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

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

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

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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 providers established or recognized under a plan or health insurance coverage (45 CFR § 146.136(c)(2)(ii)(A)(1)). See special rule for plans with multiple network tiers in paragraph (c)(3)(iii)(B) of 45 CFR§146.136.

a. If a plan provides benefits through multiple tiers of in-network providers (such a (o)-13 29 (a)-1Tc 0.011

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Coverage Unit refers to the way in which a plan (or health insurance coverage) groups individuals for

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

Review Procedures and Criteria

STANDARDS
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

Priority: Recommended

Documents to be Reviewed

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

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

_____ Documentation as to how the carrier demonstrates assignment to the six classifications of benefits (and

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STANDARDS
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

Priority: Recommended

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 fil11.684 38tnd3 t _____

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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

Review Procedures and Criteria

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

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Review Procedures and Criteria

QTLs include annual, episode, and lifetime day and visit limits. (45 CFR § 146.136(c)(1)(ii)). A QTL is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/ surgical benefits in that classification (45 CFR § 146.136(c)(3)(i)(A)). The level of the QTL that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the QTL (45 CFR

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STANDARDS

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shall include the following, for each NQTL applied to mental health or substance use disorder benefits, separately for each classification of benefits (42 U.S.C. § 300gg-26(a)(8)(A):

- The specific coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which such NQTL applies in each respective benefits classification;
- The factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits;
- The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits;
- The comparative analyses demonstrating that the procn35cTJ04sn5d3(ct)-2.6 (o)1d( )TjEMC /Lt.6 (v)2 (at)8.2 (i

Review the health carrier's letters providing the reason for any denial of reimbursement for mental health or substance use disorder benefits and verify that the letters are dated within 30 days of the request (45 CFR § 146.136(d)(2)).

Review the health carrier's policy & procedure for responding promptly to requests for all documents, records and other information relevant to an adverse benefit determination, including medical necessity criteria and the comparative analysis required under (42 USC 300gg-26(a)(8)(A)), disclosures referenced above (45 CF(in in.6 9 (r)6-

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STANDARDS
Mental Health and Substance Use Disorder Parity Compliance

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

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

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Priority: Recommended

Documents to be Reviewed

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

_____ Policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with MHPAEAD 13 BDC T*Tw 0 -1.1 (oc)9d(l)-4. T*[_____)11 ( )T0.044(AD 13 BDC Tc -0.005 Td[P

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