indicator	pscarve	103	1 = no; 2 = yes	Only 7 plans indicate they do not carve-out MH/SUD. 97 plans (93%) say they do. Plans reporting they do not include 1 HMO, 1 Non-cap POS, 3 PPO, and 2 CDHP.
Psychiatric and SA coverage different from medical indicator	psychsub	103	1 = yes covered differently; 2 = no not different	55 plans (53%) are shown to have no different coverage from medical, but as the above information above suggests, this can't be right. We don't know what criteria it is being based off of however.
Annual limit individual IP psych SA	ailps	6	\$500	
Annual limit individual psych	ialp	0		
Annual limit individual SA	ials	2	\$25,000	
Annual max out-of-pocket individual	iop	80	\$300 - \$5,500	
Annual max out-of-pocket -- family	foop	78	\$600 - \$11,500	
Annual max out-of-pocket for medical services -- indiv	loop	80	\$300 - \$5,500	
Annual max out-of-pocket for medical services -- family	foop	78	\$600 - \$11,500	
Individual deductible	ided	60	\$100 - \$2,000	
Individual deductible psych SA	idedps	6	\$75 - \$500	
Family deductible	fded	60	\$100 - \$4,000	
Lifetime limit individual	ilifelim	52	\$300K - \$5 mil	
Lifetime limit flag -- modifies the lifetime limit for medical services	ilifeflg	103	0 = set limit; 4 = no lifetime limit	50 plans (48%) do not set a lifetime limit. 54 plans do, although we only have data on 52 report (per previous variable ilifelim).
Lifetime limit individual psych	ialponi	0		
Lifetime limit individual psych SA	illps	0		
Co-insurance ER	coinser	101	70% - 100%	
Co-payment ER	copayer	47	\$5 - \$250	
Employer contribution -- family	fempcon	9	\$800 - \$2,000	
Employer contribution -- individual	iempcon	9	\$400 - \$1,000	
CDHP = consumer-directed health plan EPO = exclusive provider organization ER = emergency room HMO = health maintenance organization IP = inpatient MH = mental health			OON = out-of-network OP = outpatient POS = point of service PPO = preferred provider organization SA = substance abuse	

To obtain a printed copy of this report, send the full report title and your mailing information to:

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Office of Disability, Aging and Long-Term Care Policy
Room 424E, H.H. Humphrey Building
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Washington, D.C. 20201
FAX: 202-401-7733
Email: webmaster.DALTCP@hhs.gov

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APPENDIX E

Summary of Stakeholder Calls

Compiled by Truven Health

Summary of DOL Stakeholder Calls

July 27, 2015

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Executive Summary

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) established requirements for behavioral health benefits offered by specified health plans to be provided at a level that is at least equivalent to medical/surgical benefits, particularly in terms of financial coverage and quantitative and nonquantitative treatment limitations (NQTLs). Most health plans that offer coverage for behavioral health services now must ensure that treatment limitations are comparable and that they are no more restrictive for behavioral health than they are for medical/surgical benefits.

To aid in the implementation of MHPAEA, the Department of Labor (DOL) and the Substance Abuse and Mental Health Services Administration (SAMHSA) created several online tools and overview materials to help clarify the Act's regulations (see Appendix A). Most of these documents were updated when the final MHPAEA rules became applicable in July 2014. However, DOL and SAMHSA remain interested in receiving feedback on available resources and in identifying areas where greater technical assistance is needed to correctly implement the parity regulations. DOL and SAMHSA also are vested in targeting gaps in the resources that aid in both assessing and increasing MHPAEA compliance. Finally, DOL is interested in identifying new sources of information for issues related to compliance.

To identify gaps within the existing body of resources and address implementation and compliance issues, DOL and SAMHSA invited several stakeholder groups to share their questions, concerns, and other comments on MHPAEA through conference calls and written correspondence. Representatives from the Centers for Medicare & Medicaid Services (CMS) also participated. The agencies held four conference calls between March and May 2015 with the following groups: (1) the Parity Implementation Coalition (PIC); (2) the Association for Behavioral Health and Wellness (ABHW), America's Health Insurance Plans (AHIP), the Blue Cross Blue Shield Association, behavioral health organizations (BHOs), and health plans; (3) providers and provider representatives; and (4) consumer representatives.

DOL distributed a list of questions to each stakeholder group in order to structure the conversations about implementation of and compliance with MHPAEA. Stakeholders were invited to stray from the set list of questions so the dialog could evolve to encompass any and all questions or concerns related to MHPAEA. This report outlines stakeholder responses for all of DOL's questions, including comments on standards for compliance and methods to assess it as well as effective strategies for communication with interest groups and the general public.

Key Concern: Compliance

Stakeholders representing health plans and BHOs suggested that processes (rather than outcomes) should be the focus of assessing compliance. Other stakeholders agreed that outcomes alone do not determine compliance, but they felt that any major discrepancy in denial rates between behavioral health and medical/surgical benefits should constitute a "red flag" for noncompliance with MHPAEA. For many stakeholders, these discrepancies serve to illuminate critical process differences that potentially violate MHPAEA.

Health plans and providers agreed that there are fewer established sources for medical necessity guidelines and related evidentiary standards for behavioral health conditions than for medical/surgical conditions. Stakeholders representing health plans and BHOs spoke about creating their own guidelines by considering an amalgamation of various professional associations and other nationally recognized guidelines and by conducting a process of internal decision-making. The health plan and BHO representatives conveyed this practice as an accepted status quo, but providers and the PIC identified it as a concern.

Consumer and provider groups raised a lack of transparency in health plan decision-making as a major concern. Providers and the PIC viewed the internal decision-making conducted by health plans as a mostly nontransparent process that needed additional oversight for enhanced transparency. The topic of increasing transparency around health plans' development of non-quantitative treatment limitations was of particular concern on all stakeholder calls. Stakeholders representing health plans and BHOs noted a willingness to disclose more information to the federal and state regulatory agencies and auditors than to the general public. The PIC members strongly felt that protecting proprietary information could render NQTLs unenforceable. The PIC members also stated that health plans are in the practice of denying behavioral health claims and declining to provide sufficient explanation. The PIC members further explained that MHPAEA, as well as other provisions under the Employee Retirement Income Security Act (ERISA), including the claims procedures and appeals regulations, clearly indicate that medical necessity criteria must be disclosed upon request. Some of the stakeholders cited the clear, enforced compliance requirements in California and Washington states as best-practice policies that DOL should examine when drafting any new compliance assessment methodology.

In their quest to identify constructive methods for assessing compliance, DOL is actively searching for more detailed information on NQTLs. During their call with health plan representatives, DOL spoke about the importance of obtaining medical management documents, understanding utilization review processes, and reviewing medical necessity criteria. One key question to stakeholders pertained to which search terms could easily provide clear information about compliance within documents. Health plans conceded that a high-level, summary report of the aforementioned information, including details on admissions criteria and determinations on medications, would reduce the complexity of compliance reviews. They also indicated interest in being provided with model language or model forms or notices that could assist them in attaining compliance.

The stakeholder groups supported the practice of forming a panel of content experts to provide more clarity around compliance. Although the suggested background knowledge of these expert panelists differed slightly, stakeholders seemed comfortable using such a group to advance standards for MHPAEA compliance.

Key Concern: Communication

A major driving factor for holding the stakeholder calls was identifying meaningful methods of communication and areas in current resources that need improved clarity. Feedback generally was positive regarding MHPAEA regulations, frequently asked questions (FAQs), and DOL's compliance tool. If MHPAEA is going to have a significant impact on consumers' lives, stakeholders across all groups felt that consumers must be informed about their new health care protections. Health plans, providers, and the PIC outlined specific recommendations to improve consumers' knowledge of the law

and the appeals process. Critical suggestions included a public service announcement campaign and simplifying written language to ensure that messages within the FAQs and compliance tool are easily understood across many demographic groups.

Next Steps

These stakeholder calls provided critical insight, informing next steps that will ensure not only the full implementation of MHPAEA, but also a meaningful understanding of MHPAEA among the general public. Specific suggestions are described in the body of the report and summarized in the appendices. The detailed feedback that DOL and SAMHSA received on developing compliance criteria, assessment tools, and ways to better disseminate educational materials will allow both organizations to move forward, thereby implementing MHPAEA to the full extent of the requirements under the final rules.

Introduction

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)¹ established requirements for behavioral health benefits offered by specified health plans to be provided at a level that is at least equivalent to medical/surgical benefits, particularly in terms of financial coverage and quantitative and nonquantitative treatment limitations (NQTLs). Most health plans that offer coverage for behavioral health services now must ensure that treatment limitations are comparable and that they are no more restrictive for behavioral health than they are for medical/surgical benefits.

MHPAEA created parity protections for individuals in large group plans. The Affordable Care Act³ further extended these protections to a variety of other plan types. Providers of these plans now must ensure that quantitative treatment limitations, which include co-pays and the number of treatment visits, and nonquantitative treatment limitations, which include medical management techniques such as prior authorization, must be comparable and no more restrictive for behavioral health than they are for medical/surgical benefits.

After initial implementation of MHPAEA, the Department of Labor (DOL) and the Substance Abuse and Mental Health Services Administration (SAMHSA) created several online tools and overview materials to help clarify the Act's regulations (Appendix A). Most of these documents were updated when the final rules under MHPAEA became applicable in July 2014. However, DOL and SAMHSA remain interested in receiving feedback on available resources and in identifying areas where greater technical assistance is needed to correctly interpret the parity regulations. Additionally, DOL and SAMHSA are vested in targeting gaps in the resources that aid in both assessing and increasing MHPAEA compliance. DOL is a key entity responsible for MHPAEA enforcement. Therefore, DOL also is interested in identifying new sources of information for issues related to compliance.

To identify gaps within the existing body of resources and address other issues, DOL and SAMHSA invited several stakeholder groups to share their questions, concerns, and other comments on MHPAEA through conference calls and written correspondence. Representatives from the Centers for Medicare & Medicaid Services (CMS) also participated. The agencies held four conference calls between March and May 2015 with the following groups: (1) the Parity Implementation Coalition (PIC); (2) the Association for Behavioral Health and Wellness (ABHW), America's Health Insurance Plans (AHIP), the Blue Cross Blue Shield Association, behavioral health organizations (BHOs), and health plans; and (4) consumer representatives. For detailed information regarding stakeholders in attendance for each call, see Appendix C.

¹ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. (2008). Pub. L. No. 110-343, 122 Stat. 3765. Retrieved from <http://www.gpo.gov/fdsys/pkg/PLAW-110publ343/pdf/PLAW-110publ343.pdf>

³ Patient Protection and Affordable Care Act. (2010). Pub. L. No. 111-148, 124 Stat. 119. Retrieved from <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>

DOL distributed a list of questions to each stakeholder group in order to structure subsequent conversations about implementation of and compliance with MHPAEA. Stakeholders were invited to stray from the set list of questions so that the dialog could evolve to encompass any and all questions or concerns regarding MHPAEA. Stakeholders were interested in improving consistency between DOL enforcement of MHPAEA and the enforcement of state health insurance departments, which are responsible for ensuring that health insurance policies sold to Employee Retirement Income Security Act (ERISA) plans are compliant with MHPAEA.

This report outlines stakeholder responses for all of DOL's questions regarding MHPAEA, including comments on standards for and methods to assess compliance as well as effective communication strategies for interest groups and the general public.

Questions for Stakeholders

This section lists the questions that DOL and SAMHSA asked the four stakeholder groups and summarizes their responses. Stakeholder suggestions also are highlighted in Appendices B and D.

Topic 1: Documents for MHPAEA Compliance

Can you suggest a specific list of documents you recommend that we request from group health plans to check for compliance with MHPAEA?

To assess the consistency between the behavioral health coverage provided by a plan and the requirements of MHPAEA, all stakeholders suggested that DOL review medical management documents to gain a better understanding of medical necessity criteria and utilization review processes, which could be categorized by stage of care. The PIC, providers, and consumer representatives also suggested that DOL examine outcomes such as the following:

- Paid claims, which could be compared for in-network and out-of-network providers to glean additional information about adequacy of provider networks and corresponding out-of-pocket payments
- Claims denials.

A representative from America's Health Insurance Plans (AHIP) noted that a variety of materials would provide insight into a health plan's internal processes and procedures, including certificates of coverage, medical necessity criteria, utilization management guidelines, summary plan descriptions, and procedures for claims review and internal appeals. The stakeholders representing health plans and BHOs acknowledged that assessing medical necessity criteria is challenging and suggested that DOL could help by providing a summary document to assess compliance with MHPAEA. The AHIP representative and a representative from ABHW said they would like DOL to provide them with model language or a model form that can be adapted for this purpose. A health plan representative indicated that they include experts in behavioral health and medical/surgical benefits as a part of the process of developing NQTLs, and they have created a summary report that compares behavioral health NQTLs with medical/surgical NQTLs. This summary report could serve as a useful model.

When developing a model summary, some stakeholders and DOL emphasized the importance of including any specific cost benchmarks that trigger imposition of an NQTL. Another consideration was what could be shared with the public versus with the federal government for the purposes of audits and consumer compliance reviews. Stakeholders also felt that transparency provisions should be required to explain disparities in behavioral health and medical/surgical NQTLs in order to ensure compliance with MHPAEA.

A representative from AHIP suggested that DOL could review summaries of benefits and coverage provided to enrollees to determine whether enrollees know which services are covered and whether they understand what types of utilization review might be necessary to obtain services. These documents also would provide insight into the information that enrollees have about their appeal rights. The AHIP representative also recommended that DOL work with state regulatory agencies to coordinate audits of insured health plans to ensure efficiency and minimize overlap.

Some stakeholders recommended additional analyses or investigations that DOL could use to help flag potential issues:

- Side-by-side comparison of the percentage of denials for behavioral health and medical/surgical benefits
- Percentage of Medicare rates that health plans are paying for behavioral health and medical/surgical services
- Percentage of claims paid for in-network versus out-of-network providers
- Utilization criteria, categorized by stage of care.

A representative of Mental Health America indicated that such analyses could help uncover issues within the system that the plans may not even know exist because NQTLs are so new. He expects that there are differences between the behavioral health and medical/surgical systems (e.g., workforce issues) that these types of analyses may help illuminate. He feels that it is important to be mindful of the multitude of ways that parity could “show up” outside of issues related to service coverage (e.g., care coordination, provider reimbursement).

A representative of Capitol Decisions said that currently the highest reported rates of denials are for residential substance use disorder treatment and eating disorder treatment. She also feels that there is a lack of clarity about whether intermediate levels of care are covered.

Topic 2: Search Terms for Plan Procedural Materials

Can you suggest specific search terms on which we should focus when reviewing large volumes of plan procedural materials? For example, are there terms or phrases related to scope of services that we could search when reviewing plan utilization review processes to help us hone in on related plan practices that need to be reviewed for MHPAEA compliance?

DOL is interested in learning more about the ways that health plans implement standards related to NQTLs. They are particularly interested in (1) identifying key search terms for health plan documents, (2) learning more about how health plans currently are operating and how they are documenting their processes, and (3) learning more about how plans strategize differently for medical/surgical and behavioral health issues, including preauthorization requirements.

Most of the stakeholders did not suggest specific search terms that would provide a useful mechanism for assessing compliance, although a representative of the Association of Behavioral Health and Wellness (ABHW) mentioned the search terms *medical necessity*, *prior authorization*, and *medical management* and included a longer list in their written response to these questions, which is included as an appendix.

A representative of Mental Health America noted that it is hard to find all NQTLs in plan documents. Plan documents may indicate areas of broad coverage without providing many details about specific services that are offered or how medical management processes determine who will receive offered services. Furthermore, providers do not know specifically what will be covered, which can impact what they offer.

One way to remedy this problem may be to ask health plans to provide more detailed information about what they cover. For example, a representative of Legal Action Center stated that it would be helpful to see admission criteria, determinations on medications, and medical necessity criteria detailed in plan documents.

A representative of Mental Health America thought that usage and spending indicators would be more helpful in showing how parity is being implemented. However, results and outcomes are not determinative in the rule; instead, evidentiary standards and processes of mental health services must be comparable.

Topic 3: Best Practices for Disclosure Related to NQTLs

Can you point to examples of best practices among group health plans, especially in terms of disclosure related to NQTLs?

Most stakeholders indicated that there is a lack of transparency regarding how plans develop NQTLs. This general sentiment was reflected in conversations with the PIC as well as providers and consumers. Representatives from each of these groups noted that they would like to see more investigation into the disclosure practices and level of transparency among health plans. A representative of Mental Health America said that the lack of transparency led providers to be concerned that they will not be paid for particular behavioral health services, which therefore made them less likely to provide those services. A representative of the PIC and the National Association of Psychiatric Health Systems noted that health plans often stated that their practices were proprietary and could not be shared. This stance makes it difficult for the PIC to analyze impacts for those health plans that have been identified as “best practices.” The PIC is currently working with some health plans to see what agreements can be reached regarding the disclosure of information.

The health plan and BHO representatives indicated that best practices vary, depending on whether (1) the health plan coverage is self-funded versus insured, (2) the state has coverage mandates, and (3) the state has its own parity law or different disclosure requirements. Representatives also wanted more information from DOL regarding the following questions:

- What is considered vital to the analyses of NQTLs?
- How are medical therapies for behavioral health diagnoses analyzed under NQTLs?
- How can clinically appropriate standards be considered meaningfully?

Finally, they sought answers to other questions in a letter that ABHW sent to DOL last year. They noted an earnest interest in complying with the law. They acknowledged DOL's effort to address some of their questions last year through additional examples provided in DOL's updated MHPAEA self-compliance tool, but felt that more information was needed in order for them to do so.

A representative of the Centers for Medicare & Medicaid Services (CMS) noted that he would like for consumers to receive information, but he acknowledged concerns that have been raised regarding health plans' proprietary information. He suggested that the white paper that the PIC was developing should address how to balance those two conflicting concerns. However, the PIC responded with a letter stating that the idea of compromising on this issue was alarming to them and that it did not have any legal basis (Appendix D). In the letter, the PIC noted that this type of exception could render the NQTL rule unenforceable by creating loopholes that could undermine implementation and enforcement of MHPAEA. They stated that this would potentially override a section of the ERISA rules and regulations⁴ and stated their concern that consumer protections would be undermined. They stated that they believe the MHPAEA, as well as other parts of ERISA, particularly ERISA's claims procedure and appeals regulations, all clearly indicate that medical necessity criteria and guidelines must be disclosed upon request. They also expressed concern that there are no definitional parameters as to what constitutes *proprietary* or *commercially available*.

The PIC noted that California has extensive records on compliance and disclosure related to NQTLs that DOL could reference. They also noted that Washington State asks for evidence on quantitative aspects but does not request information on comparative aspects. Similarly, a representative of Watershed Addiction Treatment Program said that guidance needs to be tailored to the state level. Several states are unsure about how to ask health plans for documents and how to respond when health plans simply say that they are compliant without providing evidence.

A representative from the American Psychiatric Association said that concrete requirements about compliance disclosure are needed for health plans to have policies and procedures in place. For example, to be in compliance with Medicare certification, psychiatric hospitals must have clear policies and procedures regarding health, safety, clinical involvement, staffing, and so forth. Consequences are explicitly laid out for any infractions to compliance. He felt that a similar system should be in place regarding parity compliance. Currently, parity compliance is based on an individual health plan's interpretations of the regulations. He thought that having consequences for noncompliance would give health plans incentives to provide a full analysis of their compliance.

Topic 4: Suggested Guidelines

Are there certain guidelines or evidentiary standards that you would recommend as reliable or unreliable with respect to mental health benefits?

Are there guidelines that you would recommend as reliable with respect to medical/surgical benefits or organizations whose recommendations regarding guidelines you find to be reliable?

⁴ Section 104(b); 29 CFR 25202520.104b-1; "the claims procedure and appeals regulations;" MHPAEA Final rules; FAQs for Employees about MHPAEA, Q:11; FAQs about ACA Implementation (Part V), and MH Parity Implementation, Q:10; Advisory Opinion 96-14A.

DOL is interested in learning more about medical necessity and other related issues in order to identify similarities and differences between medical/surgical and behavioral health coverage. They are interested in identifying models with good reputations and in knowing which models are less reliable. They would like to know how to best reference these documents as they continue to review health plans for compliance with MHPAEA.

Stakeholders agreed that there is no single source that shows everything that should be provided to beneficiaries and providers. There are various resources for different conditions and spectrums of care, but there is no national standard for medical necessity. This leaves health plans free to choose which guidelines to incorporate as their own standard of care. A representative of the PIC and the National Association of Psychiatric Health Systems felt that plans did not use the same pick-and-choose approach for medical/surgical health, and he finds the discrepancy disconcerting. He feels that the government needs to develop clear expectations regarding plan policies and procedures so that plans know the standard to which they will be held. He shared that many members of the National Association of Psychiatric Health Systems consider the American Society of Addiction Medicine criteria to be a gold standard.

When discussing this issue with the Association for Behavioral Health and Wellness, which represents specialty behavioral health and wellness companies, a representative of DOL asked if, in terms of how plans develop medical necessity criteria, it might be typical that a health plan look at two years of professional guidelines from all sources as well as recent studies from peer-reviewed medical journals as a basis of developing their own internal guidelines for specific health benefits. This description was affirmed by ABHW as a reasonable description of a common approach.

A representative from a BHO said that his group is always reviewing the literature to identify new guidelines and practices. Guidelines in the literature come from a variety of sources including commercial, governmental, private, and professional organizations. He emphasized that guidelines older than 5 years should not be considered, as recommended by the Agency for Healthcare Research and Quality. He stated that this recommendation is practical, because over the past five years multiple publications have provided guidelines that are newer and more relevant.

The behavioral health organization relies on published literature, internal documents, and their knowledge of medical necessity criteria to stay current with various suggested guidelines. A provider committee reviews their internally drafted guidelines and provides feedback, which also is considered in the final issue of guidelines. Because the BHO is certified by the National Committee of Quality Assurance (NCQA) they are required to be compliant with at least two internal clinical practice guidelines. For example, these guidelines ensure that an individual who is taking certain flagged medications also receives specific blood tests.

A representative of Mental Health America thought that acceptable levels of intervention could be tied to risk scores to indicate medical necessity instead of simply good practice. He agreed with SAMHSA that the regulations did not call for a particular level of intervention, but he felt that there should be greater global specificity. A representative of the Legal Action Center felt that better medical necessity criteria could help determine which services can be excluded or not excluded for people with particular needs. She specifically mentioned methadone maintenance therapy and exclusions for residential treatment.

Representatives of a health plan and the Association for Behavioral Health and Wellness stressed the difference between process and outcomes and noted that a clear line needs to be drawn between these two separate issues. They would like DOL to provide some examples of best practices for documenting compliance.

Topic 5: Additional Resources

What might we be able to learn from or what resources might we consider accessing from organizations such as the Utilization Review and Accreditation Commission (URAC), the Agency for Healthcare Research and Quality (AHRQ), the National Committee for Quality Assurance (NCQA), and any other organizations you might raise to our attention?

A health plan representative suggested that NCQA or other accrediting organizations could be used as a way to identify compliant plans, and a representative of both the PIC and the providers agreed. Representatives of several health plans stressed that NCQA should be encouraged to build parity compliance and transparency regulations into their accreditation process. DOL felt that accreditation from one of these programs should not signal compliance, but it could be a component to facilitate plan compliance. Health plan representatives agreed and stressed that NCQA accreditation should not be instituted as a requirement for compliance; rather, it should be used as a tool that facilitates analysis of compliance status.

A representative of a BHO indicated that NCQA's background knowledge of health plans, benefit design, and other compliance-related topics would be useful, particularly for states struggling with these issues. Because they are a national entity, their involvement also would promote greater consistency and ease of enforcement of MHPAEA, which is currently being interpreted differently across states.

Topic 6: Subject-Matter Experts

With respect to analyzing for parity of specific NQTLs, what types of experts would you expect the departments would need to enlist and what issues would you expect the particular expert would be best able to address?

This question was not addressed with the PIC, but all other stakeholders supported the idea of using an expert panel to assist DOL in their auditing of or advancing standards for MHPAEA compliance. The experts could include researchers, academic faculty, physicians, clinicians, actuaries, or other appropriate professionals. All health plan stakeholders agreed that each panel member would be expected to have expertise only in one or two areas, but their combined areas of training and expertise should cover the following topics:

- Behavioral health and medical/surgical health
- Managed care and health management techniques
- Existing guidelines and evidentiary standards
- Nonquantitative treatment limitation areas such as provider payment
- Quality analysis
- Examination of mathematical algorithms outlined under MHPAEA to explain them in more accessible ways.

A representative of Mental Health America also suggested that the Department should work with accountable care organizations (ACOs) that provide strong benefits and have a model for the ideal system.

Other Agenda Items

Feedback on MHPAEA Regulations

When the final MHPAEA rules became applicable, the PIC felt that the final regulations were very good with respect to disclosure. Unfortunately, the PIC stated that they are not seeing such disclosures being made or regulations related to them being enforced. Disclosure compliance is essential to MHPAEA. Additional guidance and investigations therefore are necessary to improve adherence to this regulation and to implement law that enforces disclosure compliance.

Health plan representatives said that they are doing analyses of compliance, but they are not sure that releasing this complex and lengthy information to individual beneficiaries or providers is required by the law or will be of any use to them. They may, however, release the results to DOL.

The PIC has over 100 examples of appeals that challenge medical necessity determination and administrative denial. They have set forth a parity challenge but have not received any response.

The final regulations contain a good body of guidance, but a representative of Capital Decisions raised issues related to health plans' lack of transparency regarding MHPAEA compliance and the processes they put in place to assure compliance. A representative of DOL said that attesting to compliance is not all that health plans need to do, and that is not the message that DOL has been sending. DOL would be interested in knowing whether other regulators are providing guidance on compliance.

A DOL representative said that Capital Decisions raised some interesting points about why a detailed analysis is not being provided. The representative of Capital Decisions used the term *privileged information*; DOL would be interested in any feedback about the specifics of what the PIC is hearing, what aspect of the information is privileged, and what they are using to determine that information could not be provided. DOL also would be interested in learning the source of the attestation claims.

The PIC members felt that no one is receiving compliance analyses of policies and procedures from health plans and that there is widespread noncompliance within the industry. They reported that health care plans are engaging in the following activities:

- Challenging medical necessity claims
- Responding to claims with administrative detail based on the scope of their specific medical plan
- Not responding to appeals challenging parity compliance and not disclosing their compliance policies and procedures because they have been told that all they need to do is attest to the fact that they are compliant without saying how they are compliant
- Not disclosing their compliance policies and procedures because they do not believe that they need to share the information with anyone except DOL
- Responding to requests for information by paraphrasing DOL FAQs without providing substantive information
- Administering summary denials

- Not providing information as required under MHPAEA and ERISA, based on misinterpretations of the regulations

Feedback on MHPAEA FAQs

A representative of the American Psychological Association Practice Organization said that the existing FAQs are useful, but their language could be made clearer. The current FAQ language tends to be too esoteric, making explanations difficult for consumers and providers to fully understand.

A representative of the National Association of Psychiatric Health Systems echoed these sentiments. He added that although his providers are sophisticated in how insurance works and are accustomed to interfacing with health plans, the parity rules and regulations are extremely complicated. His group tries to provide education to their members to impart a better understanding of parity requirements, but interpreting them is challenging. He stated that the language is understandable from a conceptual standpoint, but it is difficult to make that information operational. He requested that DOL simplify the information by clearly specifying consumer rights and defining utilization reviews. He suggested that information be directed more toward consumers to help providers advocate on behalf of their patients.

Representatives of the National Association of Psychiatric Health Systems and the American Psychological Association Practice Organization mentioned that the November 2011 FAQs were still available online; this is confusing because updated information has been issued since these older FAQs. A SAMHSA representative commented that it would be good to review the websites to see what reflects the final MHPAEA rules. A DOL representative explained that the old FAQs are not incorrect; they simply lack some of the greater detail that was made available in the final rules.

Feedback on the MHPAEA Compliance Tool

A representative of the Tennessee Department of Mental Health and Substance Abuse Services commented that the compliance tool available on the DOL's website is fairly extensive. She would like to see a similar tool made available for Medicaid regulations.

A CMS representative commented that a tool was developed when the State Medicaid Director letter was issued. He stated that his group would wait until the release of the final rule on Medicaid regulations before updating that tool. However, he is very interested in feedback on how to improve it. He also is looking at commercially available tools that might be helpful templates for the Medicaid tool.

A Legal Action Center representative asked if participants would like to have more tools that individual states could use to conduct their own analyses, such as practical checklists. These could be materials aimed at state regulators to enable them to do some of the analysis and oversight as well as to take a stronger role in enforcement.

Are there broader resources that can be made available to educate consumers and providers about parity and what expectations should be?

The PIC noted in writing that the American Psychological Association commissioned a May 2014 survey, which revealed that only four percent of Americans knew that the parity law had passed or what this law means to them. A representative of Legal Action Center also mentioned in a separate call that more

should be done to inform people about the parity law and their protections. She stated that it seems to be a good time to do a public service announcement campaign to improve the following:

- *Knowledge of the Law.* It may be helpful to work with SAMHSA to produce a message about MHPAEA that is geared toward the consumer and family members and is written at the ninth-grade education level. Some information that has been disseminated is too detailed, and people may not be paying attention to it.
- *Knowledge of Appeals.* There is a lot of confusion about appeals. There are different types of appeals for different plan types. It would be beneficial to have some information on government websites that helps patients understand their rights and the appeals process.

The PIC has specific suggestions for SAMHSA and DOL's respective websites. On SAMHSA's website, the PIC wants parity information under a separate tab in *Topics* rather than under *Laws, Regulations, and Guidelines*. On DOL's website, the PIC would like to see de-identified findings from investigations of MHPAEA, which would help improve MHPAEA implementation and may reduce the need for further subregulatory guidance and litigation. They indicated that it would be very helpful to identify common themes that arise from investigations and to receive written guidance for states on implementation of MHPAEA.

It would be helpful for both websites to have a chart that shows plan types, how MHPAEA applies to benefits, the timelines, how to appeal, appeal rights, the agencies responsible, and how to contact those agencies. It also would be helpful to have some materials geared toward providers who want to help patients with appeals. These materials could explain (1) types of appeals and their timelines; (2) how MHPAEA, ERISA, and the Affordable Care Act affect appeals for different plan types; and (3) which agencies handle complaints. The materials should explain that providers need to assist patients with appeals, given the level of complexity of the appeals process and impairment of some of their patients or clients.

A representative of Legal Action Center noted that her groups do a lot of work to inform providers about protections of the parity law so that they can challenge any denial of reimbursement using the protections. She can identify people providing these services. She thought it would be helpful to try to structure some tools aimed at benefit managers interacting with plans to determine what concrete, practical tools would be helpful in guiding these discussions.

In addition, the PIC suggested that both websites offer a web-based portal for MHPAEA compliance questions that could be answered quarterly. They agreed that terminology and language needed to be simplified and directed toward individuals and families.

A representative of Mental Health America would like to see consumer versions of benchmark plan documents that outline what the consumer can expect to have covered. Right now, the plan language says "outpatient mental health and outpatient substance abuse services," which might not be meaningful. Now that more benefits are billable, it would be helpful to include more detailed descriptions of services consumers can expect to receive at various stages.

A representative of Legal Action Center stated that it also is important to reach other audiences outside the traditional health care field (e.g., the criminal justice system, department of corrections). These constituents appreciate their need for access to behavioral health treatment more than in previous years,

and providers want to ensure that their clients will be enrolling in Medicaid and other insurance. For example, being able to delve into issues that are unique to substance use disorders (e.g., medication-assisted treatment) would be helpful, because many issues are different for addiction.

A representative of the American Psychological Association Practice Organization said that it would be useful to have reports on enforcement decisions. Although her organization might hear about potential noncompliance issues, they often are not informed of the end result. She understands that certain information in these decisions might be proprietary, but any degree of information on enforcement decisions would be useful to consumers, providers, and insurance companies.

Next Steps

These stakeholder calls provided critical insight informing next steps that will ensure not only the full implementation of MHPAEA, but also a meaningful understanding of MHPAEA among the general public. Specific suggestions are described in the body of the report and summarized in the appendices. The detailed feedback that DOL and SAMHSA received on developing compliance criteria, assessment tools, and ways to better disseminate educational materials will allow both organizations to move forward, thereby implementing MHPAEA to the full extent of its final ruling.

Appendix A. Resources for MHPAEA Compliance

The following documents and online tools were made publically available at various points throughout the Mental Health Parity and Addiction Equity Act (MHPAEA) implementation and after the final ruling. The Department of Labor, Substance Abuse and Mental Health Services Administration, and Centers for Medicare & Medicaid Services specifically requested stakeholder reflections on the usefulness of these resources and how they might be improved.

Resources for MHPAEA Compliance	
Resource Type	Access
<i>Department of Labor</i>	
Mental Health Parity webpage	http://www.dol.gov/ebsa/mentalhealthparity/
MHPAEA Factsheet webpage	http://www.dol.gov/ebsa/newsroom/fsmhpaea.html
FAQs specific to different parts of the legislation webpage	ACA and MHPAEA Part V Part VII Part XVII
FAQs specific to employees webpage	For Employees
FAQs specific to outpatient benefits webpage	Outpatient Benefit Sub-classifications
FAQs specific to implementation webpage	Understanding Implementation of MHPAEA
Report, <i>Self Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions</i> . Updated Mental Health Parity section.	http://www.dol.gov/ebsa/pdf/cagappa.pdf
<i>Substance Abuse and Mental Health Services Administration</i>	
Implementation of MHPAEA webpage	http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act
<i>Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight</i>	
MHPAEA Factsheet webpage	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

Abbreviations: ERISA, Employee Retirement Income Security Act; FAQ, frequently asked question; MHPAEA, Mental Health Parity and Addiction Equity Act

Appendix B. Resources Stakeholders Requested From DOL and SAMHSA to Improve MHPAEA Awareness and Compliance

The following table describes documents that stakeholders feel would improve awareness and compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). In some cases, stakeholders gave specific direction on which organization should be authoring the document or where the resource should be posted online. Each resource is listed with the stakeholder(s) who made the request.

Organization	Requested Resource(s)
American Psychiatric Association	<ul style="list-style-type: none"> • Create a document that explains requirements about compliance disclosure and includes explicit descriptions of consequences for any failures to comply • Disseminate the document to health plans
American Psychological Association Practice Organization	<ul style="list-style-type: none"> • Write reports explaining the decision process and final ruling on MHPAEA compliance investigations
Association for Behavioral Health and Wellness America’s Health Insurance Plans Blue Cross Blue Shield Association	<ul style="list-style-type: none"> • Create a DOL-authored document that answers the following: <ul style="list-style-type: none"> ○ What is considered vital to the analyses of NQTLs? ○ How are medical therapies for behavioral health diagnoses analyzed under NQTLs? ○ How can clinically appropriate standards be considered meaningfully? • Create a DOL-authored document that accomplishes the following: <ul style="list-style-type: none"> ○ Explains the difference between process and outcomes as they relate to MHPAEA compliance ○ Includes examples of best practices for documenting compliance • Provide model language and/or a model form that health plans can adopt to share information regarding their individual medical necessity criteria
Legal Action Center	<ul style="list-style-type: none"> • Create tools that are structured to help benefit managers who interact with plans; need to determine what concrete, practical tools would help guide these discussions • Create tools such as practical checklists that individual states can use to conduct their own analyses <ul style="list-style-type: none"> ○ These tools could be materials aimed at state regulators to enable them to do some of the analysis, oversight, and methods to take a stronger role in enforcement • Create PSAs to inform the general public about MHPAEA with the following goals: <ul style="list-style-type: none"> ○ Increase general knowledge of the law ○ Increase general knowledge of the appeals process

Mental Health America	<ul style="list-style-type: none"> • Create consumer versions of benchmark plan documents that contain the following: <ul style="list-style-type: none"> ○ Outline of the services consumers can expect to have covered ○ Detailed descriptions of the services consumers can expect to receive at different stages
Parity Implementation Coalition	<ul style="list-style-type: none"> • Provide written guidance to states that helps explain how MHPAEA should be implemented • On the SAMHSA website, place parity information under <i>Topics</i> rather than under <i>Laws, Regulations, and Guidelines</i> • Create a chart showing different plan types while explaining the following: <ul style="list-style-type: none"> ○ How MHPAEA applies to benefits ○ Types of appeals and their associated timelines ○ Consumer appeals rights and how individuals can appeal ○ A list of agencies responsible for appeals and their associated contact information ○ How MHPAEA, ERISA, and the Affordable Care Act affect appeals for each plan type • Create web-based portals on the DOL and SAMHSA websites for MHPAEA compliance questions that will be answered quarterly • Share de-identified findings from investigations of MHPAEA compliance on DOL website
Tennessee Department of Mental Health and Substance Abuse Services	<ul style="list-style-type: none"> • Create a tool for Medicaid regulations compliance that is similar to the existing MHPAEA compliance tool on the DOL website

Abbreviations: Department of Labor (DOL); Employee Retirement Income Security Act (ERISA); Mental Health Parity and Addiction Equity Act (MHPAEA); nonquantitative treatment limitation (NQTL); public service announcement (PSA); Substance Abuse and Mental Health Services Administration (SAMHSA)

Appendix C. Stakeholder Participants in the Four Calls

The following call log lists the names and organizational affiliations of stakeholders who participated in the conference calls with the Department of Labor, Substance Abuse and Mental Health Services Administration, and Centers for Medicare & Medicaid Services.

Call 1 (3/24/2015): Parity Implementation Coalition

Stakeholder Name	Organization
Sam Muszynski	American Psychiatric Association
Carol McDaid	Capitol Decisions
Bethann Middlebrook	Watershed Addiction Treatment Programs
Mark Covall	National Association of Psychiatric Health Systems

Call 2 (4/28/2015): Association for Behavioral Health and Wellness

Stakeholder Name	Organization
Pamela Greenberg	Association for Behavioral Health and Wellness
Tim Stover	Aetna
Suzanne Yale	Aetna
Sally Cooper	Aetna
Tracy Scraba	Aetna
Brad Lerner	Beacon Health Options
Sam Donaldson	Cenpatico
Miriam Burdson	Cenpatico
Pam Mobberley	Cigna
John Emerick	New Directions Behavioral Health
Adam Easterday	Optum
Michael Bresolin	Optum
Amy Watson	Optum
Rebecca Klein	Association for Behavioral Health and Wellness
Joel Slackman	Blue Cross Blue Shield Association
Tom Wilder	America's Health Insurance Plans
Devan Cross	Managed Health Network

Call 3 (4/30/2015): Providers and Provider Representatives

Stakeholder Name	Organization
Mark Covall	National Association of Psychiatric Health Systems
Cynthia Shelton	New Mexico Human Services Department
Ty Thornton	Tennessee Department of Mental Health and Substance Abuse Services
Suzanne Weed	Tennessee Department of Mental Health and Substance Abuse Services
Maria Abraham	New York State Office of Mental Health
Tom Smith	New York State Office of Mental Health
Gary Weiskopf	New York State Office of Mental Health
Stacey Larson	American Psychological Association
Alan Nessman	American Psychological Association Practice Organization

Call 4 (5/7/2015): Consumer Representatives

Stakeholder Name	Organization
Nathaniel Counts	Mental Health America
Gabrielle De La Gueronniere	Legal Action Center
Andrew Sperling	National Alliance on Mental Illness

Appendix D. Documents and Letters Received After Conducting Stakeholder Calls

Following the stakeholder meetings where participants shared their thoughts verbally, some stakeholders sent written documents to the Department of Labor, Substance Abuse and Mental Health Services Administration, and/or Centers for Medicare & Medicaid Services. These documents are provided in order of their receipt.

D1. Letter from the Parity Implementation Coalition

April 10, 2015

Elena Lynett,
Senior Health Law Specialist, Employee Benefits Security
Administration, U.S. Department of Labor
200 Constitution Avenue NW Washington, DC 20210

James A. Mayhew
Director, Market Rules Division
Center for Consumer Information and Insurance Oversight (CCIIO) U.S.
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Christopher Carroll
Director, Division of Health Care Financing and Systems Integration
U.S. Department of Health and Human Services
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Lynett, Mr. Mayhew, and Mr. Carroll,

We thank you for the opportunity during our March 24, 2015 call to discuss SAMHSA/ DOL MHPAEA outreach materials and strategies. We are pleased that additional sub-regulatory guidance may be a part of these materials.

While we are preparing our more detailed responses to DOL's questions with respect to implementation, we would like to provide you with some important feedback regarding the issue of plans' assertions of the "proprietary" or "commercially valuable" nature of plan instruments and documents related to the development of nonquantitative treatment limitations (NQTLs). Specifically, we are concerned about this type of assertion in the context of a plan participant's or their authorized representative's request for disclosure of information related to their mental health and substance use disorder (MH/SUD) benefits.

In our discussions with plans, it is our understanding that some believe that they can raise the "proprietary" or "commercially valuable" nature of their NQTLs as a reason to avoid disclosure, despite the absence of any legal or regulatory authority. Yet others believe that they need regulators to establish an exception to their disclosure obligations to protect this information. Our understanding of the plans' positions is consistent with comments made during our call by James Mayhew, Acting Director, Enforcement Group, CCIIO. Mr. Mayhew stated that based on a MHPAEA compliance challenge to an adverse benefit determination, health plans are indicating that "how they develop

nonquantitative treatment limitations” is proprietary information, and therefore should not have to be disclosed. Mr. Mayhew also stated that this issue may warrant a balancing of interests approach.

The comments made by plans regarding this type of exception and a solution that could allow health plans to avoid disclosure of important NQTL information is alarming to us. We are extremely concerned that, in the absence of transparency, plans will avoid the disclosure of information necessary for plan participants and beneficiaries to determine whether a plan has conducted a required compliance review that ensures that its NQTLs meet the regulatory tests as to comparability and stringency of application between MH/SUD and medical/surgical benefits. This type of exception could very likely render the NQTL rule entirely unenforceable. In addition, the ability to avoid disclosure of information related to NQTLs in the context of a claims denial could interfere with a plan participant’s or beneficiary’s ability to appeal a denial of benefits, leaving plan participants and beneficiaries without medically necessary MH/SUD services.

Adoption of the plan’s position or a compromise on this issue does not seem to have a legal foundation nor would it be good policy.

1) This policy would create loopholes and override existing federal laws that protect consumers.

In our view, any accommodation created for a plan’s assertion of the “proprietary” or “commercially valuable” nature of its criteria or plan documents or instruments, to excuse or exempt a plan’s compliance with the disclosure requirements, not only would create an enormous loophole in the implementation and enforcement of MHPAEA, but would override existing federal laws, regulations and opinions of the DOL, not only with respect to MH/SUD disclosure requirements, but also with respect to medical/surgical disclosure requirements. This includes ERISA section 104(b), 29 CFR 2520.104b-1, the claims procedure and appeals regulations, MHPAEA Final Rules, FAQs for Employees about MHPAEA, Q:11, FAQs about ACA Implementation (Part V) and MH Parity Implementation, Q:10, Advisory Opinion 96-14A (specifically opposing a plan’s position that underlying information from which its usual and customary fee determination was derived is proprietary and thus not disclosable).

It is clear to us, as well as other state regulators we have been conferring with that, once the door is open for a plan’s “proprietary” or “commercially valuable” assertion to negate or compromise disclosure requirements, provisions of the ACA and pre-existing regulations on disclosure that were intended to protect consumers will be undermined, and insureds and their authorized representatives will be denied the right to know the bases for denials of their insurance coverage claims and to assess a plan’s compliance with the law.

As we discussed, some plans are stating that medical necessity criteria for both behavioral and medical benefits are “proprietary” or “commercially valuable”, based on the position taken by vendors that sell those products, such as McKesson and Milliman. We believe that the MHPAEA, ERISA and the claims procedure and appeals regulations are clear that medical necessity criteria and guidelines must be disclosed upon request; absent which a tremendous obstacle is created toward discerning plan compliance with the parity law. Without the ability to establish plan compliance, plan participants and beneficiaries are in danger of being denied medically necessary MH/SUD services that they should rightfully be able to access.

2) *There are no definitional parameters to what constitutes “proprietary” or “commercially available”.*

Our review of the law and regulations reveals no definitional parameters for the terms “proprietary” or “commercially valuable”. It is then up to the health plans to define the nature of their NQTLs. In the context of plan benefits, it is quite possible for a health plan to label almost anything “commercially valuable”. As a result, the ability to label documents “proprietary” or “commercially valuable” poses a real danger to plan participants and beneficiaries, as plans could evade disclosure provisions and regulations by claiming vital instruments and documents to be nondisclosable.

3) *There is no legal basis for an exception based on the “proprietary” or “commercially valuable” nature of NQTLs.*

Based on our legal reviews, as well as input from multiple stakeholders, we have found nothing in federal law or regulations that permits a plan’s assertion of “proprietary” or “commercially valuable” to trump the medical necessity criteria disclosure requirements for either medical/surgical or MH/SUD benefits under MHPAEA, the Final Rules and related federal regulations. As we also discussed, some plans are stating that plan instruments and documents related to the processes, strategies, evidentiary standards and other factors used in applying a nonquantitative treatment limitation to behavioral and/or medical benefits is also “proprietary” in nature and therefore should not have to be disclosed. Again, the MHPAEA Final Rules, including the provisions therein regarding the applicability of ERISA and claims and appeals regulations), make clear that this information must be disclosed upon request, particularly in the context of an adverse benefit determination and appeal. Again, our legal reviews and input from stakeholders reveals nothing in federal law or regulations that permits a plan’s assertion of “proprietary” or “commercially valuable” to trump the disclosure of plan documents and instruments requirements for either medical/surgical or MH/SUD benefits under MHPAEA, the Final Rules and related federal regulations.

We find your example from the Final Rules regarding application of the NQTL rule to be quite helpful in illustrating our point:

Example 2. (i) Facts. A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorders, but only 30 percent of medical/surgical conditions.

(ii) Conclusion. In this Example 2, the plan complies with the rules of this paragraph (c)(4) because the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions. [78 F.R. 68272].

Here, disclosure of the evidentiary standard of the coefficient of variation in lengths of stay exceeding 0.8, and the analysis conducted and the results of that analysis, are fundamental and vital in determining whether there is parity compliance (although it would also be important to understand the actual data that this coefficient of variation was based on). This example necessarily relies on the disclosure of essential plan documents, such as evidentiary standards, the processes used to apply those standards, and the results

of the plan's analysis. If the plan did not have to disclose this information based on the asserted "proprietary" or "commercially valuable" nature of the information, the analysis undertaken here to determine plan compliance with the NQTL rule would be impossible.

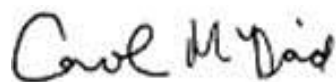
In addition, examples in the Final Rules with respect to financial requirements and quantitative treatment limitations set forth in paragraph (c)(3)(iv) are also helpful in illustrating our point. These examples contain information from plan documents and instruments that could be deemed "proprietary" by the plan. In Examples 1 and 2 regarding a plan's imposition of levels of coinsurance and copayments, the plan discloses its projection, using a reasonable method, of its payments for the upcoming year (coinsurance rates and copayment amounts, projected plan payments, percent of total plan costs and percent subject to coinsurance levels and copayment amounts). Based on this disclosure, a conclusion may be reached whether the two-thirds threshold of the substantially all standard has been met. If the plan did not have to disclose this information based on the asserted "proprietary" or "commercially valuable" nature of this information, it could withhold the various calculations used to establish financial requirements or treatment limitations, thereby making an analysis to determine plan compliance with the substantially all test impossible.

In Example 4 regarding financial requirements for prescription drug benefits, the example is prefaced on the fact that the plan's process for certifying a particular drug as "generic", "preferred brand name", "non-preferred brand name", or "specialty" complies with the requirements of the NQTL rule. Thus, this example presumes plan disclosure necessary to make an NQTL rule compliance determination.

In our repeated legal reviews, we have found no evidence that the MHPAEA disclosure provisions and related federal laws and regulations provide an exception for "proprietary" or "commercially valuable" criteria. If they did, all plans could evade these vital disclosure provisions and regulations by simply purchasing proprietary medical necessity criteria, or claiming that its own criteria are proprietary. Likewise, our legal reviews find no evidence that the MHPAEA disclosure provisions and related federal laws and regulations provide an exception for "proprietary" or "commercially valuable" plan instruments and documents. If they did, all plans could evade these vital disclosure provisions and regulations by labeling certain plan instruments proprietary or commercially valuable, and claiming that their parity compliance analyses are contained within those proprietary documents.

We look forward to continuing to work with SAMHSA and DOL on outreach materials and additional guidance toward our shared goal of full implementation and enforcement of MHPAEA. Once we complete our written responses to DOL's questions, we would be happy to convene a call or meeting to discuss any outstanding questions regarding our responses and would appreciate hearing your response to the issue raised in this letter at that time.

Sincerely,



Carol McDaid
Co-Chair, Parity Implementation Coalition



Sam Muszynski
Co-Chair, Parity Implementation Coalition

CC:
Elizabeth Siegel-McNamee
Substance Abuse and Mental Health Services Administration (SAMHSA)

Karen Chaves
Substance Abuse and Mental Health Services Administration (SAMHSA)

John O'Brien
Centers for Medicare and Medicaid Services (CMS)

D2. A List of Materials the Parity Implantation Coalition Identified as Useful to MHPAEA Implementation and Compliance

Suggested Agency	Material(s)
DOL, SAMHSA, & CCIIO	<ul style="list-style-type: none"> • <i>PSA campaign</i> to address the fact that a May 2014 survey commissioned by the American Psychological Association found that only 4% of Americans know that the parity law passed or what the law means to them • <i>Training curriculum</i> on MHPAEA for DOL and CCIIO. These documents should be written at the ninth grade education level • <i>Web-based information</i> with terminology geared toward plan audience and/or individuals and families • <i>Chart</i> on all websites that shows plan types, how MHPAEA is applied and appeals rights, timelines, and agency responsible • <i>Web-based portal</i> for MHPAEA compliance questions that could be answered quarterly
SAMHSA	<ul style="list-style-type: none"> • <i>Materials for providers</i> on how to help patients with appeals. Materials would explain different appeals, timelines, and how MHPAEA, ERISA, and the Affordable Care Act affect appeals for different plan types. They would also name the agency that should receive complaints. The materials should clarify that providers should assist with patient appeals, given the complexities of the appeals process and impairment of some of their patients or clients. • <i>Structure the website</i> to have parity listed as a key issue under <i>Topics</i> rather than under <i>Laws, Regulations & Guidance</i>
DOL	<ul style="list-style-type: none"> • <i>Web-based materials</i> to disseminate de-identified findings from investigations to help improve MHPAEA implementation, thereby reducing need for further subregulatory guidance and litigation
CCIIO	<ul style="list-style-type: none"> • <i>Written guidance to states</i> on MHPAEA implementation rather than conference calls • <i>Personal communication</i> with state representatives regarding CCIIO enforcement authority in the event the states are not complying with the law

Abbreviations: Department of Labor (DOL); The Center for Consumer Information and Insurance Oversight (CCIIO); Employee Retirement Income Security Act (ERISA); Mental Health Parity and Addiction Equity Act (MHPAEA).

D3. Letter from Mental Health America

May 15, 2015

Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

U.S. Department of Labor
200 Constitution Ave., NW
Washington, DC 20210


Thank you again for taking the time to convene the SAMHSA-Department of Labor (DOL) stakeholder's call on MHPAEA. In addition to a letter on MHPAEA oversight MHA and other stakeholders will be sending, we wanted to follow-up with our recommendations for two tools to support MHPAEA implementation.

First, states should be supported in creating a guide for consumers on the specific minimum benefits that must be covered given the state's benchmark plan and applicable state and federal parity laws. When outlining the mandatory benefits, states should consider not only the presently existing services that fit within the benchmark plan's definition of medical necessity, but other community-based services, which will become increasingly available as the behavioral health system develops.

Second, SAMHSA, in conjunction with DOL, should draft guidance on what MHPAEA means for the future of the behavioral health workforce, since more trained individuals will be necessary to provide all of the services now required under MHPAEA. The increase in demand for services will facilitate an increase in supply, and federal agencies should issue guidance on new workforce opportunities, i.e. increased job prospects for licensed counselors and certified peer specialists, to meet the increased demand from MHPAEA.

Thank you for your time and I look forward to opportunities to engage with you in the future.

Sincerely,



Nathaniel Counts, J.D.
Policy Associate
Mental Health America
2000 North Beauregard Street, 6th Floor
Alexandria, VA 22311
Office: 703.797.2583

Email: ncounts@mentalhealthamerica.net

D4. Second Letter from Mental Health America

May 29, 2015

Attn: Elena Lynett and Amber Rivers
U.S. Department of Labor
Frances Perkins Building
200 Constitution Ave. NW
Washington, DC 20210

Dear Ms. Lynett and Ms. Rivers:

The undersigned organizations would like to follow-up on the SAMHSA and Department of Labor (DOL) stakeholders call regarding Mental Health Parity and Addiction Equity Act implementation. We recommended the use of indicators to promote parity compliance. Below we present: (1) the need for evolving oversight and enforcement, (2) our proposal for possible indicators, and (3) the advantages of collecting these indicators.

1. The need for evolving oversight and enforcement

Currently, DOL oversees parity compliance by examining (a) health plan language, (b) denial rates, and (c) complaints. These three oversight mechanisms are excellent for the beginning of parity oversight, but will become less valuable over time as more obvious instances of non-compliance recede and more obscured instances remain. To further explore this point, we will look at each oversight mechanism separately.

a. Health plan language

Examining plan language will reveal quantitative treatment limitations and non-compliant treatment exclusions, rapidly improving parity in coverage. After several years though, many of these more obvious violations will disappear and instances of non-compliance will be more difficult to find. Even if DOL were able to pour through all plan documents to search for non-quantitative treatment limitations (NQTLs), it may be unclear what pieces of plan language amount to a NQTL in practice. Thus, analysis of plan language will have diminishing returns as time goes on.

b. Denial rates

Comparing service denial rates finds instances where behavioral health services are denied at a higher rate and which cannot be explained by a reasonable, neutral policy. Currently though many behavioral health services that would likely be considered medically necessary under reasonable criteria are not available in most areas. True parity should also examine how plans recruit and encourage providers to join their networks and gaps in the care they provide. Examples of benefits that are medically necessary but may not be available include peer support, home visitation and parenting supports, crisis respite, and

multidisciplinary care teams. Since these benefits are not available, they will not be denied, and a look at denial rates alone will not detect this gap in coverage of necessary benefits.

c. Complaints

Collecting complaints provides a catch-all for issues that are not detected by other oversight mechanisms, but places a burden on the consumer to pursue the complaint. Using collected complaints to measure parity relies too heavily on a certain level of consumer awareness to find appropriate areas for complaint. When possible, the regulatory agencies or the entities being regulated should shoulder more of the burden of oversight.

2. Proposals for possible indicators

In support of the next phase of parity oversight, we recommend collecting indicators. First, we would like to present our ideal indicator that we hope to work toward, and second we will present indicators that we believe are practically available and can be employed until a more ideal indicator is available.

Our ideal indicator would be a comparison between behavioral health and medical/surgical outcomes across the beneficiary population, taking into account both prevention and recovery outcomes adjusted by relative prevalence of the health need, relative severity of health need, and relative expense of effective treatments. This would require widespread adoption of behavioral health assessment tools, greater focus on outcomes, and further research on effective systems of care, but should be our goal for the future.

Presently, we can use readily available information to create indicators in four domains of parity compliance. Where necessary, indicators could be compared with epidemiologic estimates, similar indicators taken from health systems believed to be in complete parity compliance, and other information taken from the literature to make necessary adjustments. We propose four domains for indicators:

- **Provision of care** includes the extent to which individuals receive the medically appropriate care that meets their level of need, and the quality of the care they receive. This could include indicators that compare the extent to which treatment reduces expected co-morbidities, the number of effective service bundles provided (i.e. is diagnosis coupled with expected follow-up services), and the total spending on services.
- **Assessment of need** includes the extent to which behavioral health needs are assessed during visits and linked to treatment, given their prevalence and severity. This could include indicators that compare the numbers of assessments administered, and the number of unique service utilizers as compared to epidemiologic estimates of need.
- **Network development** includes the extent to which effective prevention and treatment is accessible in the network. This could include indicators that compare the number and distribution of providers, provider reimbursement, the number and distribution of available treatments interventions, the process for recruiting providers to the network, the incentive and quality initiatives, and the transparency and accuracy of the reported network.

- **Network administration** acknowledges the changing role of the health plan away from strict insurer to active provider of care, and includes all other activities performed by a health plan that affect treatment but are not reimbursement for the service itself. This could include indicators that compare all network administration spending, and qualitative aspects of administrative policies and practices.

3. The advantage of collecting indicators

Indicators are well suited as mechanisms for the next phase of promoting parity. They confer three major advantages: they may be less burdensome to administer, provide more comprehensive oversight, and support the system as a whole.

First, analyzing indicators may be less burdensome for DOL. Although indicator design and analysis would require time upfront, the quantitative analysis may be less burdensome thereafter when compared to analysis of plan language.

Second, indicators can provide evidence of a NQTL, which would otherwise be difficult to discover. While it may be challenging to discover all NQTLs through a health plan's written policies, disparities in between medical/surgical and behavioral health indicators could indicate an NQTL in the health plan's policies and practices, and DOL could collaborate with the health plan in determining the reason for the discrepancy. Because NQTLs may be difficult to find even for the health plan, collaboration and technical assistance in ensuring parity may often be more appropriate in many situations than direct enforcement.

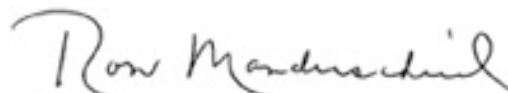
Third, indicators can support the growth of our behavioral health systems as a whole, furthering the overall aims of parity. Because an indicator discrepancy is not necessarily proof of a MHPAEA violation in and of itself, the health plan may have reasonable justification for the disparity. These explanations can provide more information to stakeholders about barriers facing the development of behavioral health systems and support the growth of these systems beyond MHPAEA enforcement alone.

Thank you for your time and your ongoing dedication to the oversight of the new parity requirements. We would welcome the opportunity to meet with you and further discuss these ideas and determine a set of practicable indicators to support parity compliance and the growth of our behavioral health systems. Please follow up at any time with Nathaniel Counts at 703-797-2583 or ncounts@mentalhealthamerica.net to arrange a time to meet or with any additional questions. We look forward to continuing to collaborate with you in the future.

Sincerely,



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D5. Comments Sent by the Association for Behavioral Health and Wellness

ANSWERS TO DEPARTMENT OF LABOR QUESTIONS FOR MHPAEA STAKEHOLDER CALL

- 1. Can you suggest a specific list of documents you would recommend we be requesting from group health plans to check for compliance with MHPAEA?**
 - Regulators auditing MHPAEA compliance by health plans and health insurers are seeking to determine if (a) shoppers and enrollees are adequately informed about what is covered; (b) enrollees and health care providers are aware of plan and insurer policies for managing behavioral health and substance use disorder benefits; and (c) if enrollees are informed about their rights to appeal benefit denials.
 - Regulators are also looking for information to determine if the insurer or plan is complying with the parity requirements with respect to financial requirements and treatment limits.
 - Key documents that should be examined include: (a) Summary of Benefits and Coverage; (b) health insurer Evidence of Coverage; (c) health plan Summary Plan Description; (b) disclosure of internal appeal and external review rights; (d) disclosure of medical necessity criteria; (e) utilization review and medical management criteria; (f) plan formularies; (g) marketing materials; and (h) documentation of parity testing. In addition, auditors should first have a discussion with the plan regarding the types of information they are looking to uncover before requesting documents to streamline the process and ensure they are not requesting a large number of documents that are not relevant to their inquiries.
 - Federal regulators should work to coordinate market conduct exams, state regulatory inquiries, attestations and questionnaires with state insurance regulators and the National Association of Insurance Commissioners. It is critical that these requests of plan sponsors and health insurers are done in an efficient and uniform manner and coordination between reviewing agencies promotes that goal.
 - Regulators should use existing documents as vehicles for plans to disclose necessary information instead of creating new documents.
 - The agencies should provide information about what content they'd like to see in existing documents.

- 2. Can you suggest specific search terms on which we should focus when reviewing large volumes of plan procedural materials? For example, are there terms or phrases related to scope of services that we could search when reviewing plan utilization review processes to help us hone in on related plan practices that need to be reviewed for MHPAEA compliance.**

- While not all plan terms are identical there certainly are many common terms that plans use.
- Specific search terms include: approval, case management, medical necessity, prior authorization, notification, utilization management, utilization review, medical management, retrospective review, covered benefit/service, precertification, clinical guidelines, evidence based, concurrent review, utilization control, length of stay, limit, patient placement criteria, outcomes, outlier, network credentialing, network participation, pre-certification, exclusions, limitations, pre-approval, provider qualifications, reimbursement, penalty, credential, DRG, exclusion, level of care, care management, fail first, claims based reviews, DSM etc. – terms should be linked to mental health and substance use to link parameters of the searches.

3. Are there examples of best practices among group health plans that you can point to, especially in terms of disclosure related to NQTLs?

- This is an area where we would like more illustrative examples from the regulators on what they consider best practices. We would like information on what should be included/considered in terms of disclosure related to an NQTL analysis. In terms of the NQTL analysis we would also like to know how plans can use clinically appropriate standards when determining parity in NQTLs.
- Best practices may vary from state to state and region to region depending on the regulatory environment. If regulators can provide more information like that mentioned above in combination with educating us about real life examples that are best practices and examples that fell short (and explaining why) this will lead to best practices across the board.

4. Are there certain guidelines or evidentiary standards that you would recommend as reliable or unreliable with respect to mental health benefits?

- We distinguish guidelines from evidentiary standards. Guidelines are the criteria against which an assessment of a particular patient/member's clinical circumstances and condition is assessed with the aim of the criteria to guide a decision regarding coverage of the requested treatment or services which reflects the circumstances of the individual patient, evidence-based practices and the standard of care as applied to the specific patient/member's circumstances. In comparison, evidentiary standards are standards based on scientific literature that define what level of evidence supports a best practice, evidence base or standard of care that would support the development of the criteria. For example, what is the threshold of evidence that would make something a best practice – is it merely a preponderance of clinical studies? Is it that the practice must be proven by 80% of valid published clinical studies etc.?
- Valid guidelines and evidentiary standards are a moving target and change as the evidence changes.

- Health plans and MBHOs work with their provider networks and/or external experts to make sure the guidelines and standards they use are up to date and accurate; this partnership is important in guideline development.
- We do not suggest mandating use of a certain guideline as there are a variety that are available.
- Valid guidelines come from: American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, Canadian Medical Association, American Academy of Pediatrics, Department of Defense, Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, National Institute for Health and Care Excellence, McKesson, internally developed health plan guidelines that are externally validated, etc.

5. Are there guidelines that you would recommend as reliable with respect to medical/surgical benefits or organizations whose recommendations regarding guidelines you find to be reliable?

- As stated above, there is some regional variation in guidelines.
- Some of the guidelines used by health plans and MBHOs are: Milliman Care Guidelines (MCG), internally developed health plan guidelines, BCBSA/Kaiser technical advisory center (plans rely on information from this center for analysis and evidence).

6. What might we be able to learn from or what resources might we consider accessing from organizations such as the Utilization Review and Accreditation Commission (URAC), The Agency for Healthcare Research and Quality (AHRQ), National Committee for Quality Assurance (NCQA) and any other organizations you might raise to our attention?

- We would recommend that you work with the accreditation bodies such as URAC and the National Committee for Quality Assurance (NCQA) to establish standards and measure MHPAEA compliance as a component of their accreditation process. While accreditation would not be a requirement of MHPAEA, such accreditation would have the benefit of deeming the plan compliant. This would ease the administrative burden of confirming compliance on the regulators as well as the plans, while improving the reliability and depth of the MHPAEA compliance review. Accreditation reviewers are highly knowledgeable about health plans, in some cases more so than state enforcers. This would also permit standardization of assessment across various states which are currently using varied and inconsistent approaches.
- NCQA and URAC have standards related to the handling of internal appeals/external review and accreditation with those standards should demonstrate compliance with requirements to provide patients/providers with appeal rights in issues related to the provision of behavioral health/substance use disorder benefits.

7. With respect to analyzing for parity of specific NQTLs, what types of experts would you expect the departments would need to enlist and what issues would you expect the particular expert would be best able to address?

- NQTLs are susceptible to being misunderstood so we suggest you seek out experts who understand the challenging aspects of NQTLs.
- Experts should have a clinical background in both behavioral health and medical surgical.
- In addition they should have training and experience in managed care and management techniques.
- They should also have a background in quality and knowledge of: guidelines, evidentiary standards, provider reimbursement methodologies, network criteria, etc.
- The experts should not only be knowledgeable about the types of conditions being treated but also in how health plans typically pay for and manage benefits. For example, experts from NCQA or URAC.

ANSWERS TO QUESTIONS ON AGENDA

I. What kinds of information do your organizations/members need related to MHPAEA? Are there specific topics which people need more information about?

- Clarify the application of parity to residential treatment, involuntary commitment, autism, DRGs, etc.
- Issue model language/notices/formats would be helpful.
- Increase coordination with state regulators, especially around enforcement, this would decrease administrative burden and help create a more uniform interpretation and implementation of MHPAEA.
- Distinguish between disclosures to regulatory authorities with enforcement power under federal and state law (e.g. DOL auditors, state DOI and AG investigators etc.) and the public disclosure requirements under MHPAEA and ERISA.
- Our organizations have multiple areas where they would like more information. ABHW, AHIP and BCBSA will submit these to you under separate cover.

II. Specifically, what are the needs related to

- a. Consumers**
 - b. Practitioners**
 - c. Provider organizations**
 - d. Substance use disorder treatment services**
 - e. Mental health services**
- We did not answer the question in this section.

III. Does guidance need to be tailored to the state level or for different situations?

- We need commonality and would like the federal regulators to give guidance to the states on what should and shouldn't be included in market conduct exams, state regulatory inquiries, attestations and questionnaires. States are asking for voluminous amounts of information that is taking an inordinate amount of time and much of what is being requested will not help in determining parity compliance.
- States also need to be reminded that we are talking about parity in process, not outcomes and that adverse benefit determinations do not defacto mean noncompliance.
- As stated in I., we would like a distinction between disclosure of compliance versus disclosure under MHPAEA; disclosure of compliance to the public is different than the detailed documentation that federal or state regulators might need to investigate MHPAEA compliance.

IV. What kinds of resources would be most useful?

- More FAQs based on the material we will submit related to I.
- If the regulators identify specific concerns, or best practices, we would like to know about them.
- It would be helpful to have model disclosures.

V. Suggestions for improving current resources including the FAQs and the DOL MHPAEA compliance assistance tool?

- We did not answer this on the call.

