The Puzzle of Parity: Implementing Behavioral Health Parity

Friday, September 16, 2016

Analyzing Parity Case Studies Panel:

Excerpts of Federal Parity Statutes, Regulations and Guidance[1]

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42 U.S.C. § 300gg-26(a):

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(3) **Financial requirements and treatment limitations.**

(A) **In general.** In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that--

(i) the financial requirements applicable to such mental health or substance use disorder 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 with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder 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 with respect to mental health or substance use disorder benefits.

(B) **Definitions.** In this paragraph:

(i) **Financial requirement.** The term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit . . . .

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[1] *See* conference website for additional parity resource materials. Footnotes have been omitted from these excerpts.

(ii) **Predominant.** A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) **Treatment limitation.** The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) **Availability of plan information.** The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. 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 shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

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45 C.F.R. §§ 146.136

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(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.

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(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.

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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.

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(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.

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U.S. Dep'ts of Treasury, Labor, & Health & Human Servcs., *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Final Rule*, 75 Fed. Reg. 5,410 (Feb. 2, 2010), *available at* https://www.gpo.gov/fdsys/pkg/FR-2010-02-02/pdf/2010-2167.pdf

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The phrase, ''applied no more stringently'' was included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face are applied in the same manner to medical/surgical benefits and to mental health or substance use disorder benefits. Thus, for example, assume a claims administrator has discretion to approve benefits for treatment based on medical necessity. If that discretion is routinely used to approve medical/surgical benefits while denying mental health or substance use disorder benefits and recognized clinically appropriate standards of care do not permit such a difference, the processes used in applying the medical necessity standard are considered to be applied more stringently to mental health or substance use disorder benefits. The use of discretion in this manner violates the parity requirements for nonquantitative treatment limitations.

Different types of illnesses or injuries may require different review, as well as different care. The acute versus chronic nature of a condition, the complexity of it or the treatment involved, and other factors may affect the review. Although the processes, strategies, evidentiary standards, and other factors used in applying these limitations must generally be applied in a comparable manner to all benefits, the mere fact of disparate results does not mean that the treatment limitations do not comply with parity.

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U.S. Dep'ts of Treasury, Labor, & Health & Human Servcs., *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*, 78 Fed. Reg. 68,240 (Nov. 13, 2013), *available at* http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=27169

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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.'' 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 FAQs 18 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.

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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.

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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.

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

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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 user 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.

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U.S. DEP'TS OF LABOR, HEALTH & HUMAN SERVCS., & TREASURY, "FAQs about Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation" (Oct. 23, 2015), *available at* https://www.dol.gov/ebsa/pdf/faq-aca29.pdf

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Q12: I am a participant in a group health plan that provides treatment for anorexia as a mental health benefit. In accordance with the plan terms, my provider, on my behalf, requested prior authorization for a 30-day inpatient stay to treat my anorexia. The request was denied based on the plan's determination that a 30-day inpatient stay is not medically necessary under the plan terms.

I then requested from the plan administrator a copy of its medical necessity criteria for both medical/surgical and MH/SUD benefits (including anorexia), as well as any information regarding the processes, strategies, evidentiary standards, or other factors used in developing the medical necessity criteria and in applying them. May the plan administrator deny me this information based on an assertion that the information is "proprietary" and/or has "commercial value"?

No. The criteria for making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing the underlying NQTL and in applying it, must be disclosed with respect to both MH/SUD benefits and medical/surgical benefits, regardless of any assertions as to the proprietary nature or commercial value of the information.

Whether a plan that is subject to ERISA can refuse to provide "instruments under which the plan is established or operated" on the basis that the information is "proprietary" was specifically addressed in the Department of Labor's Advisory Opinion 96-14A. The Advisory Opinion rejected that basis for refusal. In that Advisory Opinion, the Department of Labor stated that any documents or instruments that specify formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan (in that case, a schedule of a plan's usual and customary fees) would constitute "instruments under which the plan is established or operated," and must be provided, notwithstanding that the plan asserted that such fee schedules are of a " proprietary" nature. Such information must be disclosed, even in cases where the source of the information is a third-party commercial vendor.

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U.S. DEP'TS OF LABOR, HEALTH & HUMAN SERVCS., & TREASURY, "FAQs about Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, and Women's Health and Cancer Rights Act Implementation" (Apr. 20, 2016), *available at* https://www.dol.gov/ebsa/faqs/faq-aca31.html

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Disclosure

The Departments have issued multiple rounds of guidance to address disclosure obligations under MHPAEA and other laws. The MHPAEA final regulations expressly provide that the plan administrator or the health insurance issuer must disclose the criteria for medical necessity determinations with respect to MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request and the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits to the participant or beneficiary. In addition to these disclosure obligations under MHPAEA, 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. If an ERISA plan or administrator fails to provide these documents, a court may hold it liable for up to $110 a day from the date of failure to provide these documents. Instruments under which the plan is established or operated include documents with comparative information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.

The DOL claims procedure regulations, as well as the internal claims and appeals and external review requirement under section 2719 of the PHS Act, which apply to non-grandfathered group health plans and issuers of non-grandfathered group or individual health insurance coverage, 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 comparative information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.

Additionally, employers and issuers sometimes contract with Managed Behavioral Health Organizations (MBHO) or similar entities to provide or administer MH/SUD benefits under the plan or coverage. The preamble to the MHPAEA final regulations clarifies that the coverage as a whole must still comply with the applicable provisions of MHPAEA, and the responsibility for compliance rests with 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 MH/SUD benefits are coordinated with the medical/surgical benefits for purposes of compliance with the requirements of MHPAEA.

Q9: I am a provider acting as an authorized representative for an ERISA group health plan participant. The health plan has requested that I complete a pre-authorization form after the patient's 9th visit for the treatment of depression. I understand that there are a number of documents that plans must provide upon request. Which of those documents would generally be most helpful for me to request regarding the plan's compliance with MHPAEA?

You may request the following documents and plan information, which could be helpful in evaluating the plan's compliance with MHPAEA. While it may not be necessary to review all of the following documents and plan information, the plan must provide any of these documents and plan information to you if requested, when you as a provider are acting as an individual's authorized representative:

1. A Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;

2. The specific plan language regarding the imposition of the NQTL (such as a preauthorization requirement);

3. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit;

4. Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;

5. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and

6. Any analyses performed by the plan as to how the NQTL complies with MHPAEA.

For example, if the plan can demonstrate that it imposes pre-authorization requirements for both MH/SUD and medical/surgical benefits in the outpatient, in-network classification when the length of treatment for a condition exceeds the national average length of treatment by 10% or more, it has identified a factor on which the NQTL is based. Furthermore, to the extent the plan can document, via studies, schedules or similar documents that contain relevant information or data, that the national average length of outpatient treatment for depression is eight visits, it has identified an evidentiary standard used to evaluate the factor. Finally, by applying the eight visit

standard to the case at hand, it demonstrates how the evidentiary standard is applied and the result.

Accordingly, to be in compliance with the MHPAEA and ERISA disclosure requirements, the plan must furnish to the provider sufficient documentation of the NQTL factor, evidentiary standard and the analysis outlined above. Additionally, it must produce documentation of how the factor, evidentiary standard and analysis is applied in the outpatient, in-network classification for medical/surgical benefits to demonstrate that the NQTL is not being applied to MH/SUD benefits more stringently than to medical/surgical benefits in the classification. As the Departments indicated in prior guidance, the fact that any information (including factors and evidentiary standards used for medical/surgical benefits) may be characterized as proprietary or commercially valuable is not legitimate grounds for not providing the information.

The information outlined in 1-6 above must also be provided by non-grandfathered health plans under PHS Act section 2719 in instances of internal claims and appeals related to the application of an NQTL to a MH/SUD benefit.

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