

A Newton's cradle with five silver spheres is shown in the background, with the spheres slightly out of focus. The image is set against a light gray background.

Employer Guide for Compliance with the Mental Health Parity and Addiction Equity Act

Developed by Milliman, Inc. in
conjunction with the Partnership for
Workplace Mental Health

The logo for the Partnership for Workplace Mental Health features a stylized white wave or swoosh above the text.

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Employer Guide for Compliance with the Mental Health Parity and Addiction Equity Act

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Preface

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)¹ requires group health plans, health insurance issuers, and individual health insurance plans to have parity between mental health and substance use disorder (MH/SUD) benefits and medical/surgical benefits with respect to financial requirements and treatment limitations. This law and its implementing regulations, the Final Rules,² are very detailed and contain many complex concepts that may be difficult to implement. However, despite the law's complexities, covered health plans are required to comply with the law and its implementing regulations or face penalties for noncompliance.

This Guide was developed to provide a reference for employers who offer MH/SUD benefits as part of their health plans, informing them of certain key requirements of MHPAEA, the Final Rules, and other federal guidance provided to the industry and offering them a reasonable approach to MHPAEA compliance. It presumes a basic familiarity with the law and regulations and directs the reader to sources where more detailed information can be obtained and reviewed. (See Endnotes as appropriate.) It is our hope that this Guide will aid the reader in understanding the parity requirements and how to assess compliance with the parity tests and standards embedded in the law and regulations.

This Guide was prepared by Milliman, Inc. (Milliman), at the request of the Partnership for Workplace Mental Health (the Partnership), a subsidiary of the American Psychiatric Association (APA).

Milliman, Inc.

Known for its technical and business acumen, Milliman provides expert consultation on both the financing and delivery of healthcare. Milliman's clients include most of the leading health insurers, including Blue Cross plans and HMOs, as well as providers, employers and sponsors, government policymakers, pharmaceutical companies, and foundations. Milliman consultants include actuaries, clinicians, and information-technology specialists—offering a diversity of experience to help organizations cost-effectively manage their businesses without compromising quality of care. Milliman has more health insurance actuaries (220) who are members of the Society of Actuaries than any other consulting firm in the United States. Its actuaries have worked extensively in the area of behavioral healthcare and have significant experience in evaluating MHPAEA compliance.

The Partnership for Workplace Mental Health

The Partnership for Workplace Mental Health works with businesses to ensure that employees and their families living with mental illness, including substance use disorders, receive effective care. It does so with the recognition that employers purchase healthcare for millions of American workers and their families. The Partnership promotes the business case for quality mental healthcare, including early recognition, access to care, and effective treatment. The Partnership also identifies and highlights the successful approaches employers are already taking to address mental health. The Partnership's network includes more than 5,000 employers and related purchasing stakeholders. For more information, see www.workplacementalhealth.org.

Milliman and the Partnership, along with the APA are working to provide employers and the industry with the benefit of our collective knowledge and experience in implementing MHPAEA. As developments warrant, we will provide updates to this Guide. Any questions or comments about this Guide are welcome and should be directed to Clare Miller at the Partnership (cmiller@psych.org).

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Introduction: MHPAEA, the Final Rules, and Supporting Guidance

MHPAEA prohibits covered health plans³ that offer MH/SUD benefits from imposing financial requirements or treatment limitations on those benefits that are more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits covered by the health plan. MHPAEA also prohibits separate financial requirements or treatment limitations applicable only to MH/SUD benefits.⁴ MHPAEA was passed into law on October 3, 2008, with a general effective date for plan years beginning on or after October 3, 2009. Noncompliance with the requirements of MHPAEA poses a significant financial risk for employers. Penalties can be as high as \$100 per member per day of noncompliance.

On November 8, 2013, the Final Rules under MHPAEA were published by its sponsoring departments, the Department of Labor (DOL), the Department of the Treasury (Treasury), and the Department of Health and Human Services (DHHS) [DOL, Treasury, and DHHS are collectively, the Departments] and became generally applicable on or after July 1, 2014. Before this time, plans and issuers had to comply with the Departments' Interim Final Rules (IFR).⁵ Both MHPAEA and its Final Rules are referred to collectively hereinafter in this Guide as "MHPAEA."

The Final Rules incorporate important clarifications made by the Departments since the enactment of MHPAEA through subregulatory guidance and provide new guidance on issues such as how to perform testing of nonquantitative treatment limitations (NQTLs), disclosure of plan information, testing of tiered networks, and scope of services. The Final Rules also implement the provisions of MHPAEA for individual health insurance coverage and non-grandfathered plans in the individual and small-group markets that are required by the Patient Protection and Affordable Care Act (ACA) to provide Essential Health Benefits (EHBs).⁶ Prior to the ACA, MHPAEA applied only to group health plans and group health insurance coverage.

The DOL's Employee Benefits Security Administration (EBSA) has issued a series of Frequently Asked Questions (FAQs) about MHPAEA implementation, providing relevant information on the Final Rules and how they are to be interpreted and applied.⁷ The EBSA has also provided the *Self-Compliance Tool for Part 7 of ERISA: HIPAA and Other Health Care-Related Provisions* (Self-Compliance Tool),⁸ which is also a reference and meant to assist the reader in determining whether a health plan is in compliance with certain provisions of Part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), including the Health Insurance Portability and Accountability Act (HIPAA). These FAQs and the Self-Compliance Tool provide additional and important guidance for employers beyond the law and the regulations.

It should be noted that URAC (formerly the Utilization Review Accreditation Committee) has published compliance standards for health plans with respect to MHPAEA that are discussed in this Guide.⁹ URAC's standards require that health plans document their basis for compliance with MHPAEA. URAC also includes important standards for consumer and employer plan information disclosure. At this time, URAC is reviewing its standards in light of the issuance of the Final Rules by the Departments and may make changes to their standards. This Guide will be revised to reflect any changes to the URAC standards when they are issued.

Purpose of This Guide

Milliman has found that many employers have limited knowledge of the details of MHPAEA requirements, even though it is the employer who is liable for noncompliance and subject to potentially significant penalties. The primary purpose of this Guide is to provide employers with the benefit of our collective experience in evaluating MHPAEA and our advice on its implementation so they have a resource to assist them in determining whether their health plans comply with important aspects of the law and its rules. This Guide is based on the many questions Milliman has received while working with insurers and employers regarding MHPAEA compliance. It is intended for employers to use as an explanatory guide and supplement to the Final Rules, FAQs, and the Self-Compliance Tool and highlights certain pertinent standards promulgated by URAC.

The law and the Final Rules contain parity tests that assist the employer in determining their plan's compliance. However, these tests are not safe harbors that an employer can use to ensure compliance. The outcome of the tests depends heavily on the facts and circumstances at hand. It is helpful when performing these tests to look at all of the guidance provided by the Departments to see how the Departments view certain plan requirements or limitations, but the ultimate result of a compliance analysis will be dependent on the facts concerning and surrounding the actual health plan policy requirements, processes, and standards.

This Guide provides a series of questions that an employer should ask in connection with compliance testing. The health plan, or whichever entity performs MHPAEA compliance testing for its health plan (e.g., a contractor to the health plan, such as a managed behavioral carveout), can also use the questions set forth in this Guide to assist in a thorough assessment of the health plan's compliance.

It is important that employers ensure that their health plans keep a detailed, written record of each MHPAEA compliance test and that this record be available for the employer to review as needed. A more detailed analysis and a more comprehensive rationale to explain any differences in the treatment of benefits offered increases the likelihood that a plan will be found MHPAEA compliant if challenged. Furthermore, it may be necessary for a plan to repeat certain recommended MHPAEA compliance analyses if there is a change in plan benefit design, cost-sharing structure, or utilization that would affect financial requirements or treatment limitations within a classification or sub-classification of benefits that could, in turn, affect the results of the applicable parity tests described herein.¹⁰

This Guide and its suggested approach to compliance review can be used not only by employers but also by appropriate state agencies, such as departments of insurance or state attorneys general, for their reviews of MHPAEA compliance with regard to health plans, or by any other entity that is charged with assuring compliance with aspects of the law (e.g., external review entities).

There are five parts to this Guide:

Part 1: Determining Classifications of Benefits and Coverage Requirements (Including Scope of Service Considerations)

Part 2: Complying with Parity Standards Regarding Financial Requirements and Quantitative Treatment Limitations

Part 3: Complying with Parity Standards Regarding Nonquantitative Treatment Limitations

Part 4: Other Issues Related to MHPAEA and the Final Rules

Part 5: URAC Standards Requiring Documentation of Compliance with MHPAEA

Limitations of This Guide

MHPAEA and its rules are very detailed and complex. We have done our best to simplify this subject matter and to provide an interpretation of MHPAEA that is consistent with the intent and letter of the law. This Guide was written based on our best understanding of the provisions of MHPAEA (as of our date of publication) and our projection as to how they will be enforced by the applicable Departments and state agencies. Because the Final Rules have been in effect for less than one year, there is still some uncertainty as to how the Departments, applicable state agencies, and courts will interpret some of its provisions.

This Guide is not a substitute for, is not designed to provide, and does not provide legal advice. The authors shall not be liable to users or any third party if readers of this Guide disregard professional legal advice, or delay in seeking such advice, because of something they have read in this Guide. The authors shall not be liable to the reader or to any third party if readers rely on information in this Guide in place of seeking professional and/or legal advice or conducting their own legal research. RELIANCE ON ANY INFORMATION CONTAINED IN THIS GUIDE IS SOLELY AT THE READER’S OR USER’S OWN RISK.

PART 1: DETERMINING CLASSIFICATIONS OF BENEFITS AND COVERAGE REQUIREMENTS (INCLUDING SCOPE OF SERVICE CONSIDERATIONS)

MHPAEA and the Final Rules set forth a general parity requirement, which prohibits health plans and health insurance issuers from: (a) applying any financial requirement or treatment limitation to MH/SUD benefits in any benefits classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same benefits classification; and (b) imposing separate financial requirements or treatment limitations that are applicable only with respect to MH/SUD benefits.¹¹ Based on this general requirement and as described in more detail later, the Final Rules provide specific rules for determining benefits classifications that must be analyzed in order to: (1) determine appropriate MH/SUD benefits coverage requirements;¹² and (2) apply the general requirement and other parity standards to financial requirements and treatment limitations (both quantitative and nonquantitative).¹³

Classification of Benefits

Health plans vary financial requirements and treatment limitations imposed on benefits on the basis of whether a treatment is provided on an inpatient, outpatient, or emergency basis; whether a provider is a member of the plan's network; or whether the benefit is for a prescription drug. Therefore, to apply MHPAEA's parity standards with respect to financial requirements and treatment limitations (whether quantitative or nonquantitative), the Final Rules establish six benefits classifications, as follows:

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network
4. Outpatient, Out-of-Network
5. Emergency Care
6. Pharmacy¹⁴

According to the Final Rules, the parity standards for financial requirements and treatment limitations are applied on a classification-by-classification basis and, with the exception of certain permissible sub-classifications, these classifications are the only classifications permitted for purposes of satisfying MHPAEA.

The Final Rules do not provide definitions for these benefits classifications, but they do note that the terms (e.g., inpatient, in-network or outpatient, out-of-network) are subject to plan design, and the meanings may differ from plan to plan. Nevertheless, health plans must apply definitions for benefits classifications in a uniform manner to both MH/SUD and medical/surgical benefits.¹⁵

Similarly, the Final Rules do not define the scope of services to be covered within the six classifications of benefits, but they do require that health plans assign MH/SUD benefits and medical/surgical benefits to each classification in a consistent manner.¹⁶ For example, plans must "assign covered intermediate [MH/SUD] benefits to the existing six benefits classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications."¹⁷

Therefore, while there is no requirement to provide any one service within a benefits classification, if a health plan provides MH/SUD benefits, it must assign comparable MH/SUD benefits to classifications in which it has provided medical/surgical services. By way of example, if a plan classifies inpatient care in non-hospital facilities (e.g., skilled nursing facilities or rehabilitation hospitals) as inpatient benefits, the plan must also classify inpatient care in non-hospital facilities (e.g., residential treatment facilities) for MH/SUD benefits as inpatient benefits.¹⁸ Also by way of example, if a plan treats home healthcare as an outpatient benefit, then the plan must cover intensive outpatient MH/SUD services and partial hospitalization as an outpatient benefit.¹⁹

It is essential to note that, by virtue of the parity tests for NQTLs in Part 3, plans are required to have comparability of facility types and levels of care between the medical/surgical benefits covered and those covered for MH/SUD benefits. See specifically Part 3, Illustration H.

The Final Rules provide examples of this analysis to illustrate permissible and impermissible arrangements regarding the classification of benefits as follows:

1. A group health plan offers inpatient and outpatient benefits, does not contract with network providers, and imposes the following: (1) a \$500 deductible on all benefits, (2) a coinsurance amount for inpatient medical/surgical benefits, (3) copayments for outpatient medical/surgical benefits, and (4) no other financial requirements or treatment limitations. Since the plan has no provider network, all benefits are considered out-of-network benefits. Because inpatient, out-of-network medical/surgical benefits and outpatient, out-of-network medical/surgical benefits are subject to separate financial requirements, the parity rules apply separately with respect to any financial requirement or treatment limitation in each classification.²⁰
2. A group health plan imposes a \$500 deductible and 20% coinsurance requirement on all benefits, has no provider network, and imposes no other financial requirements or treatment limitations. Because the plan does not impose separate financial requirements or treatment limitations based on classification, the parity rules apply with respect to the deductible and coinsurance requirements across all of the benefits.²¹
3. A group health plan has no provider network and imposes a \$500 deductible on all benefits and a 20% coinsurance requirement on all benefits (except for emergency care benefits). The plan imposes no other financial requirements or treatment limitations. Because the plan imposes separate financial requirements based on classifications, the parity rules apply with respect to the deductible and coinsurance separately for benefits in the emergency care classification and all other benefits.²²
4. A group health plan imposes a \$500 deductible and 20% coinsurance requirement on all benefits and has no provider network. The plan imposes a preauthorization requirement for all inpatient treatments, but not for outpatient treatments. Because the plan has no provider network, all benefits provided by the plan are out-of-network. Because the plan imposes separate treatment limitations

based on classifications, the parity rules apply with respect to the deductible and coinsurance separately for inpatient, out-of-network benefits and all other benefits.²³

Medical/Surgical Versus MH/SUD Benefits

A determination of whether a benefit is a medical/surgical benefit as opposed to an MH/SUD benefit depends on the definitions of the same under the Final Rules.²⁴ According to the Final Rules, medical/surgical benefits are benefits with respect to items or services for medical or surgical conditions (as defined under the terms of the health plan and in accordance with applicable federal and state laws) and do not include MH/SUD services.²⁵ MH/SUD benefits, on the other hand, are benefits with respect to items or services for mental health conditions and substance abuse disorders (as defined under the terms of the health plan and in accordance with applicable federal and state laws).²⁶ Health plan terms that define whether the benefits are medical/surgical or MH/SUD must be consistent with “generally recognized independent standards of current medical practice.”²⁷ Generally recognized independent standards of current medical practice include the most current version of the *International Classification of Diseases (ICD)*, *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or applicable state guidelines.²⁸ Health plans, therefore, must classify a benefit as a medical/surgical or MH/SUD benefit using the definitions provided in the Federal Rules. These definitions are intended to prevent a health plan or health insurance issuer from classifying an MH/SUD condition as a medical/surgical condition and avoiding the parity tests described herein.

Permissible Sub-classifications

Even though the Final Rules state that there are only six classifications of benefits for the purposes of applying the parity tests, the Final Rules specifically permit three sub-classifications that were established to accommodate certain features of plan designs.²⁹ Once a sub-classification is established by a health plan, it must perform the appropriate parity analysis within the sub-classification to determine its compliance with MHPAEA (i.e., the “predominant” and “substantially all” tests for financial requirements and quantitative treatment limitations (QTLs) or the “stringency” and “comparability” tests for NQTLs discussed later in more detail).³⁰

The permissible sub-classifications established by the Final Rules are as follows:

Multi-tiered prescription drug benefits

A health plan may divide its benefits to address multiple tiers of prescription drug benefits. If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors, the plan satisfies the parity requirements with respect to prescription drug benefits.³¹ The reasonable factors used to determine the levels of financial requirements must be determined in accordance with the parity rules relating to NQTLs and must not take into consideration whether the drug is generally prescribed with respect to medical/surgical benefits or

MH/SUD benefits.³² They include cost, efficacy, generic versus brand name, and mail order versus retail pharmacy pick-up.³³

A permissible example of this type of sub-classification would be where a health plan applies certain financial requirements for prescription drug benefits based on certain tiers (e.g., generic drugs, preferred brand name drugs, non-preferred brand name drugs, and specialty drugs).³⁴ In this permissible example, the financial requirements would be applied without regard to whether the drug was prescribed with respect to medical/surgical or MH/SUD benefits, and the process of certifying the drugs as generic, preferred name brand, non-preferred name brand, or specialty complies with the parity tests related to NQTLs, described in more detail in Part 3.

Multiple network tiers

Health plans may also create a sub-classification to address plan designs that have two or more network tiers of providers within the inpatient, in-network or outpatient, in-network classifications.³⁵ These tiered networks are an important tool for plans to control costs and manage the quality of care.³⁶ Therefore, by way of example, if a health plan provides in-network benefits through multiple tiers of network providers, the plan may divide its benefits furnished on an in-network basis into sub-classifications that reflect the network tiers, as long as tiering is based on reasonable factors and without regard to whether the provider is an MH/SUD provider or a medical/surgical provider.³⁷

After a plan forms a sub-classification for network tiers, it may not impose financial requirements or QTLs on MH/SUD benefits in any sub-classification that are more restrictive than the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits in the sub-classification.³⁸ See Part 2 and Part 3 for detailed information on the parity tests for financial requirements and treatment limitations.

A permissible illustration of the use of this type of sub-classification would be the imposition of a preferred provider tier and a participating provider tier, where providers are placed in a tier based on reasonable factors which meet the parity tests related to NQTLs described in Part 3 (e.g., accreditation; quality and performance measures, including customer feedback; and relative reimbursement rates).³⁹ In addition, in this permissible illustration, provider tier placement would be determined without regard to the provider's specialty (i.e., MH/SUD or medical/surgical). Finally, the plan would not impose any financial requirement or treatment limitation (whether QTL or NQTL) on MH/SUD benefits in either sub-classification that violates the applicable parity tests as described in Parts 2 and 3 of this Guide.⁴⁰

Office visits, separate from other outpatient services

For purposes of applying the parity tests with regard to financial requirements and QTLs described in Part 2, a health plan may also divide its benefits furnished on an outpatient basis (i.e., outpatient, in-network and outpatient, out-of-network) into two sub-classifications: office visits and all other outpatient items and services.⁴¹ In addition to this permissible sub-classification, a plan must not use

any other sub-classifications for purposes of determining parity. For example, a plan may not create separate sub-classifications for generalists and specialists.⁴² After a health plan forms the sub-classifications, it may not impose financial requirements or QTLs on MH/SUD benefits in either sub-classification (i.e., office visits or non-office visits) that do not meet the appropriate parity tests described in Part 2.

A permissible example of the use of these sub-classifications would be the imposition by the health plan of a \$25 copayment for office visits and a 20% coinsurance requirement for outpatient surgery, and the health plan does not impose a financial requirement or QTL on MH/SUD benefits in either sub-classification that is more restrictive than the predominant financial requirement or QTL that applies to substantially all medical/surgical benefits in each sub-classification.⁴³

Benefits Coverage/Scope of Services

Employers can ensure that they meet the parity requirements for financial requirements and treatment limitations if they design all of their MH/SUD benefits to be at least as rich as the richest medical/surgical benefit in each benefits classification. Additionally, MHPAEA compliance can be guaranteed by providing 100% benefit coverage without limits for all MH/SUD benefits in each classification.

Notwithstanding the foregoing, MHPAEA does not require a health plan to provide MH/SUD benefits at all. However, if the health plan does provide benefits coverage for an MH/SUD in one classification, it must also provide coverage in other classifications if a corresponding medical/surgical benefit exists in that classification.⁴⁴ For example, if coverage for MH/SUDs is provided in the outpatient, in-network classification, it cannot offer medical/surgical coverage for the inpatient, in-network classification and not provide coverage for inpatient, in-network MH/SUD care.

There is nothing in MHPAEA or the Final Rules that specifically sets forth the scope of services (i.e., types of treatment or treatment settings) that must be covered by a health plan within each benefits classification.⁴⁵ However, the Final Rules do clarify that geographic location, facility type, provider specialty, and any other criteria that limit the scope or duration of benefits for services are illustrations of nonquantitative treatment limitations and must comply with the applicable parity tests of comparability and stringency under the Final Rules.⁴⁶ For a discussion of these tests, please see Part 3. As a result, while the Final Rules do not require the provision of specific services to be covered by a health plan, they do provide guidance on the type of services to be provided, and compliance requires comparability between the types of services to be provided for medical/surgical and MH/SUD services (if they are covered). For example, if a health plan provides nonhospital inpatient benefits for medical/surgical services (e.g., nursing facilities), it cannot unconditionally exclude all types of nonhospital inpatient MH/SUD benefits.⁴⁷ Plans can decide how they want to classify nonhospital inpatient medical/surgical services, and the similar services for MH/SUD would have to be classified similarly.

Questions for Analysis of Benefits Classifications, Benefits Coverage, and Scope of Services

What follows are key questions regarding the requirements with regard to benefits coverage and scope of services to ask the person(s)/entity(ies) performing MHPAEA compliance testing. While the Final Rules do

not address the services required to be provided by a plan, these questions can help in the evaluation of whether a plan complies with the requirement to comparably cover MH/SUD services in each classification (or sub-classification) where medical/surgical benefits are covered.

1. How does the health plan determine the required types and levels of treatment services for MH/SUD benefits for each benefits classification, including any permissible sub-classifications, under the Final Rules?
2. How was it determined that benefits are provided for covered MH/SUDs in every benefits classification in which medical/surgical benefits are provided, including in-network and out-of network benefits?
3. Were there any differences in how MH/SUD treatment types or levels of care were defined within any benefit classification as compared to medical/surgical treatment types or levels of care? Since many health plans use different definitions for treatment programs for medical/surgical benefits as opposed to MH/SUD benefits, the following link provides additional useful information for defining and comparing similar levels and types of service definitions and benefit options between MH/SUD services and medical/surgical services: <http://www.workplacementalhealth.org/scopeofservices>.
4. Does the health plan cover different types of inpatient, nonhospital settings for medical/surgical conditions, like sub-acute, nonhospital, 24-hour, inpatient services (intermediate care facilities), but exclude coverage for sub-acute, nonhospital, 24-hour, inpatient residential treatment services for MH/SUDs?
5. Were there any treatment types and/or levels of care that have been offered for medical/surgical conditions but were excluded for MH/SUDs? For example, is a range of diagnostic lab tests covered for medical/surgical benefits but not for MH/SUD benefits?
6. Does the health plan offer coverage for specialty medical/surgical hospitals (that are not part of a general hospital) but exclude coverage for MH/SUD specialty inpatient programs (that are not part of a general hospital)?
7. If emergency benefits varied between in-network versus out-of-network providers, how was this handled in the compliance testing?
8. Do the final benefits determinations for each class comport with the parity tests for nonquantitative treatment limitations?

PART 2: COMPLYING WITH PARITY STANDARDS REGARDING FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

As stated earlier, MHPAEA and the Final Rules set forth a general parity requirement that prohibits health plans and health insurance issuers from (a) applying any financial requirement or treatment limitation to MH/SUD benefits in any benefits classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same benefits classification; and (b) imposing separate financial requirements or treatment limitations that are applicable only with respect to MH/SUD benefits. The Final Rules address the application of this general parity requirement to financial requirements and QTLs.⁴⁸

In order to determine compliance of a financial requirement or QTL with the general parity rule, a health plan must first divide benefits into the six benefits classifications (and permissible sub-classifications as appropriate), as discussed earlier in Part 1 of this Guide. Then, the health plan must determine if the applicable financial requirement or QTL applies only to MH/SUD benefits and not to medical/surgical benefits for each benefits classification. If the applicable financial requirement or QTL only applies to MH/SUD benefits, the financial requirement or QTL is a separate treatment limitation and, by virtue of the statute, its application to MH/SUD benefits is prohibited.⁴⁹ On the other hand, if the financial requirement or QTL applies to both MH/SUD benefits and medical/surgical benefits, then the health plan must determine if the applicable financial requirement or QTL meets the “predominant” and “substantially all” tests.⁵⁰ The details of this testing are set forth in the following text.

Key Terms

The Final Rules define certain key terms that are important to understand when performing the parity tests. Some of these key terms are as follows:

Financial Requirements, QTLs, NQTLs

The Final Rules include and define key concepts fundamental to MHPAEA compliance: financial requirements and two types of treatment limitations, quantitative and nonquantitative. Financial requirements are defined in the Final Rules as aspects of the plan design that outline cost sharing between the plan and the enrollee (including copays, coinsurance, deductibles, and out-of-pocket limits).⁵¹ Treatment limitations, on the other hand, can be quantitative or nonquantitative. QTLs are defined to include treatment limitations that are expressed numerically, such as calendar-year limits on the number of office visits or inpatient days, or lifetime limits on the coverage of benefits.⁵² NQTLs are treatment limitations that are not necessarily numerically expressed. NQTLs are further defined and explained in Part 3 of this Guide.

Type

The term *type* refers to financial requirements and treatment limitations of the same nature (e.g., copayments, coinsurance, annual visit limits, and episode visit limits).⁵³ Plans usually apply more

than one financial requirement or treatment limitation to benefits. For the purposes of applying the parity requirements, each financial requirement or treatment limitation must be compared only to financial requirements or treatment limitations of the same type within a classification. By way of example, copayments can *only* be compared to other copayments, and copayments *cannot* be compared to visit limitations or coinsurance amounts.⁵⁴

Level

It is typical for plans to vary financial requirements or treatment limitations in terms of magnitude.⁵⁵ Per the Final Rules, a *level* of a financial requirement or treatment limitation refers to the magnitude of the financial requirement or treatment limitation. A dollar amount, percentage, number of days, or visit amount is the level of an applicable financial requirement or treatment limitation.⁵⁶ For example, different levels of copayments would be \$10 and \$20.

Coverage Unit

The term *coverage unit* refers to the way a plan groups individuals for the purpose of determining benefits, premiums, or contributions.⁵⁷ Plans usually distinguish between coverage for a single participant, a participant plus spouse, or a family. The Final Rules state that if a plan provides benefits for more than one coverage unit and applies different levels of financial requirements or QTLs to coverage units within a classification, then the health plan must apply the parity requirements to the applicable financial requirement or QTL for each coverage unit separately.⁵⁸ For example, if a health plan has different copayments for participant-only and family coverage units, then the health plan must determine the “predominant” level of the copayment for employee-only and for family coverage units separately. See upcoming text for information on determining the “predominant” level.

Measuring Plan Benefits

If a health plan provides benefits in a benefits classification and imposes a financial requirement or QTL on benefits in that benefits classification, the general parity rule related to financial requirements and QTLs applies. The Final Rules require that, in order to determine compliance with the general parity rule, each financial requirement or QTL within a coverage unit must be analyzed separately within each benefits classification.⁵⁹

The Final Rules also state that the portion of plan payments subject to a financial requirement or QTLs (or subject to any level of a financial requirement or QTL) 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.⁶⁰ A health plan can use any reasonable method to determine this dollar amount.⁶¹ Plan benefits are to be measured based on the amount the plan allows (before enrollee cost sharing) rather than on the amount the plan pays, because the payment based on the allowed amount covers the full scope of the benefit.⁶²

The following are key questions regarding these benefits classifications requirements to ask the person(s)/entity(ies) performing MHPAEA compliance testing:

1. When the plan was tested, was it tested at the coverage unit level (participant-only, participant plus spouse, family, etc.)?
2. How were detailed medical/surgical benefits costs divided into each of the six benefits classifications?
3. Were healthcare costs considered on a paid-dollar basis or on an allowed-dollar basis?
4. Did the plan develop healthcare costs for each classification in total or for different services categories within each classification?
5. What percentages of medical/surgical benefits within each benefits classification are subject to each type of financial requirement or QTL for each benefit design tested?
6. If a plan's in-network benefits have different cost sharing for a subset of in-network providers, how was this handled in the testing? Were the permissible sub-classifications used for outpatient benefits? If so, how were MH/SUD benefits and medical/surgical benefits classified into these sub-classifications?

Applying the General Parity Rule for Financial Requirements and QTLs

Once the benefits are separated into the six benefits classifications and it is determined that there is a financial requirement or QTL that applies within a benefits classification, the health plan must first determine if the financial requirement or QTL applies only to MH/SUD benefits. If that is the case, the analysis ends, because a financial requirement or treatment limitation that only applies to MH/SUD benefits is a separate treatment limitation and violates MHPAEA.

If the financial requirement or QTL applies to both MH/SUD and medical/surgical benefits, the health plan must determine if the financial requirement or QTL applies to “substantially all” of the medical/surgical benefits within the same classification.⁶³ A financial requirement or QTL is considered to apply to substantially all medical/surgical benefits in a benefits classification if it applies to at least two-thirds of all medical/surgical benefits in that classification. As discussed earlier, this two-thirds rule is to be calculated using a reasonable method and should be based on the dollar amount of plan payments for the year.

If a type of financial requirement or QTL does not apply to substantially all of the medical/surgical benefits in that benefits classification, that type of financial requirement or QTL cannot be applied to the MH/SUD benefits in that classification.

If the type of financial requirement or QTL does apply to substantially all of the medical/surgical benefits in that classification, then the health plan must apply the “predominant” test.⁶⁴ In other words, the health plan must determine the level of the type of financial requirement or QTL that is the “predominant” level in a classification of benefits. The “predominant” level means that the financial requirement or QTL applies to more than half of the medical/surgical benefits in that benefits classification based on plan costs.

If a single level of a type of financial requirement or QTL applies to more than one-half of the medical/surgical benefits subject to the financial requirement or QTL within a benefits classification (based on plan costs), it is the “predominant” level and the health plan cannot apply that financial requirement or QTL to MH/SUD benefits at a level that is more restrictive.⁶⁵ By way of illustration, if there is a copayment requirement of 20% that applies to more than one-half of all outpatient services, then the plan cannot impose a greater copayment requirement for MH/SUD outpatient services.

However, if there is no one level that applies to more than half of the medical/surgical benefits subject to the financial requirement or QTL in a benefits classification, the health plan can combine levels (starting with the most restrictive level and then combining with the next most restrictive level) until the combination of levels applies to more than half of medical/surgical benefits subject to the financial requirement or QTL in the classification and be in compliance with the general parity rule as long as it does not apply the financial requirement or QTL to MH/SUD benefits at a level that is more restrictive than the least restrictive medical/surgical level within the combination.⁶⁶

The Final Rules provide examples of this analysis to illustrate permissible and impermissible arrangements as follows:

- A group health plan imposes five levels of coinsurance for inpatient, out-of-network medical/surgical benefits. The plan uses a reasonable method to project its payments for the 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% (100x/800x)	56.25% (450x/800x)	12.5% (100x/800x)	18.75% (150x/800x)	

The group health plan projects plan costs of \$800x (i.e., \$100x + \$450x + \$100x + \$150x) to be subject to coinsurance. Eighty percent (or \$800x/\$1,000x) of the benefits are subject to coinsurance, and 56.25% of the benefits subject to coinsurance are projected to be subject to the 15% coinsurance level. In this example, the “substantially all” test is met, because 80% of all inpatient, out-of-network medical/surgical benefits are subject to the coinsurance requirement.

Fifteen percent coinsurance is the “predominant” level, because it is applicable to 56.25% (i.e., more than one-half) of inpatient, out-of-network medical/surgical benefits that are subject to the requirement. Therefore, the plan cannot impose a level of coinsurance for inpatient, out-of-network MH/SUD benefits that is greater than the 15% level of coinsurance.⁶⁷

- A group health plan imposes five levels of copayments for outpatient, in-network medical/surgical benefits. The plan uses a reasonable method to project its payments for the 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% (200x/800x)	25% (200x/800x)	37.5% (300x/800x)	12.5% (100x/800x)	

The group health plan projects plan costs of \$800x (i.e., \$200x + \$200x + \$300x + \$100x) to be subject to copayments. Eighty percent (or \$800x/\$1,000x) of the benefits are subject to a copayment. In this example, the “substantially all” test is met, because 80% of all outpatient, in-network medical/surgical benefits are subject to a copayment. Also, looking at the percent subject to copayments, there is no single level that applies to more than half of medical/surgical benefits in a classification subject to a copayment. The plan can combine any level of copayment to determine the “predominant” level that can be applied to MH or SUD benefits. If the plan combines the highest two copayment levels (i.e., the \$50 copayment and the \$20 copayment), the combination is exactly one-half of the outpatient, in-network medical/surgical benefit (\$300x + \$100x = \$400x; \$400x/\$800x = 50%), but not more than one-half. The combined projected payments for the three highest copayment levels (i.e., \$50 copayment, \$20 copayment, and \$15 copayment) are equal to more than half of the outpatient, in-network medical/surgical benefits subject to the copayments (\$600x/\$800x = 75%). Thus, the plan may not impose any copayment on outpatient, in-network MH/SUD benefits that is more restrictive than the least restrictive copayment in the combination, the \$15 copayment.⁶⁸

- A group health plan has a \$250 deductible on all medical/surgical benefits for self-only coverage, a \$500 deductible for medical/surgical benefits for family coverage, and a coinsurance requirement for all medical/surgical benefits. The plan has no network of providers and no other financial requirements or treatment limitations. Because there is no provider network, all benefits are out-

of-network benefits. To determine whether the deductible meets the “substantially all” test of the general parity rule, the plan must look at the self-only medical/surgical benefits and the family coverage medical/surgical benefits separately and apply the general parity test to the deductible for each coverage unit. Because the coinsurance requirement is applied to all medical/surgical benefits, the coverage unit is not regarded when determining the “predominant” coinsurance level that applies to substantially all of the medical/surgical benefits.⁶⁹

It should be noted that there is sometimes confusion as to what level of copayment is acceptable under the law and Final Rules, because MH/SUD providers are often considered specialists by health plans. Regardless of how they are regarded, what copayment or coinsurance amount complies with MHPAEA depends on the outcome of the application of the general parity rule. Depending on actual data, the correct copayment or coinsurance amount for MH/SUD services may be the primary care copayment. In other cases, the correct copayment may be the same as the specialist copayment.

The following are key questions regarding these quantitative testing requirements to ask the person(s)/entity(ies) performing compliance testing:

1. Are there financial requirements or QTLs applied to MH/SUD benefits that are not applied to medical/surgical benefits? If so, have they been removed?
2. Describe the financial model that was used to test for MHPAEA compliance related to financial requirements and QTLs for MH/SUD benefits. What claims data were used in the model? What calendar period was used to develop the claims data? What level of detail was used for different healthcare benefits and service categories? Can a copy of the financial cost model used for the “predominant” and “substantially all” testing by benefits classification be provided?
3. What percentages of medical/surgical benefits within each classification are subject to each type of financial requirement or QTL for each benefit design tested? Have the types of financial requirements or QTLs that did not pass the “substantially all” test been removed from MH/SUD benefits? Or, have the types of financial requirements or QTLs that apply to MH/SUD benefits that did not pass the “substantially all” test been added to enough of the medical/surgical benefits to pass the “substantially all” test?
4. How were single copayments that apply to all services during an office visit (e.g. evaluation and management services, lab services, radiological services, etc.) treated in the testing?
5. What is the “predominant” level of financial requirement or QTL for each type of financial requirement or QTL that passed the “substantially all” test within each classification of benefits for each benefit design tested? Is the level of financial requirement or QTL that applies to MH/SUD benefits within each classification less than or equal to the “predominant” level? Or, has the level of financial requirement or QTL for medical/surgical benefits been raised on enough of the medical/surgical benefits so that it is greater than or equal to the level that applies to MH/SUD benefits?

6. In the plan, does cost sharing for pharmacy benefits vary based on whether the drug is for a medical/surgical condition versus a MH/SUD condition? If so, have these differences been removed?

Cumulative Financial Requirements and QTLs

The Final Rules also state that a plan cannot apply any cumulative financial requirements (e.g., deductibles or out-of-pocket maximums) or cumulative QTLs (e.g., annual or lifetime day or visit limits) on MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or cumulative QTL established for medical/surgical benefits within the same benefits classification.⁷⁰ In addition, cumulative requirements and limitations must also satisfy the general parity rule described earlier.⁷¹

The Final Rules provide examples of cumulative financial requirements and QTLs to illustrate permissible and impermissible arrangements as follows:

- A plan that imposes a combined annual \$500 deductible on all medical/surgical and MH/SUD benefits complies with the requirements of the Final Rules, because it is a combined annual deductible.⁷²
- A plan that imposes an annual \$250 deductible on all medical/surgical benefits and an annual \$250 deductible on all MH/SUD benefits violates the requirements of the Final Rules, because there is a separate annual deductible on MH/SUD benefits.⁷³
- A plan that imposes an annual \$300 deductible on medical/surgical benefits and an annual \$100 deductible on MH/SUD benefits violates the requirements of the Final Rule, because there is a separate annual deductible on MH/SUD benefits.⁷⁴
- A plan generally imposes a combined annual \$500 deductible on all benefits (including MH/SUD benefits and except prescription drugs and preventive care). The imposition of other financial requirements and QTLs vary within each classification. Using reasonable methods, the plan projects payments for medical/surgical benefits in each classification for the 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%

The general parity tests are met, except for emergency care. Emergency care MH/SUD benefits cannot be subject to the \$500 deductible, because it does not apply to substantially all emergency care medical/surgical benefits.⁷⁵ However, the two-thirds threshold of the “substantially all” test is met with respect to all other classifications of benefits, because at least two-thirds of medical/surgical benefits are subject to the \$500 deductible. The \$500 deductible is also the “predominant” level with respect to these classifications, because it is the only level.

The following are key questions regarding separately accumulating financial requirements and QTLs to ask the person(s)/entity(ies) performing compliance testing:

1. If the plan applies accumulating financial requirements to plan benefits, have the accumulating financial requirements been aggregated so that both medical/surgical and MH/SUD benefits accumulate to satisfy the same financial requirement?
2. If the plan applies accumulating QTLs to plan benefits, have the accumulating QTLs been aggregated so that both medical/surgical and MH/SUD benefits accumulate to satisfy the same QTL?
3. If the plan has separate accumulating financial requirements or QTLs, what technological systems changes have been made to ensure that the integrated accumulation of medical/surgical and MH/SUD benefits, as described earlier, is occurring on a timely and accurate basis?

Aggregate Lifetime and Annual Dollar Limits

The Final Rules provide that a health plan that provides both medical/surgical and MH/SUD benefits must comply with the general parity requirements with respect to aggregate lifetime and annual dollar limits.⁷⁶

However, these provisions in the Final Rules only apply to MH/SUD benefits that are not subject to the EHB requirement for plans governed by the ACA. The ACA prohibits lifetime and annual limits on the dollar amount of EHBs. EHBs include MH/SUD services, including behavioral health treatment.⁷⁷ Therefore, despite the provisions of MHPAEA and the Final Rules that would permit aggregate lifetime and annual dollar limits as long as they comply with the parity requirements of the law and its regulations, these types of limits are prohibited with respect to plans regulated by the ACA.⁷⁸

For those plans not covered by the ACA, in order to help determine compliance with this requirement, the following question should be addressed:

1. Have the annual dollar limits been removed from all MH/SUD benefits, or have they been matched to comparable medical/surgical limits by classification?

PART 3: COMPLYING WITH PARITY STANDARDS REGARDING NONQUANTITATIVE TREATMENT LIMITATIONS

The Final Rules recognize that health plans impose treatment limitations that are not numerical in nature but otherwise may limit the scope or duration of MH/SUD benefits. The Final Rules call these treatment limitations nonquantitative treatment limitations (NQTLs)⁷⁹ and prohibit the imposition of such NQTLs on MH/SUD benefits unless the health plan can demonstrate that certain requirements are met.⁸⁰

As with financial requirements and QTLs, a health plan cannot impose NQTLs that only apply to MH/SUD benefits. NQTLs that apply only to MH/SUD benefits are separate treatment limitations and, per se, violations of MHPAEA.⁸¹

The “predominant” and “substantially all” tests that apply to financial requirements and QTLs do not apply to a health plan’s NQTLs. The Final Rules require the application of a different test because NQTLs are not mathematical in nature.⁸² Specifically, the Final Rules provide that, for NQTLs that apply to both MH/SUD benefits and medical/surgical benefits, any processes, strategies, evidentiary standards, or other factors used in applying NQTLs to MH/SUD benefits in any benefits classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to medical/surgical benefits in the same benefits classification.⁸³

In other words, to be in compliance with the Final Rules, a health plan must meet certain tests when imposing NQTLs on medical/surgical benefits and MH/SUD benefits within the same benefits classification. An appropriate analysis of the NQTL tests requires that a covered health plan cannot impose an NQTL to MH/SUD benefits in any classification unless:

- (1) the NQTL is comparable to an NQTL imposed on medical/surgical benefits; **AND**
- (2) the NQTL is applied no more stringently to the MH/SUD benefits than to the medical/surgical benefits.⁸⁴

Comparable and No More Stringent

The terms “comparable” and “no more stringent than” are not defined in the law or Final Rules. Given the general lack of clarity in the Final Rules and FAQs, employers should carefully consider whether the NQTLs imposed by a health plan on MH/SUD benefits are comparable and no more stringent than the NQTLs imposed by the health plan on medical/surgical benefits and undertake a clear analysis as to whether the NQTLs are compliant with the law and Final Rules. Despite the examples in the Final Rules and FAQs, a determination of whether a health plan is in compliance with the law or Final Rules must be made based on the facts related to and the specific circumstances surrounding a health plan’s NQTLs.

A common area for confusion in many plans is whether there is comparability among benefits if the health plan applies an NQTL to the MH/SUD benefit and does not apply the NQTL to some minimum level of medical/surgical benefits in the same classification. Clearly, if an NQTL applies only to MH/SUD benefits and

never to medical/surgical benefits in a classification, this is a separate treatment limitation and not in compliance with MHPAEA or the Final Rules.⁸⁵

Some health plans have taken the position that any NQTL that is applied to the medical/surgical benefit, even if it is applied to a very small percentage of the medical spending (e.g., 2%), can then be applied to all or most of the MH/SUD benefit. However, if the NQTL applies to all or most MH/SUD benefits, but only to a small percentage of medical/surgical benefits in a classification, it would likely be noncompliant.⁸⁶ The FAQs and an example from the Final Rules provide some guidance on this issue, stating that if the quantitative imbalance is too great between the application of the NQTL to medical/surgical benefits and to MH/SUD benefits, then the NQTL would not be considered to be “comparable” or “no more stringent than.”⁸⁷

A permissible example from the Final Rules that addresses this is as follows. A plan considers a wide number of factors in designing its medical management techniques for both MH/SUD and medical/surgical benefits (e.g., cost of treatment, high cost growth, variability in cost and quality, elasticity in demand, provider discretion in determining diagnosis or type or length of treatment, clinical efficacy of proposed treatments or services, licensing and accreditation of providers, and claim types with a high percentage of fraud).⁸⁸ These factors are applied in a comparable way for MH/SUD and medical/surgical benefits, and prior authorization is required for some, but not all, MH/SUD and medical/surgical services. These services include 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 thirty days.

Another example found in the FAQs illustrates a scenario that does not comply with the NQTL tests. In this example, the plan requires prior authorization for all outpatient mental health benefits but for only a few types of medical/surgical benefits (i.e., outpatient surgery; speech, occupational, and physical therapy; and skilled nursing services).⁸⁹ In this case, it is unlikely that the processes, strategies, evidentiary standards, and other factors considered by the plan in determining that only three types of medical/surgical benefits require prior authorization would also result in *all* outpatient MH/SUD benefits requiring prior authorization.⁹⁰

Yet another common area of confusion is where a plan imposes comparable NQTLs among plan benefits but applies the NQTLs in a more stringent manner when dealing with MH/SUD benefits as opposed to the medical/surgical benefits. The Departments included the term “no more stringently” in the NQTL tests to ensure that processes, strategies, evidentiary standards, and other factors that are comparable on their face are also applied in the same manner.⁹¹ While a health plan has discretion to approve benefits, if the plan uses an NQTL to routinely deny MH/SUD benefits and approve medical/surgical benefits, its application of the NQTL is considered to be applied more stringently, and this violates one of the NQTL tests.⁹²

The FAQs and an example in the Final Rules both include an identical illustration where a health plan requires prior authorization for all inpatient benefits (both medical/surgical and MH/SUD) in order to determine whether services are medically necessary.⁹³ In practice, the utilization reviewer approves all

medically necessary medical/surgical services for seven days but routinely approves all MH/SUD services for only one day. This illustration was found to be impermissible because the plan is applying a stricter NQTL in practice to MH/SUD benefits than to medical/surgical benefits.

Nevertheless, it is important to note that the denial of MH/SUD benefits itself is not an indication that a plan's processes, strategies, evidentiary standards, or other factors have been applied to MH/SUD benefits in a manner that is more stringent than the manner in which such processes, strategies, evidentiary standards, or other factors are applied to medical/surgical benefits.⁹⁴ For example, an identical example in the FAQs and the Final Rules provides an illustration in which a health plan applies concurrent review to outpatient care where there are high levels of variation in length of stay.⁹⁵ In practice, the application of the concurrent review affects 60% of MH/SUD conditions and 30% of medical/surgical conditions. This type of NQTL (i.e., concurrent review) is applied no more stringently, even though it impacts the benefits in a disparate manner. As long as a health plan has NQTLs that are comparable and applied "no more stringently," the health plan complies with the law and the Final Rules. The examples provided, however, do not address additional analyses that may be required; i.e., the medical necessity criteria used to conduct concurrent review and/or the results (e.g., additional days approved or denied) or the review itself.

NQTL Illustrations in the Final Rules

In order to assist health plans in determining if a treatment limitation is an NQTL, the Final Rules provide an illustrative (but not exhaustive) list of NQTLs, which includes:

- (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 (e.g., 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 determination of usual, customary, and reasonable charges;
- (F) Refusal to pay for higher cost therapies until it can be shown that a lower cost therapy is effective (i.e., 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.⁹⁶

The Final Rules emphasize that these illustrations are not a comprehensive list of NQTLs and that all NQTLs are subject to the tests provided by MHPAEA and the Final Rules.⁹⁷

It must be remembered that, regardless of whether it is covered in the list of illustrations, any health plan provision that otherwise limits the scope or duration of a service is an NQTL, subject to the NQTL tests explained earlier. Other NQTLs not specifically enumerated in the illustrative list include: (i) in- and out-of-network geographic limitations; (ii) limitations on inpatient services for situations where the participant is a threat to self and others; (iii) exclusions for court-ordered and involuntary holds; (iv) experimental treatment limitations; (v) service coding; (vi) exclusions for services provided by clinical social workers; and (vii) network adequacy.⁹⁸ An analysis of these NQTLs (as well as any other NQTLs not mentioned in the Final Rules or its Preamble) must be performed to ensure that they comply with the NQTL tests set forth in the Final Rules and detailed herein.

The Final Rules provide guidance through additional examples with respect to utilization review techniques or medical management standards commonly used by plans (e.g., prior authorization or concurrent review). These examples illustrate permissible and impermissible arrangements and include the following:

- It is impermissible for a plan to utilize a prior approval process that uses comparable criteria for both outpatient, in-network medical/surgical and MH/SUD benefits, if its process results in no MH/SUD benefits being paid and only a 25% reduction in benefits paid for medical/surgical benefits.⁹⁹ Although prior approval is applied to both MH/SUD benefits and medical/surgical benefits for outpatient, in-network services, it is not applied in a comparable way.
- It is permissible for a plan that generally covers medically appropriate treatments to use evidentiary standards to determine whether treatments are medically necessary that (i) are based on recommendations made by panels of experts with appropriate training and expertise in the fields concerned and (ii) are applied in a manner that is based on clinically appropriate standards of care for the condition, for both MH/SUD and medical/surgical benefits.¹⁰⁰ This example complies with the NQTL tests because the application of the standards to MH/SUD benefits is comparable to and applied no more stringently than application of the standards to medical/surgical benefits.
- It is impermissible for a plan to require prior authorization for all outpatient MH/SUD services after the ninth visit and only approve up to five additional visits per authorization when, with respect to outpatient medical/surgical services, the plan allows an initial visit without prior authorization and then preapproves benefits based on the individual treatment plan developed by the attending physician.¹⁰¹ Although prior authorization is applied to both MH/SUD and medical/surgical benefits, it is not applied in a comparable way.

A more detailed look at these illustrations is provided in the following text, along with key questions related to compliance testing. Keep in mind that the following questions are applicable to both medical/surgical benefits and MH/SUD benefits and that you must consider each NQTL within each benefits classification separately. You must also ask if the NQTLs are comparable. Are there differences in processes, strategies,

evidentiary standards, or other factors used to manage medical/surgical and MH/SUD benefits? Are NQTLs applied to MH/SUD benefits that are not applied to medical/surgical benefits? Are there differences in how stringently NQTLs are applied to medical/surgical benefits as opposed to MH/SUD benefits?

Regarding the illustrations, the following are key questions regarding the NQTL illustrations to ask the person(s)/entity(ies) performing compliance testing.

Illustration A: Medical Management Standards

A health plan's medical management standards that exclude or limit benefits based on medical necessity or appropriateness or whether a treatment is experimental or investigative are NQTLs and subject to the NQTL tests set forth earlier.

Utilization management practices (e.g., preauthorization, concurrent review, and retrospective review). A plan's utilization review processes are NQTLs, which must be conducted in compliance with MHPAEA and the Final Rules. These utilization review or management approaches (i.e., when to conduct review processes) must be analyzed in addition to a plan's medical necessity criteria, which are also NQTLs.

1. Is utilization review prospective, concurrent, or retrospective, and does this differ between medical/surgical benefits and MH/SUD benefits?
2. What is the total annual allowed cost of services (each for medical/surgical and MH/SUD treatment separately) subject to utilization review for each type of utilization management practice, including but not limited to, preauthorization requirements and concurrent review? This should be provided for each benefits classification.
3. How is utilization review performed? Are any published standards/manuals used to guide decisions? Ask to be provided with any protocols that are used to guide the application of these processes. The DOL has issued some guidance on whether a plan's utilization review processes meet the requirements of MHPAEA and the Final Rules.¹⁰²
4. Do the same personnel perform utilization review for medical/surgical benefits and MH/SUD benefits? If not, what steps are taken to ensure that policies are being administered in a comparable manner and not more stringently for MH/SUD benefits in each classification?
5. For both medical/surgical and MH/SUD benefits, how often does utilization review result in denials or limitations?
6. If a type of utilization review (e.g., prior authorization) is not sought by covered members as may be required under the plan design, what are the penalties for not doing so, and do the penalties differ between medical/surgical benefits and MH/SUD benefits?

7. Is the plan applying NQTLs to only a few medical/surgical services while applying these same NQTLs to most or all MH/SUD services? If so, this may appear to be noncompliant (since this is noncomparable and more stringent), as this may be noncomparable per the quantitative balancing discussed earlier. An example of this would be performing concurrent review for all psychotherapy visits under the MH/SUD benefit while only performing concurrent review for physical therapy and occupational therapy under the medical/surgical benefit.

Medical necessity criteria.

8. For each of the six classifications of benefits, what are the plan's standards for determining whether a treatment is medically necessary for both MH/SUD benefits and medical/surgical benefits? A plan's medical necessity criteria are NQTLs and subject to the requirements of MHPAEA and the Final Rules, and a separate analysis, regardless of whether the criteria are applied and/or used as part of a plan's utilization review processes, is necessary.
9. For each classification of benefits (i.e., MH/SUD and medical/surgical) and type of medical necessity criteria, how often is a request for payment denied on the grounds that the service is not medically necessary?
10. How are the criteria (and protocols used to implement the criteria) utilized in determining medical necessity under the plan made available to any current or potential participant, beneficiary, or contracting provider upon request? The DOL has issued guidance that information on medical necessity criteria (e.g., "processes, strategies, evidentiary standards, and other factors") must be disclosed for both medical/surgical and MH/SUD benefits to both providers and plan participants.¹⁰³ A compliance analysis is required for both the actual medical necessity criteria and protocols and how and when the medical necessity criteria and protocols are applied (e.g., through a utilization review process).

Experimental treatment exclusions. Exclusions of drugs for MH/SUD conditions based on the experimental or investigational status must be applied comparably to and no less stringently than exclusions of drugs for medical/surgical conditions based on experimental or investigational status. For example, it is impermissible for a plan that generally covers medically appropriate treatments to automatically exclude coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration, if for other drugs with a black box warning, the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate.¹⁰⁴ Under these circumstances, although the standard for applying the NQTL is the same for MH/SUD and medical/surgical benefits (e.g., whether the drug has a black box warning), it is not applied in a comparable manner. The plan has an unconditional exclusion for antidepressant drugs and a conditional exclusion for other drugs.

11. Are “experimental” and/or “investigational” defined identically or separately for both medical/surgical and MH/SUD treatments?
12. What level of evidence is needed for a treatment to be considered nonexperimental or noninvestigational? For each type of benefit?
13. Has the plan analyzed what portion of both the medical/surgical and MH/SUD benefits in each classification has met the minimum standard for a nonexperimental treatment?
14. Does the plan use the same scientific criteria for medical/surgical and MH/SUD services, and are these criteria applied in the same manner? For example, if a medical or surgical service or diagnostic test is considered nonexperimental because two randomized controlled trial research studies have been completed, is this the same criterion applied for determining that a MH/SUD service is nonexperimental?
15. In addition, the compliance analysis should include how these scientific criteria are applied in each benefits classification. For example, what portion of the spending in the outpatient, in-network classification has met the scientific criteria for medical/surgical services, as compared to the portion of spending for MH/SUD services? What is the health plan’s basis if a large portion (e.g., 50%) of medical/surgical services in a classification is reimbursed, even though these services would be considered experimental or investigational by the health plan’s definition, but a small portion (e.g., only 10%) of the MH/SUD services judged to be experimental or investigational are reimbursed?

Primary care physician or other gatekeeping (referral requirements).

16. Does the health plan require a referral to specialty care from a primary care provider? What is the total annual allowed cost of services (each for medical/surgical and MH/SUD benefits) subject to this type of requirement for each benefits classification?
17. What steps are taken to ensure that members comply with referral requirements? Is the level of monitoring consistent between medical/surgical benefits and MH/SUD benefits?
18. If a referral is not obtained when required, what are the penalties and do they differ between medical/surgical benefits and MH/SUD benefits in each classification?
19. What are the written/advance treatment plan requirements?
20. Does the health plan require any type of advance written treatment plan in order for a service (or series of services) to be covered? What is the total annual allowed cost of services (each for medical/surgical and MH/SUD benefits) subject to this type of requirement in each classification?

21. If this type of requirement applies, who reviews the treatment plans? How often are requests for services denied due to lack of a suitable treatment plan?

Illustration B: Formulary Design (and Management) for Prescription Drugs

The Final Rules provide that Formulary Design and Management are illustrations of NQTLs. Therefore, the methods by which a plan designs and manages its formulary are NQTLs and subject to the NQTL rule set forth earlier.

Approval of formulary drugs.

1. What portion of all FDA-approved prescription treatments for MH/SUD conditions is listed on the formulary? How does this compare to the portion of drugs for medical/surgical disorders? How are MH/SUD drugs identified?
2. What are the evidentiary standards for inclusion on the formulary? Are there any differences between these standards for medical/surgical and MH/SUD drugs?
3. What are the plan's rules for covering drugs prescribed off-label? Do these rules differ if a drug is being used off-label for a MH/SUD condition?
4. Are branded drugs (for which no generics are available) approved for MH/SUD conditions as covered benefits? If not, are they approved for medical/surgical conditions?

Placement of drugs on formulary tiers.

5. Is there any consideration of a drug being used to treat MH/SUD conditions when making formulary tier placement decisions?
6. If cost, generic substitutability, or other factors are generally used in the formulary decision-making process, are the standards the same for medical/surgical and MH/SUD drugs?
7. How are MH/SUD prescription drugs distributed on the formulary tiers? Are they disproportionately on the more expensive tiers as compared to medical/surgical drugs?

Generic substitution/therapeutic interchange, or substitution.

8. Does the plan require generic substitution if a generic version of a drug is available? If so, are the rules different depending on whether the drug is for a medical/surgical condition or MH/SUD condition?

9. Does the plan cover branded versions of drugs for which generics are available? If so, does it do so regardless of whether the drug is for a medical/surgical or MH/SUD condition?

Pharmacy benefit management protocols.

10. What criteria are used to establish prior authorization, step therapy, or other requirements for approval of a requested drug for drugs commonly used for medical/surgical conditions?
11. Are the criteria for these requirements different for MH/SUD drugs?
12. Similarly, how are restrictions on fill limits, available dosages, and so on, established for both MH/SUD and medical/surgical drugs?

Illustration C: For Plans with Multiple Network Tiers (such as Preferred Providers and Participating Providers), Network Tier Design

As was set forth earlier, the Final Rules state that a plan may provide benefits through multiple tiers of in-network providers and divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers as long as the tiering is based on reasonable factors (e.g., quality, performance, and market standards) that meet the NQTL parity standards and do not take into account whether a provider renders medical/surgical or MH/SUD services. This means that the comparability and stringency tests for NQTLs apply to the factors that the health plan used to determine tier assignment.

1. How does the plan determine (i.e., what factors are used) which MH/SUD providers get placed in a preferred tier(s) or specific tier level?
2. Are these factors comparable to and applied no more stringently than those that determine the placement of a medical/surgical provider in a preferred tier or specific tier level?

Illustration D: Standards for Provider Admission to Participate in a Network (Including Reimbursement Rates)

NQTLs include standards for provider admission to participate in a provider network. In other words, the contractual requirements for network providers to participate in a network providing medical/surgical services must be comparable to the contractual requirements for network providers to participate in a network providing MH/SUD services, and the contractual requirements for network providers providing MH/SUD services must be applied in a manner no more stringent than the contractual requirements applied to network providers providing medical/surgical services.

These contractual requirements specifically include the reimbursement rates provided to network providers, which are set forth in provider contracts and/or provider contract fee schedules. Plans may consider a number of factors in determining provider reimbursement rates for both medical/surgical and MH/SUD services, including service type, geographic market, demand for services, supply of providers, provider

practice size, Medicare reimbursement rates, training, experience, and practice size.¹⁰⁵ To comply with MHPAEA and the Final Rules, these factors used to determine the reimbursement rate of MH/SUD services must be applied comparably to and no more stringently than the factors used to determine reimbursement rates for medical/surgical services.¹⁰⁶

These contractual requirements also include training and state licensing requirements. It is permissible for a plan to apply a general licensing standard in order to participate in the plan's provider network (e.g., a requirement that a provider meet the highest licensing requirement related to supervised clinical experience under applicable state law), as long as the plan applies this general standard in a way that complies with the NQTL parity tests.¹⁰⁷ For example, a plan that requires master's-level mental health therapists to have postgraduate, supervised clinical experience but does not require master's-level general medical providers to meet this requirement (because the scope of licensure under state law does not require clinical experience and does not require post degree, supervised clinical experience for psychiatrists or PhD-level psychologists since their licensing already requires supervised training) complies with NQTL tests.¹⁰⁸ A requirement that master's-level mental health therapists must have supervised clinical experience to join the network complies with the tests related to NQTLs as long as the plan consistently applies the same standard to all providers, even though it has a disparate impact on certain providers of MH/SUD services.

1. What credentials are required to be an in-network provider? Are there any differences between the standards used for medical/surgical providers and those used for MH/SUD providers? If non-MD/DO providers can be in-network providers for medical/surgical care, are non-psychiatrist, non-psychologist providers permitted to be in-network providers for MH/SUD care?
2. What are the administrative requirements to join the network? For example, does the plan rely on state licensure standards and/or national accreditation standards for medical/surgical and MH/SUD, or does it apply other internal or external standards?
3. How does the plan determine how many providers to admit to its network by type of provider or specialty?
4. What is the typical wait time for a member to obtain an appointment with a primary care provider for medical services? How does this vary between emergency services and routine services? How does this compare to wait times to obtain a behavioral care appointment from a MH/SUD provider? Is this different for rural versus urban areas?
5. Are specialty inpatient or non-hospital facilities included in the provider network for treatment of specific medical/surgical conditions? If so, are specialty inpatient or non-hospital psychiatric and substance use treatment facilities available in the network? Are those facilities that are not contracted as network providers comparably covered out of network, separately for medical/surgical and MH/SUD conditions?

6. Are there major variances in contract reporting and documentation obligations for MH/SUD in-network/out-of-network providers as compared to medical/surgical in-network/out-of-network providers (e.g., reporting requirements on quality, patient outcome measures, etc.)?
7. What are the fees paid to MH/SUD specialty physicians for medical evaluation and management (E&M) services? What are the fees for these same E&M services paid to other physicians? Is the methodology for establishing the fees comparable?
8. Are there analyses that demonstrate comparability of factors used to determine fee levels and equity in their application with respect to medical/surgical providers and MH/SUD providers by benefits classification? For example, how do fees for non-E&M services for MH/SUDs (e.g. Current Procedural Terminology [CPT] codes 90785–90899) compare to non-E&M fees for surgical services (CPT codes 10021–69990)? For radiology services (CPT codes 70010–79999)? For pathology services (CPT codes 80047–89398)? For dialysis services (CPT codes 90935–90999)? For gastroenterology services (CPT codes 91010–91299)? For cardiovascular services (CPT codes 92950–93799)?
9. Can the methodology used be demonstrated in such a manner that it supports a conclusion that the comparability and stringency tests have been met? How much discretion is involved in applying these factors to establish a final fee schedule? Are MH/SUD providers consistently paid less than medical/surgical providers?

Illustration E: Plan Methods for Determining UCR Charges

NQTLs include the determination of usual, customary, and reasonable (UCR) fee amounts for providers (e.g., facility and professional services for both in-network and out-of-network providers). While there is no standard analysis to determine that MH/SUD fees and medical/surgical fees are comparable, one such approach is to complete an analysis of the fee levels relative to an accepted standard such as Medicare allowable levels. Provider payments can be calculated for each classification separately (i.e., MH/SUD services and medical/surgical services), using a combination of fee schedules and utilization rates by service, and compared to a recognized benchmark (e.g., Medicare payment schedules). For example, it could be determined that outpatient office visits for medical/surgical services are paid at a level comparable to X% of Medicare allowable levels and that outpatient office visits for MH/SUD services are paid at a level comparable to Y% of Medicare allowable levels. These two levels could then be evaluated to determine whether provider payments for MH/SUD and medical/surgical benefits were comparable.

Consider the following questions separately for each classification (whether you are addressing reimbursement rates for in-network providers or UCR charges to determine allowable rates for out-of-network providers) as applicable to medical/surgical and MH/SUD provider rates:

1. How are fee schedules and reimbursement rates determined for medical/surgical providers as compared to those for MH/SUD providers? How do the processes vary between in-network and out-of-network allowable rates for medical/surgical providers as compared to MH/SUD providers?
2. Is there a common benchmark fee schedule (e.g., Medicare) or methodology used in developing allowed fee levels? If so, how do rates vary between medical/surgical and MH/SUD providers (as a percentage of the benchmark fee schedule) for each benefits classification?
3. When reimbursement is on the basis of UCR charges (most commonly for out-of-network services), what methods does the plan use to determine UCR charges, separately for medical/surgical services and MH/SUD services?
4. If there is a standard process or procedure for determining UCR charge levels, are exceptions ever made? Are exceptions made more or less frequently with respect to medical/surgical services or MH/SUD services? Do exceptions result in higher or lower allowed amounts for medical/surgical services and MH/SUD services in each benefits classification?
5. Is there a difference in how often an inflation adjustment is given for medical/surgical providers as compared to MH/SUD providers?
6. Can the methodology used be demonstrated in a manner that supports a conclusion that the comparability and stringency tests have been met? How much discretion is involved in applying these factors to establish a final fee schedule? Are MH/SUD providers consistently paid less than medical/surgical providers?

Illustration F: Fail-First Policies (Also Known as Step Therapy Protocols)

Fail-first policies, or step therapy protocols, are most commonly applied for prescription drugs and/or for behavioral health inpatient and residential treatment. An example of a fail-first policy is a policy requiring a member to use a generic antidepressant first without treatment success before a single- source brand antidepressant will be covered. Another example of a fail-first policy is a policy denying inpatient treatment for a covered condition until outpatient treatment is attempted and is found unsuccessful.

Standards for requiring fail-first policies.

1. What is the basis for determining whether fail-first policies will be required? Is the basis solely the cost of therapy, regardless of the condition being treated?
2. Are there exceptions (e.g., fail-first not required for a particular treatment even though the treatment is sufficiently expensive)? If so, what are the bases for these exceptions?

Results of applying standards.

3. For which MH/SUD services and for which medical/surgical services must a member try and fail at a lower cost therapy first? What is the total annual allowed cost of services subject to fail-first policies, separately for medical/surgical and MH/SUD services, and for each of the six benefits classifications?
4. When lower cost therapy is attempted, how often does a member “progress” to the next step (the more expensive therapy)? Are there differences between this rate for medical/surgical conditions and MH/SUD conditions?

Denial of higher cost therapies.

5. How frequently in each benefits classification is a patient denied a higher cost therapy based on fail-first policies for medical as compared to MH/SUD conditions?

Illustration G: Exclusions Based on Failure to Complete a Course of Treatment.

The Final Rules state that coverage exclusions by a health plan that are based on the failure of the patient to complete a course of treatment are NQTLs and subject to the NQTL tests set forth earlier.

Employee Assistance Plans (EAPs).

1. Does eligibility for coverage for a health plan’s MH/SUD services begin only after all pertinent EAP benefits for MH/SUDs have been exhausted?
2. Does the health plan require referral from an EAP in order to receive coverage for MH/SUD benefits?
3. Are there any requirements similar to this for medical/surgical benefits? If not, this would be a separate treatment limitation and should be removed. If there is a similar requirement, the NQTL tests should be performed.

Requirements to attend classes or programs.

4. Does the health plan cover smoking cessation prescription drugs, but only for members who participate in a class, support group, or similar program?
5. Does the health plan require attendance at Alcoholics Anonymous or any similar programs as a condition of receiving inpatient or outpatient care for alcoholism or other substance use disorders?

6. Are there any medical/surgical conditions with similar requirements? If not, these may be separate treatment limitations and should be removed. If there is a similar requirement, the NQTL tests should be performed.

Visit minimums.

7. Does the health plan deny coverage for psychotherapy or other behavioral services unless the member attends a minimum number of sessions?
8. Does the health plan impose penalties if the member misses a psychotherapy visit, fails to refill a prescription related to a MH/SUD condition in a timely manner, etc.?
9. If a member leaves a hospital or other inpatient facility against medical advice while being treated for a MH/SUD, does the plan impose any penalties (e.g., not paying for the hospital stay or for follow-up care)? Are there any similar penalties for leaving against medical advice during a medical/surgical stay?
10. Are there any medical/surgical conditions with similar requirements? For example, will the health plan refuse inpatient treatment for a diabetic patient in the emergency room who meets criteria for admission but who has been noncompliant with outpatient visits to a primary care physician, has not taken medications consistently, or has not lost weight when recommended by the primary care physician?

Illustration 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

Plan or coverage restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope and duration of benefits must also meet the requirements of the parity tests for NQTLs that are described earlier.

Examples provided in the Final Rules illustrate how coverage exclusions may or may not violate the NQTL rules. For example, if a plan generally covers medically appropriate treatments (including inpatient treatment outside of a hospital) but automatically excludes coverage for inpatient treatment in any setting outside of a hospital for substance use disorders, the plan would be in violation of the NQTL rules, as it contains an unconditional exclusion of substance use disorder treatment in any setting outside of a hospital. This exclusion is not comparable to the conditional exclusion for inpatient treatments outside of a hospital for other conditions (i.e., coverage of medically appropriate inpatient treatment).¹⁰⁹

In addition, it would be a violation of the NQTL rules if a plan generally provides coverage for medically appropriate treatments provided outside the state where the policy is written but excludes coverage for inpatient, out-of-network treatment of chemical dependency when obtained outside of the state where the policy is written. The plan, in this case, imposes an NQTL that restricts benefits based on geographic location for substance use disorders and does not impose a comparable exclusion for medical/surgical benefits.¹¹⁰

1. Does the plan include any treatment limitations to MH/SUD coverage for out-of-hospital inpatient benefits? If so, do comparable treatment limitations exist for out-of-hospital inpatient medical/surgical benefits?
2. Does the plan include any treatment limitations for medically necessary out-of-state MH/SUD benefits? If so, do comparable treatment limitations exist for out-of-state medical/surgical benefits?

There may be other criteria not noted that similarly limit the scope or duration of benefits, and similar or identical questions would need to be asked about those specific criteria.

PART 4: OTHER ISSUES RELATED TO MHPAEA AND THE FINAL RULES

Covered Health Plans

With certain exceptions, MHPAEA and the Final Rules apply to fully insured and self-funded employment-related group health plans and health insurance coverage offered in connection with a large group health plan. MHPAEA also applies to non-grandfathered plans in the individual and small-group markets that are required by the ACA to provide EHBs, regardless of whether such plans are sold on a health insurance exchange. Nevertheless, there are certain health plans specifically excluded from MHPAEA, including health plans provided by small private employers that have fifty or fewer employees, which are not required by the ACA to provide EHBs (referred to as the *small employer exception*);¹¹¹ plans that meet the increased cost exemption requirements (described below);¹¹² self-funded state or local governmental plans that request an exemption; retiree-only plans; Medicare plans; and VA and TriCare plans.

Compliance Analysis

The Final Rules provide that covered health plans must provide an analysis of their MHPAEA compliance. By the time the Departments issued the Final Rules, they believed that health plans had developed the familiarity and expertise necessary to implement parity standards and requirements. Therefore, plans are not required to perform an annual parity analysis unless the plan changes the benefit design, cost-sharing structure, or utilization that would affect a financial requirement or treatment limitation within a classification or permissible sub-classification.¹¹³

Availability of Plan Information/Disclosure of Information

MHPAEA and the Final Rules include provisions that require for the disclosure of information about the health plan. The administrator of a health plan or the health insurance issuer is required under the Final Rules to make available the criteria used for medical necessity determinations made in connection with MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request.¹¹⁴ In addition, the plan administrator or health insurance issuer must make available the reason for denial of reimbursement or payment of services with respect to MH/SUD benefits to any participant or beneficiary in accordance with the claims procedure rules.¹¹⁵ If the denial is based on medical necessity, the medical necessity criteria for the MH/SUD benefits and for the medical/surgical benefits at issue must also be provided within thirty days of a request to a participant, beneficiary, provider, or authorized representative of a beneficiary or participant.¹¹⁶

In addition to the aforementioned disclosure requirements, there are other requirements that are applicable to the disclosure of information relevant to medical/surgical and MH/SUD benefits.¹¹⁷ These disclosure requirements include ERISA Section 104 and 29 CFR Section 2520.104b-1, which require disclosure of instruments under which the plan is established or operated to plan participants within thirty days of request. Plan instruments include documents with information on medical necessity criteria for both

medical/surgical and MH/SUD benefits and the processes, strategies, evidentiary standards, and other factors used to apply the NQTL tests.¹¹⁸

There are also disclosure requirements set forth in 29 CFR 2560.503-1 and 2590.715-2719, which cover employee benefit plans.¹¹⁹ These provisions are related to the claims and appeals processes, including the rights of claimants to receive documents, records, and other information related to a claim for benefits. This would allow the claimant to have access to medical necessity criteria for both medical/surgical and MH/SUD benefits and the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, but only after a claim is denied.¹²⁰

Moreover, there are other provisions of law related to the disclosure of information that are intended to protect patients. For example, certain provisions established by the ACA provide a federal right to internal and external appeal of health insurance coverage determinations and claims.¹²¹ The ACA provisions related to information and disclosure apply to individual, small-group, and large-group plans and to self-insured and insured plans, with the exception of certain grandfathered plans. These provisions are substantially similar to 29 CFR 2560.503-1 and 2590.715-2719 described earlier. Therefore, except for grandfathered plans, almost all plans have certain disclosure requirements related to claims and appeals of denied claims.

In addition to the right of plan participants to access information regarding medical necessity determinations and their plan benefits, plan participants have the right under other federal law to appeal a plan's decision to deny a claim. There are two levels of appeal, which include internal appeals and external review by an independent review organization.¹²²

The following are key questions regarding availability of plan information to ask the person(s)/entity(ies) performing compliance testing:

1. Does the health plan make available the criteria used for medical necessity determinations made in connection with MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request?
2. Does the health plan provide the reason for denial of reimbursement or payment of services with respect to MH/SUD benefits to any participant or beneficiary in accordance with the claims procedure rule?
3. If a denial is based on medical necessity, does the health plan provide the medical necessity criteria for the MH/SUD benefits and the medical/surgical benefits within thirty days of a request to a participant, beneficiary, provider, or authorized representative of a beneficiary or participant?
4. Does the plan provide documentation of how "comparability" between NQTLs for MH/SUD benefits and medical/surgical benefits has been determined?

Increased Cost Exemption

A health plan can claim an exemption from the requirements of MHPAEA and the Final Rules if it demonstrates an increase in costs related to changes it made in order to comply with the law or the rules.¹²³ Specifically, if the plan incurs an increased cost of at least 2% in the first year that MHPAEA applies to the plan, the plan is exempt from MHPAEA's requirements for the next plan year. After the exempt plan year, the health plan must comply with MHPAEA and the Final Rules again. If the plan incurs an increased cost of at least 1% in any following plan year, the plan can claim an exemption for the next plan year. The test for the exemption is based on the estimated increase in costs incurred by the health plan that is directly attributable to the expansion in coverage due to MHPAEA and the Final Rules' requirements. The cost estimate cannot be due to costs that are not directly incurred as a result of MHPAEA (e.g., trends in utilization and prices, random changes in claims experience, or seasonal variations in claims submission and payment patterns).¹²⁴ If the health plan claims an exemption based on increased costs, the health plan must notify the plan beneficiaries of such an exemption.¹²⁵

1. If a cost exemption has been filed by the plan, does the plan provide documentation as to how the increased cost was determined?

Employee Assistance Programs (EAPs)

The requirements of MHPAEA and the Final Rules apply to benefits provided under EAPs as long as the program does not provide significant benefits in the nature of medical care or treatment. Employers may use a reasonable and good-faith interpretation of whether an EAP provides significant medical care or treatment benefits.

Also, under the Final Rules with respect to EAPs, a plan establishes an NQTL if it limits a participant's eligibility for MH/SUD benefits until all of the benefits provided under an EAP are exhausted. This NQTL is then subject to the applicable parity tests, and if there are no comparable requirements applicable to medical/surgical benefits, the plan would violate the Final Rules.¹²⁶ For example, it would be impermissible if an employer that maintains both a major medical plan and an EAP (that provides a limited number of MH/SUD counseling sessions) provides that participants are only eligible for MH/SUD benefits under the major medical plan after they exhaust the counseling sessions provided by the EAP and no similar exhaustion requirement applies with respect to medical/surgical benefits under the major medical plan.¹²⁷

Managed Behavioral Health Organizations (MBHOs)

Many health plans contract with certain entities to provide or administer their MH/SUD benefits called MBHOs. Prior to MHPAEA and the Final Rules, these MBHOs operated separately from the plan and did not have to coordinate benefits, financial requirements, and treatment limitations related to MH/SUDs with the underlying health plan. Under MHPAEA and the Final Rules, the MBHO and the underlying health plan are required to coordinate the benefits, financial requirements, and treatment limitations and comply with all of

the requirements of MHPAEA and the Final Rules as if they were one plan.¹²⁸ It is the responsibility of the health plan to ensure compliance; therefore, the health plan is responsible for any violation of the law or rules, and it is essential for the health plan to provide the MBHO with sufficient information related to the benefits and coverage in order to ensure that benefits are properly coordinated and in compliance with the law and the rules.¹²⁹

1. Have the plan and its MBHO conducted tests on their financial requirements and treatment limitations to determine that they, on a combined basis, comply with the applicable parity tests?
2. Does the plan have an electronic interface with the MBHO such that all financial requirements that apply to MH/SUD benefits and medical/surgical benefits are integrated (e.g., deductibles, out-of-pocket limits)?
3. How has the plan conducted tests on NQTLs to determine that the MBHO complies with the “stringency” and “comparability” requirements of MHPAEA and the Final Rule?

PART 5 – URAC STANDARDS REQUIRING DOCUMENTATION OF COMPLIANCE WITH MHPAEA

In 2011, URAC released standards for accreditation of health plans that incorporated the requirements of MHPAEA and the IFR and required health plans to ensure they are in compliance.¹³⁰ URAC provides another reference for employers to consider in formulating questions about their health plans' compliance with MHPAEA. Fundamental to the URAC standards is that health plans have written documentation to substantiate the analysis discussed in Parts 2 and 3 of this Guide. Employers should be aware that these requirements also apply to any contractor that separately administers the MH/SUD benefit (e.g., a carve-out) or provides MH/SUD services to the health plan. A key component of the URAC standards is that the analysis upon which compliance is based be properly documented and, as purchasers, employers should have access to this documentation.

As of the date of this Employer Guide, URAC's standards are under internal review and will be revised to reflect changes made to the IFR by the Final Rule. It is expected that the revised standards will reflect that the IFR's exception to the NQTL parity standards has been deleted and will underscore that the documentation requirements explained in the paragraph above are important to compliance with the Final Rules, whether a health plan is URAC accredited or not.

The 2011 URAC parity-related standards are addressed in various sections as summarized in the following text. The parenthetical text identifying the standard (e.g., P-NM 4) is the URAC-designated identifier.

Regulatory Compliance (Core 4)

Core 4 of URAC's standards requires that the health plan implement a regulatory compliance program that:

1. Tracks applicable laws and regulations in the jurisdictions where the organization conducts business;
2. Ensures the organization's compliance with applicable laws and regulations; and
3. Responds to detected problems and takes corrective action as needed.

Core 4 applies to both state and federal regulations and includes provisions specific to MHPAEA.

Compliance Program: Internal Controls (P-CP 1)

P-CP 1 complements URAC's Core 4 standards and provides that, in order to effectively monitor adherence to laws and regulations, the health plan must implement internal controls, including (i) designating a compliance officer; (ii) periodic review and update of the compliance program in the organization's training and education; (iii) periodic internal monitoring and auditing; (iv) periodic review and analysis to determine any changes in its benefits, policies, and procedures, and utilization management protocols that impact compliance and communication to delegated contractors regarding changes impacting compliance (including parity of healthcare services such as MH/SUD parity); and (v) performance of a thorough review of state and federal laws and regulations related to privacy and security (including HIPAA); parity of healthcare services, including mental health parity and MHPAEA; and fraud, waste, and abuse.

Analysis of Compliance with MHPAEA (P-MHP 1)

P-MHP 1 provides that, for each health benefit plan product that provides MH/SUD services, the health plan must provide written documentation of one of the following:

1. An affirmative declaration, signed by a principal of the organization, indicating that the identified product is in “exempt status” with regard to MHPAEA, including the statutory/regulatory basis for the exempt status; **or**
2. If not exempt, a detailed analysis of the identified product documenting its compliance with MHPAEA, demonstrating that for the MH/SUD services provided, including applicable pharmacy benefits, the organization does not have more restrictive:
 - a) Financial requirements;
 - b) QTLs; or
 - c) NQTLs.

URAC requires a comparative analysis of the medical/surgical benefit for each NQTL that is applied to the MH/SUD benefit. As part of its analysis, if there is medical or scientific evidence or there are clinical practice guidelines permitting a difference in management of MH/SUD benefits as compared to medical/surgical benefits (i.e., more stringent or noncomparable application of NQTLs), the health plan needs to include such evidence or guidelines as part of its analysis and state why this standard allows more stringent or noncomparable management. A statement that the health plan has the evidence and guidelines is not sufficient to meet the URAC documentation requirement.

The standards also acknowledge that pharmacy benefits are a benefits classification under MHPAEA and must be compliant with the IFR. Formulary structure and the management of the formulary should also be in compliance with the IFR regarding financial requirements, QTLs, and NQTLs. Documentation that a compliance analysis was performed with a clear rationale supporting compliance is required.

The URAC standards also state that if a health plan provides MH/SUD services through other mental health providers (e.g., a primary care physician), then MHPAEA applies, even if MH/SUD benefits are not provided as part of the health plan.

MH/SUD Parity Addressed in Contractor Written Agreements (P-MHP 3)

P-MHP 3 provides that a health plan that enters into written agreements with contractors providing MH/SUD benefits must obtain documentation, as described earlier, from such contractors regarding MHPAEA compliance. This includes MH/SUD benefits for each of the six benefits classifications included in the IFR and compliance with all of the following:

1. Financial requirements;

2. QTLs; and
3. NQTLs.

URAC will examine client-specific documentation showing that mental health parity is addressed in contracts between the health plan and contractors for MH/SUD services. This standard applies not only to contracts between health plans and contractors of MH/SUD services but also to delegation of pharmacy benefit management services.

Consumer and Employer Purchaser Information Disclosure (P-MR 2)

P-MR 2 addresses the health plan's disclosure to consumers and employer purchasers of information about a health plan's products, which includes descriptions of the processes that the health plan uses to ensure compliance with regulatory healthcare parity requirements (including the IFR). This includes condition-specific criteria for benefits and descriptions of the processes that the health plan uses to ensure compliance with regulatory requirements, including the MHPAEA regulations. The information provided should be enough to allow a consumer to understand any benefits provisions that affect, in this case, a specific MH/SUD condition.

UM Protocols Applied to MH/SUD Benefits (P-MHP 2)

P-MHP 2 states that for all utilization review protocols or NQTLs applied to MH/SUD benefits, the health plan must provide a detailed analysis showing that the utilization management protocols do not have more restrictive treatment limitations. URAC does not judge whether the analysis is valid. URAC does require a reasoned analysis to meet the intent of the standard.

UM protocols must be comparable to, and applied no more stringently than, those used for medical/surgical benefits, and the health plan must provide a written analysis supporting its conclusion regarding compliance. A one-sentence declaration that the employer plan is MHPAEA compliant with NQTLs is not acceptable as evidence.

If a UM protocol does not meet the tests related to comparability and stringency, it must show that it has recognized, clinically appropriate medical or scientific evidence and/or clinical practice guidelines that permit a difference to the treatment of MH/SUD benefits. If the health plan has such a standard of care that permits differential treatment, the health plan must document the evidence to support its conclusion.

Health Utilization Management; Review Criteria Requirements (P-HUM 1)

P-HUM 1 provides that when MHPAEA is applicable, medical necessity criteria made under a group health plan with respect to MH/SUD benefits (or health insurance coverage offered in connection with the health plan with respect to such benefits) must be made available in accordance with the IFR by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request. When MHPAEA is applicable, health plans and entities that provide utilization management services must comply with this regulation under the Core 4 standards.

Out of Network and Emergency Services (P-NM 4)

P-NM 4 provides that (i) organizations must ensure that all out-of-network MH/SUD benefits are compliant with MHPAEA; and (ii) a health plan that provides MH/SUD benefits in any classification of benefits must provide them in every classification in which medical/surgical benefits are provided, including out-of-network classifications for emergency services. URAC provides a reminder that to be effectively implemented, a health plan's written policies and procedures must be understood by network management staff and any employee of the health plan who may be called upon to explain to a consumer the policy regarding access to emergency services or out-of-network providers.

Written Notice of Upheld Non-Certifications (P-HUM 37)

P-HUM 37 provides that when MHPAEA applies, it requires that the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment of services related to MH/SUD benefits in the case of a participant or beneficiary must be made available upon request or as otherwise required by the plan administrator (or health insurance issuer offering such coverage) to the participant or beneficiary in accordance with the IFR. Health plans and contractors that provide utilization management services must comply with this regulation under the Core 4 standards.

Filing a Complaint

If an employer or consumer has issues with an accredited health plan's compliance with the URAC standards that an employer cannot resolve with the health plan directly, an employer can make a written complaint to URAC. The complaint can be filed through URAC's webpage.

Conclusion and Endnotes

This Guide strives to provide an understandable and comprehensive guide to compliance with MHPAEA. As additional subregulatory guidance is issued and we obtain information we deem helpful in compliance efforts, we will periodically update this document. We welcome questions and/or suggestions regarding the content of this document. Inquiries should be directed to Steve Melek at steve.melek@milliman.com, Clare Miller at cmiller@psych.org, or Sam Muszynski at imuszynski@psych.org.

¹29 USC 1185a.

²29 CFR 2590.712 et al. For the text of the Final Rules, see <http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=27169&AgencyId=8&DocumentType=2>.

³See Part 4 for information on covered health plans.

⁴29 USC 1185a(a)(3)(A).

⁵On February 2, 2010, the Interim Final Rules to MHPAEA ("IFR") were published by the Departments and were generally applicable for the plan years that began on or after July 1, 2010. For the text of the IFR, see <http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=23511&AgencyId=8&DocumentType=2>.

⁶78 FR 68239.

⁷To review the FAQs related to MHPAEA, see <http://www.dol.gov/ebsa/mentalhealthparity/> under the subheading “Guidance.”

⁸To review the Updated Mental Health Parity Part II of the Self-Compliance Tool for Determining Compliance with the Mental Health Parity Act (MHPA) and the Mental Health Parity and Addiction Equity Act Provisions in Part 7 of ERISA, see <http://www.dol.gov/ebsa/pdf/cagappa.pdf>.

⁹See <http://workplacementalhealth.org/urac2> for a summary of the key issues related to the URAC parity standards. For more information on URAC, see www.urac.org.

¹⁰78 FR 68243.

¹¹See 29 USC 1185a(a)(3)(a) and 29 CFR 2590.712(c)(2). Different tests are applied to financial requirements and QTLs as opposed to NQTLs in order to determine parity compliance. These tests are described in detail in Parts 2 and 3 herein.

¹²29 CFR 2590.712(c)(2)(ii)(B).

¹³29 CFR 2590.712(c)(2)(ii)(A).

¹⁴29 CFR 2590.712(c)(2)(ii)(A)(1)–(6).

¹⁵29 CFR 2590.712(c)(2)(ii)(A).

¹⁶78 FR 68246-68247.

¹⁷78 FR 68247.

¹⁸*Id.*

¹⁹*Id.*

²⁰29 CFR 2590.712(c)(2)(ii)(C), Example 1.

²¹29 CFR 2590.712(c)(2)(ii)(C), Example 2.

²²29 CFR 2590.712(c)(2)(ii)(C), Example 3.

²³29 CFR 2590.712(c)(2)(ii)(C), Example 4.

²⁴75 FR 5412.

²⁵29 CFR 2590.712(a).

²⁶*Id.*

²⁷*Id.*

²⁸*Id.*

²⁹29 CFR 2590.712(c)(3)(iii).

³⁰See 78 FR 68242-68243 for a discussion on subclassifications.

³¹29 CFR 2590.712(c)(3)(iii)(A).

³²*Id.*

³³*Id.*

³⁴29 CFR 2590.712(c)(3)(iv), Example 4.

³⁵29 CFR 2590.712(c)(3)(iii)(B).

³⁶78 FR 68242.

³⁷78 FR 68242–68243.

³⁸29 CFR 2590.712(c)(3)(iii)(B).

³⁹29 CFR 2590.712(c)(3)(iv), Example 5.

⁴⁰*Id.*

⁴¹29 CFR 2590.712(c)(3)(iii)(C).

⁴²*Id.* See also 29 CFR 2590.712(c)(3)(iv), Example 7, in which the division of outpatient, in-network benefits into a subclassification of outpatient, in-network generalists and outpatient, in-network specialists violates the requirements of the rules.

⁴³29 CFR 2590.712(c)(3)(iv), Example 6.

⁴⁴29 CFR 2590.712(c)(2)(ii)(B). Also note that the Final Rules provide definitions for medical/surgical and MH/SUD benefits at 29 CFR 2590.712(a).

⁴⁵78 FR 68246–68247.

⁴⁶78 FR 68247. See 29 CFR 2590.712(c)(4)(ii)(H).

⁴⁷29 CFR 2590.712(c)(4)(iii), Example 9.

⁴⁸29 CFR 2590.712(c)(2)(i).

⁴⁹See 29 USC 1185(a), which prohibits the imposition of separate treatment limitations. While the Final Rules address how to apply the “predominant” and “substantially all” tests, it does not eliminate the requirement that a health plan cannot impose a financial requirement or treatment limitation on MH/SUD benefits if it does not impose them on medical/surgical benefits. See also 78 FR 68245.

⁵⁰29 CFR 2590.712(c)(3).

⁵¹29 CFR 2590.712(a).

⁵²*Id.*

⁵³*Id.*

⁵⁴*Id.*

⁵⁵29 CFR 2590.712(c)(1)(iii).

⁵⁶*Id.*

⁵⁷29 CFR 2590.712(c)(1)(iv).

⁵⁸29 CFR 2590.712(c)(3)(ii).

⁵⁹*Id.*

⁶⁰To determine how to calculate the portion of medical/surgical benefits in a classification, see 29 CFR 2590.712(c)(3)(i)(C), (D), and (E).

⁶¹29 CFR 2590.712(c)(3)(i)(E).

⁶²78 FR 68243.

⁶³29 CFR 2590.712(c)(3)(i)(A).

⁶⁴29 CFR 2590.712(c)(3)(i)(B).

⁶⁵29 CFR 2590.712(c)(3)(i)(B)(2).

⁶⁶See also 75 FR 5414-5415.

⁶⁷29 CFR 2590.712(c)(3)(iv), Example 1.

⁶⁸29 CFR 2590.712(c)(3)(iv), Example 2.

⁶⁹29 CFR 2590.712(c)(3)(iv), Example 3.

⁷⁰29 CFR 2590.712(c)(3)(v).

⁷¹78 FR 68243.

⁷²29 CFR 2590.712(c)(3)(v)(B), Example 1.

⁷³29 CFR 2590.712(c)(3)(v)(B), Example 2.

⁷⁴29 CFR 2590.712(c)(3)(v)(B), Example 3.

⁷⁵29 CFR 2590.712(c)(3)(v)(B), Example 4.

⁷⁶See 29 CFR 2590.712(b).

⁷⁷78 FR 68244.

⁷⁸*Id.*

⁷⁹29 CFR 2590.712(a).

⁸⁰29 CFR 2590.712(c)(4). See also 75 FR 5416 and 78 FR 68245.

⁸¹See 29 USC 1185(a), which prohibits the imposition of separate treatment limitations. While the Final Rules address how to apply the test related to NQTLs, they do not eliminate the requirement that a health plan cannot impose a financial requirement or treatment limitation on MH/SUD benefits if it does not impose it on medical/surgical benefits.

⁸²“For this purpose, the general parity requirement of MHPAEA applies separately for each type of financial requirement or treatment limitation. . . . The test is applied somewhat differently to non-quantitative treatment limitation, as discussed later in this preamble.” See 75 FR 5413. See also 78 FR 68245, which provides, “These final regulations continue to provide different parity standards with respect to quantitative treatment limitations and NQTLs. . . .”

⁸³29 CFR 2590.712(c)(4).

⁸⁴78 FR 68244. The Final Rules delete an exception to the NQTL parity standards for “recognized clinically appropriate standards of care” that permit a difference in treatment. There is now no exception to the NQTL tests.

⁸⁵See <http://www.dol.gov/ebsa/faqs/faq-aca7.html#UlgaelH3Bok> for a copy of FAQ #2.

⁸⁶See 78 FR 68245, which states, “as reflected in the FAQs 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.”

⁸⁷See <http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UlgaelH3Bok> for a copy of FAQ #5.

⁸⁸See 29 CFR 2590.712(c)(4)(iii), Example 8. See also FAQs about Affordable Care Act Implementation Part VII and Mental Health Parity Implementation, FAQ #4. See this FAQ at <http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UlgaelH3Bok>.

⁸⁹FAQs about Affordable Care Act Implementation Part VII and Mental Health Parity Implementation, FAQ 5 . See this FAQ at <http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UlgaelH3Bok>.

⁹⁰*Id.*

⁹¹75 FR 5416.

⁹²*Id.*

⁹³See 29 CFR 2590.712(c)(4)(iii), Example 1, and FAQs about Affordable Care Act Implementation Part VII and Mental Health Parity Implementation, FAQ 3 at <http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UlgaelH3Bok>.

⁹⁴75 FR 5416.

⁹⁵See 29 CFR 2590.712(c)(4)(iii), Example 2 and FAQs about Affordable Care Act Implementation Part VII and Mental Health Parity Implementation, FAQ 6 at <http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UlgaelH3Bok>.

⁹⁶29 CFR 2590.712(c)(4)(ii).

⁹⁷78 FR 68246.

⁹⁸*Id.*

⁹⁹29 CFR 2590.712(c)(4)(iii), Example 3.

¹⁰⁰29 CFR 2590.712(c)(4)(iii), Example 4.

¹⁰¹29 CFR 2590.712(c)(4)(iii), Example 11.

¹⁰²See FAQs about Affordable Care Act Implementation Part VII and Mental Health Parity Implementation, FAQs #2–#6 at <http://www.dol.gov/ebsa/faqs/faq-aca7.html#.UlgaelH3Bok>.

¹⁰³See FAQs about Affordable Care Act Implementation Part V and Mental Health Parity Implementation, Dec. 22, 2010, FAQ #10.

¹⁰⁴29 CFR 2590.712(c)(4)(iii), Example 5.

¹⁰⁵78 FR 68246.

¹⁰⁶*Id.* The Departments have indicated that they will provide additional guidance if there are additional questions regarding provider reimbursement rates.

¹⁰⁷29 CFR 2590.712(c)(4)(iii), Example 7.

¹⁰⁸*Id.*

¹⁰⁹29 CFR 2590.712(c)(4)(iii), Example 9.

¹¹⁰29 CFR 2590.712(c)(4)(iii), Example 10.

¹¹¹78 FR 68248 and 29 CFR 2590.712(f). The small-employer exception does not apply to nongrandfathered plans in the individual and small-group markets that are required by the ACA to provide EHB.

¹¹²78 FR 68248 and 29 CFR 2590.712(g).

¹¹³*Id.*

¹¹⁴29 CFR 2590.712(d)(1).

¹¹⁵29 CFR 2590.712(d)(2). See 29 CFR 2560.503-1 for the claims procedure rule.

¹¹⁶29 CFR 2590.712(d)(1). See also <http://www.dol.gov/ebsa/faqs/faq-aca5.html#.UKFDp6X3Bok> for ACA Implementation FAQ Part V, Question 10.

¹¹⁷29 CFR 2590.712(d)(3).

¹¹⁸*Id.*

¹¹⁹78 FR 68241.

¹²⁰*Id.*

¹²¹PHSA Section 2719.

¹²²45 CFR 147.136. See <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals.html>.

¹²³78 FR 68248 and 29 CFR 2590.712(g).

¹²⁴*Id.*

¹²⁵78 FR 68250.

¹²⁶29 CFR 2590.712(c)(4)(iii), Example 6.

¹²⁷*Id.*

¹²⁸78 FR 68250-68251.

¹²⁹*Id.*

¹³⁰To review a summary of the key issues related to URAC mental health parity standards, see <http://workplacementalhealth.org/urac2>.



For more information on the *Employer Guide for Compliance with the Mental Health Parity and Addiction Equity Act*, visit

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