AHIP Comments and Redline Edits

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

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

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

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

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

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

Mental Health and Substance Use Disorder Parity

1. Purpose

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

2. Definitions

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

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

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

Classifications of benefits used for applying parity rules:

(1) **Inpatient, In-network.** Benefits furnished on an inpatient basis and within a network of

[redacted]

requirement or treatment limitation that applies to substantially all

Financial Requirements

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

Standards for
Mental Health and Substance Use Disorder Parity Compliance

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

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

Documents to be Reviewed

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

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

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

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

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

_____ Internal department appeals/grievance files

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

Others Reviewed

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

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

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

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

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

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

Review Procedures and Criteria

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

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

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

The health carrier shall identify how it defines ! ‘ s it &

Standards for
Mental Health and Substance Use Disorder Parity Compliance

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

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

Documents to be Reviewed

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

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

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

Review Procedures and Criteria

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

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

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

The health carrier shall demonstrate that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are cov χ uo p ɹ ɕ Mh

Standards for
Mental Health and Substance Use Disorder Parity Compliance

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

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

Documents to be Reviewed

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

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

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

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

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

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

_____ Health carrier complaint records concerning mental health and/or substance use disorder (supporting documentation, including, but not " en& and oe& re of inquirie, co laints, comsa)nant correspondence and h

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

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Others Review

42 U.S. Code § 300gg–26

Publication of summary plan description

Standards for
Mental Health and Substance Use Disorder Parity Compliance

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

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

Documents to be Reviewed

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

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

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

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

_____ Internal company claim audit reports

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

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

Others Reviewed

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

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

Review Procedures and Criteria

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

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

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

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

Documents to be Reviewed

_____ Documentation, including but not limited to cComparative analyses required under 42 U.S.C. D M-Up r

_____ Claims processor and customer services MHPAEA training materials

_____ Company fraud, waste, and abuse policies and procedures

_____ Internal company claim audit reports

_____ Prescription drug formulary for each product/plan design

_____ Prescription drug utilization management documentation

_____ Fail-first policies or step therapy protocols

_____ Network development/contracting policies and procedures

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

_____ Standards for determining provider reimbursement rates

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

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

ERISA 104(b) (29 U.S.C. § 1024(b))

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

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

Review Procedures and Criteria

The health carrier shall perform and document comparative analyses demonstrating that

Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination;

4. To the extent the health carrier defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise

Standards for
Mental Health and Substance Use Disorder Parity Compliance

Standard 6 **The health carrier shall ensure that it complies with all availability of plan information and related disclosure obligations regarding: 1) criteria for medical necessity determinations; 2) reasons for denial of services; 3)**

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

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

The health carrier shall demonstrate its method for responding to requests for all documents,

Standard 7