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PARITY IMPLEMENTATION COALITION

Frequently Asked Questions and Answers about MHPAEA Compliance

These are some of the most commonly asked questions and answers by consumers and providers about their new rights and benefits under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity (MHPAEA) Act of 2008 (referred to interchangeably as MHPAEA, the Act or the statute). This document identifies and summarizes some of the most common health plan MHPAEA non-compliance issues. All of these commonly asked questions are based on real life situations where health plans have refused coverage or have been non-compliant with MHPAEA during the year 2010. MHPAEA became effective on October 3, 2009 and most health plans are expected to be in full compliance with the statute.

We provide a brief summary of your legal coverage and benefits rights under the parity statute for each of these situations. The answers were prepared by a leading health care law firm - Patton Boggs - and they are being made available to you so you can use them in your request for coverage, and or appeals for denials of treatment. You can pick which categories or questions relevant to your distinct coverage and/or reimbursement issues and use only those legal analyses that provide the legal rationale to assist with your issue.

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1. REFUSAL TO PAY FOR OR PROVIDE COVERAGE FOR SPECIFIC TYPES OF MH/SUD TREATMENT OR LEVELS OF CARE

Introduction

These questions and answers address the situation in which a managed care plan has chosen to provide benefits for one or more mental health condition or substance use disorder (MH/SUD) but has refused to reimburse for a specific type of treatment, diagnostic test or setting or level of care for that disorder. These denials of coverage can include common and essential types of treatments like residential inpatient care for substance use disorders, psychosocial rehabilitation services or even routine outpatient psychotherapy. MHPAEA does not require that specific treatments for MH/SUD conditions must be reimbursed but it holds an insurance company to the standard that the benefits and coverage policies for what treatments do get paid for cannot be more restrictive than what is paid for medical disorders like diabetes.

The parity statute and regulations have clarified that a health plan must pay for a similar range and scope of treatments for behavioral disorders as compared to medical/surgical conditions. In 2010, plans have refused to cover many essential and common MH/SUD treatments and frequently provide the rationale listed below for these decisions:

- Their policies state that certain mental health or substance use disorder treatments have no "medical analogy," meaning that these treatments are not the same as or are not comparable to other medical/surgical treatments.
- Plans state that they have no legal obligation to pay for a similar range and scope of services for behavioral as they do for medical treatments.

In this section, the Parity Implementation Coalition is providing you a legal analysis that addresses these specific issues and provides the rationale for why these denials of coverage are in fact illegal under MHPAEA.

Patton Boggs Provided the Legal Analysis for the Answers to the following Questions

a) Question:

A plan refuses to cover or reimburse for a type or level of care for MH/SUD because there is no medically-analogous type or level of care for medical/surgical conditions. Is this a violation of MHPAEA? Examples include:

- 1. Residential treatment for psychiatric or substance use disorders;**
- 2. Intermediate levels of care such as intensive outpatient treatment, psychosocial rehabilitation, partial hospitalization, and assertive community treatment; and**

3. Office-based diagnostic and treatment interventions for MH/SUD such as psychological testing for diagnostic assessments, other standardized tests like the PHQ 9, or other treatment services like psychotherapy.

a) Answer:

A plan that refuses to cover a mental health or substance use disorder (MH/SUD) service because there is no medical/surgical analogue violates both the regulations and statute if it does not likewise refuse to cover medical/surgical benefits that have no MH/SUD analogue.

In most cases, a plan that refuses to cover a MH/SUD service because it claims there is no medical/surgical analogue will make this decision based on a non-quantitative treatment limitation (NQTL). Accordingly, this action will be subject to the regulations' "comparable" and "no more stringently" standard.¹

The Interim Final Rules ("regulations") require NQTLs to be "comparable."² A provision that prohibits coverage for MH/SUD treatments that have no medical/surgical analogue, but does not prohibit coverage for medical/surgical services that have no MH/SUD analogue, is not comparable on its face. In such a situation, the plan would be in violation of the regulations.

Such a policy would also be prohibited by the underlying Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA" or "Act"). The treatment limitations section of the Act states that health plans must ensure that "there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits."³ A plan that refuses to cover a MH/SUD service that has no analogue in medical/surgical, but does not apply a similar standard to medical/surgical benefits, violates the parity requirements of the statute because it imposes a treatment limitation "applicable only with respect to" MH/SUD benefits.

¹ The "comparable" and "no more stringently" standard requires that: "Any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in a classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification." 75 Fed. Reg. 5416

² *Id.*

³ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A. § 1185a(a)(3)(A)(ii) (2009).

b) Question:

A plan refuses to reimburse for a type or level of care for a MH/SUD condition because the plan contends there is no parity requirement to cover any specific treatment service (i.e. no requirement for scope of service parity within a benefit classification or across benefit classifications) even if a full range of treatments is offered for medical and surgical treatments. Examples include:

- 1. Residential treatment for psychiatric disorders or substance use disorders;**
- 2. Intermediate levels of care such as intensive outpatient treatment, psychosocial rehabilitation, and assertive community treatment; and**
- 3. Office-based diagnostic and treatment interventions for MH/SUD such as psychological testing for diagnostic assessments, standardized tests like the PHQ 9, or other treatment services like psychotherapy.**

b) Answer:

The regulations and underlying Act require parity across classifications of benefits and within classifications. This imposes a two-fold requirement on plans: MH/SUD benefits must be provided in all classifications in which medical/surgical benefits are provided, and plans must provide a similar range of benefits to those provided for medical/surgical benefits within each classification.

In regard to the issue of parity across classifications, the Act is clear that limits on the scope and duration of treatment must be applied no more restrictively in the MH/SUD benefit than in the medical/surgical benefit. The statute defines treatment limitations as “limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the *scope or duration of treatment.*” [Emphasis added] The statute then prohibits limitations on the scope or duration of treatment under the MH/SUD benefit that are more restrictive than those imposed under the medical/surgical benefit. Thus, the plain language of the statute explicitly discusses scope of services and requires parity in scope.

The regulations create six classifications for purposes of applying the parity requirements: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. The regulations require that when a plan “provides [MH/SUD] benefits in any classification of benefits” described in the rule, MH/SUD benefits “must be provided in every classification in which medical/surgical benefits are provided.” This language demonstrates that if a plan is going to offer one MH/SUD service in any classification, it must offer MH/SUD services for each of the relevant classifications.

Similarly, the preamble and the text of the regulations state that “if a plan provides benefits for a mental health condition or substance use disorder in one or more classifications but excludes benefits for that condition or disorder in a classification in which it provides medical/surgical benefits, the exclusion of benefits in that classification for a [MH/SUD] otherwise covered under the plan is a treatment limitation.” This statement requires parity across classifications in the scope of services that are offered for a particular condition. For example, a plan provides benefits for schizophrenia in the outpatient in-network classification but excludes benefits for schizophrenia for the inpatient in-network classification, even though it offers medical/surgical benefits in that classification. The regulations prohibit such a plan design. The language of the regulations is a scope of services parity requirement because it precludes the ability of a plan to limit MH/SUD treatment services to less than all of the six classifications, provided medical/surgical benefits are offered for each classification.

The regulations’ standard governing non-quantitative treatment limitations (NQTLs) also demonstrates that a range of services must be offered in the MH/SUD benefit if offered in the medical/surgical benefit both across and within the six classifications. The regulations clearly state that NQTLs cannot be applied more stringently or in a non-comparable manner to MH/SUD benefits than to medical/surgical benefits. This limitation implicitly confers a scope of services in the MH/SUD benefit that is at least similar to the scope of services offered in the medical/surgical benefit for each classification. If a treatment limitation cannot be applied more stringently or in a non-comparable manner in one benefit than in another, the scope of services offered in each benefit classification should be largely analogous. Additionally, to remain consistent with the clear language of the Act, the regulations should also be read to prohibit NQTLs that are more restrictive in MH/SUD than in medical/surgical. This requirement again requires a similar scope of services by prohibiting more restrictive limitations on MH/SUD benefits.⁴

The regulations’ requirements for scope of services parity within classifications is well demonstrated by an example. Imagine a plan that offers only one or two types of MH/SUD treatment services or levels of care in each of the six required classes, while at the same time offering many types of treatment services for medical/surgical within each classification. Although the regulations do not require a plan to cover identical MH/SUD and medical surgical services within a classification, they do require that the limitations in each MH/SUD classification be no more restrictive than the limits in the corresponding medical/surgical classification. If limitations were being applied in a no more restrictive manner in the situation above, it is unlikely that only one or two MH/SUD services would be covered while many medical/surgical services are covered. Presumably, the plan has developed some reasoning for excluding coverage of other MH/SUD services. If the reason the plan is offering such limited MH/SUD services in a

⁴ More information on this argument can be found in the memo from Patton Boggs to the Parity Implementation Coalition, dated March 26, 2010.

classification is that the plan is applying a treatment (coverage) limitation to MH/SUD benefits that is more restrictive or not comparable than the treatment limitation applied in the medical/surgical benefit, the plan has violated the requirements of the parity regulations.

To allow otherwise would mean that a plan could, for example, offer visits to a primary care physician for a prescription of an anti-depressant medication as the only outpatient, in-network benefit for the treatment of depression. In this example, no psychotherapy treatments are covered by mental health specialists and no diagnostic tests like psychological testing are reimbursed, even though a full range of treatments and diagnostic tests are reimbursed for substantially all medical illnesses. The NQTL and other parity requirements would prohibit this benefit limitation.

Finally, the definitions of “mental health benefits” and “substance use disorder benefits” under the Act also demonstrate a scope of service parity requirement within and across classifications. The statute defines MH/SUD benefits as “benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.”⁵ Proponents of limiting services may point to the statutory definition of MH/SUD benefits to argue that there is no scope of service parity because a plan has the ability to define the services under the terms of the plan. The statute defines MH/SUD benefits as “benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.” Proponents of limiting services might argue that plans maintain the flexibility to determine which services to provide because the Act specifically allows them to be “defined under the terms of the plan.” However, the statute is clear that this process of defining the terms of the plan must be “in accordance with Federal and State law.” This means that the terms of the plan must be in harmony with the Act. This gives rise to two implications for plans. First, a plan has the flexibility to offer or not offer a MH/SUD benefit. The Act clearly states that its parity requirements apply only to a plan “that provides *both* medical and surgical benefits and mental health or substance use disorder benefits.” [Emphasis added]. However, any plan that offers both medical/surgical and MH/SUD benefits, must offer them “in accordance with Federal and State law,” including the Act. Under this reading, a plan has flexibility as to what mental health conditions and substance use disorders it covers. However, once it decides to cover the condition or disorder, it is subject to the parity requirements governing services described in the statute and regulations (predominant and substantially all, comparable and no more stringently, etc).

⁵ § 1185a(e)(4), (5).

c) Question:

If a plan offers to reimburse a range of disease management interventions such as phone-based case management, disease monitoring technology, diagnostic and tests for medical conditions but refuses to reimburse for these same services for any or most MH/SUD conditions would this be a violation of MHPAEA?

c) Answer:

A plan that provides coverage for a range of medical/surgical disease management interventions, while refusing to reimburse for such interventions for MH/SUD violates the statute and regulations if the reason for the differing coverage is a MH/SUD treatment limitation that is more restrictive, not comparable to, or more stringent than that applied to medical/surgical benefits.

The parity statute prohibits a plan from applying treatment limitations to MH/SUD benefits that are more restrictive than those applied to medical/surgical benefits. Treatment limitations are defined as various items that limit the scope and duration of treatment under a plan. In the scenario above, the plan has presumably developed some reasoning or policy for excluding coverage of MH/SUD disease management interventions. If the reason the plan is offering such limited MH/SUD services is that the plan is applying a treatment limitation to MH/SUD benefits that is more restrictive than the treatment limitation applied in the medical/surgical benefit, the plan has violated the requirements of the parity statute.

Such an exclusion may also violate the parity standards in the regulations. The regulations define NQTLs as limitations that are not numeric but that “otherwise limit the scope or duration of benefits for treatment under a plan.” Here, it appears that there is some non-numeric policy or standard that is prohibiting coverage of MH/SUD disease management interventions. As such, these policies would fall into the category of NQTLs and be governed by the NQTL parity standard.

The regulations subject all NQTLs to the comparable and no more stringently standard. The comparable and no more stringently standard states that a plan may not impose a NQTL for MH/SUD benefits unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are “comparable to, and are applied no more stringently than” those used in applying the NQTL to medical/surgical benefits.⁶ Here, the plan may be in violation of both standards.

The regulations prohibit plans from instituting a NQTL in MH/SUD while refusing to institute a “comparable” NQTL in the medical/surgical benefit. Here, if

⁶ 75 Fed. Reg. 5436.

medical/surgical and MH/SUD NQTLs were comparable, it seems unlikely that a wide range of medical/surgical disease management interventions would be covered while no or very few MH/SUD are covered. If the NQTLs are not comparable in MH/SUD and medical surgical, the plan has violated the regulations' comparable standard.

The “no more stringently” standard focuses on the manner in which NQTLs are *applied*. The regulations state that a plan may not impose a NQTL unless the processes, strategies, evidentiary standards, or other factors are “applied” no more stringently in medical/surgical than in MH/SUD.⁷ Under this rule, plans can have the same NQTL in both MH/SUD and medical/surgical and still violate the parity requirements by applying these NQTLs differently.⁸ Here, for example, the plan may have the same medical necessity standards but could be applying them more stringently to MH/SUD benefits to exclude MH/SUD disease management interventions. If so, the plan has violated the no more stringently standard.

⁷ 75 Fed. Reg. 5412.

⁸ The regulation states explicitly that the no more stringently standard was “included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face are applied in the same manner to medical/surgical and to MH/SUD benefits.” *Id.*

2. APPLICATION OF PARITY (MHPAEA) TO MEDICAL MANAGEMENT

Introduction

Many health plans and managed behavioral health organizations (MBHOs) in anticipation of the new parity statute have significantly expanded their medical management oversight of mental health or substance use disorder services. These utilization review activities such as prior authorization and concurrent review practice are much more restrictive than what is done for medical and surgical treatments.

Prior authorization and concurrent medical review are medical management protocols that are classified as non-quantitative treatment limitations in the parity regulations. As such, they must be at parity with what utilization review interventions are done on medical treatments .or they are non-compliant with MHPAEA. The legal analysis presented here addresses typical scenarios for out-patient and inpatient MH/SUD services that plans have or intend to implement and demonstrates what is legal and illegal.

Patton Boggs Provided the Legal Analysis for the Answers to the following Questions

a) Question:

Plan has a prior authorization (PA) requirement for outpatient MH/SUD services provided by MH/SUD practitioners in order to initiate treatment for in or out-of-network care. This PA requirement may include a refusal to reimburse if the patient isn't "registered" with the plan or may also require the submission of a brief treatment plan (either telephonically, electronically or submitted by mail) at the beginning of treatment or after a defined number of visits. There is no similar PA requirement for primary care doctors or specialty physicians for any medical conditions. Would this be a MHPAEA violation?

a) Answer:

A plan that implements a prior authorization (PA) requirement for outpatient MH/SUD services provided by MH/SUD practitioners but does not implement a similar requirement for medical/surgical treatment by primary care or specialty practitioners is in violation of the regulations' comparable and no more stringently standards and the underlying statute.

The treatment limitations section of the Act prohibits treatment limitations that are "more restrictive" in the MH/SUD benefit than in the medical/surgical benefit. Additionally, the Act states that health plans must ensure that "there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." Where a plan has a PA requirement

for outpatient MH/SUD services provided by MH/SUD practitioners but does not have any such requirement for medical/surgical care, it has implemented a “more restrictive” treatment limitation and has created a “separate” treatment limitation that applies “only with respect” to MH/SUD. Accordingly, it has acted contrary to the treatment limitations requirements of the statute.

The regulations state clearly that any “processes, strategies, evidentiary standards, or other factors” used in applying a NQTL to MHSUD benefits in a classification must be “comparable to” and be applied “no more stringently” than the processes, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in a classification. This standard prohibits plans from instituting a NQTL in MH/SUD while refusing to institute a “comparable” NQTL in the medical/surgical benefit.⁹ Here the plan has no similar PA requirement in the medical/surgical benefit as in the MH/SUD benefit. Thus, a NQTL is being applied in MH/SUD that does not exist in medical/surgical. This is inconsistent with the regulations’ prohibition on NQTLs that are not “comparable.”

The regulations give an example of a similar situation. In the regulations’ example 1, a plan requires concurrent review for inpatient, in-network MH/SUD benefits but does not require it for any inpatient, in-network medical/surgical benefits. The plan conducts retrospective review for inpatient, in-network medical/surgical benefits. The plan violates the regulations because the concurrent review process is not comparable to the retrospective review process. In similar fashion, the plan in the scenario above applies a PA restriction to MH/SUD benefits that is not “comparable” to any restriction on medical/surgical benefits. Accordingly, the plan in such a situation violates the clear language of the regulations.

b) Question:

A plan has a prior authorization (PA) requirement for outpatient MH/SUD services provided by MH/SUD practitioners in order to initiate treatment for in or out-of-network care. This PA requirement may include a refusal to reimburse if the patient isn’t “registered” with the plan or may also require the submission of a brief treatment plan (either telephonically, electronically or submitted by mail) at the beginning of treatment or after a defined number of visits. Plan applies a PA requirement to 30 percent of spending for outpatient medical/surgical treatments. Would this be a MHPAEA violation?

⁹ 75 Fed. Reg. 5416

b) Answer

A plan that applies a PA requirement to 30 percent of outpatient medical/surgical benefits is prohibited from applying such a PA requirement to MH/SUD benefits because the treatment limitation does not apply to substantially all medical/surgical benefits.

MHPAEA is clear that MH/SUD treatment limitations must be “no more restrictive than the predominant treatment limitations applied to substantially all” medical/surgical benefits covered by the plan.¹⁰ This phrase contains three discrete tests: (1) is the limitation applied to substantially all medical/surgical benefits; (2) is it the predominant treatment limitation; and (3) is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit? Importantly, the statute applies this standard to all treatment limitations.¹¹ Accordingly, the standard can be used here to judge the appropriateness of the plan’s action. The first issue is whether the limitation applies to substantially all medical/surgical benefits. Under the statute, the term “substantially all” is a barrier that prevents plans from applying a treatment limitation to MH/SUD benefits unless that limitation applies to substantially all medical/surgical benefits.

Although the statute does not define “substantially all,” a treatment limitation applicable to only 30 percent of benefits cannot reasonably be viewed as applying to “substantially all” benefits. In this case, the PA applies to only 30 percent of outpatient benefits. Accordingly, the treatment limitation does not apply to substantially all benefits. Because it does not apply to substantially all medical/surgical benefits it cannot apply to MH/SUD benefits.

The regulations state that a treatment limitation applies to “substantially all” medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in a classification. If a treatment limitation does not apply to at least two-thirds of the medical/surgical benefits in a classification, that type of treatment limitation “cannot be applied to mental health or substance use disorder benefits in that classification.”¹² Here, the PA limitation applies to only 30 percent of outpatient benefits. This percentage does not meet the two-thirds threshold required by the regulations. Since the limitation does not apply to at least two-thirds of medical/surgical outpatient benefits, it cannot apply to MH/SUD outpatient benefits.

¹⁰ *Id.*

¹¹ 29 U.S.C. 1185a(a)(3)(A)(ii).

¹² 75 Fed. Reg. 5414

c) Question:

A plan has concurrent review requirements for MH/SUD inpatient (in or out-of network) care but no such review is required for any medical/surgical inpatient care. Is this a MHPAEA violation?

c) Answer:

A plan that has concurrent review requirements for MH/SUD care but no similar requirement for medical/surgical care violates both the statute and the regulations.

MHPAEA is clear that MH/SUD treatment limitations must be “no more restrictive than the predominant treatment limitations applied to substantially all” medical/surgical benefits covered by the plan.¹³ This phrase contains three discrete tests: (1) is the limitation applied to substantially all medical/surgical benefits; (2) is it the predominant treatment limitation; and (3) is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit?¹⁴ Importantly, the statute applies this standard to all treatment limitations.¹⁵ Accordingly, the standard can be used here to judge the appropriateness of the plan’s action. Here, the treatment limitation does not apply at all in the medical/surgical benefit and therefore clearly fails to meet the “substantially all” and “predominant” tests above. Even if the predominant and substantially all standards were met, the treatment limitation here is “more restrictive” because it applies to MH/SUD benefits but not to medical surgical benefits.

The regulations define two types of treatment limitations: quantitative treatment limitations (QTLs) QTLs and non-quantitative treatment limitations (NQTLs). NQTLs are limitations that are not numeric but that “otherwise limit the scope or duration of benefits for treatment under a plan.” Because NQTLs are not expressed numerically, it is often challenging to identify when a NQTL is “more restrictive.” Accordingly, the regulations create the comparable and no more stringently standard to put the no more restrictive standard into practice.

The comparable and no more stringently standard states that a plan may not impose a NQTL for MH/SUD benefits unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are “comparable to, and are applied no more stringently than” those used in applying the NQTL to medical/surgical benefits.¹⁶ The “comparable to” requirement is the decisive factor in determining plan compliance under the scenario above.

¹³ *Id.*

¹⁴ More information on this argument can be found in the memo from Patton Boggs to the Parity Implementation Coalition, dated March 26, 2010.

¹⁵ 29 U.S.C. 1185a(a)(3)(A)(ii).

¹⁶ 75 Fed. Reg. 5436.

The regulations prohibit plans from instituting a NQTL in MH/SUD while refusing to institute a “comparable” NQTL in the medical/surgical benefit. Here, the plan implements a concurrent review process in the MH/SUD benefit, but does not utilize this process in the medical/surgical benefit. Thus, a NQTL is being applied in MH/SUD that does not exist in medical/surgical. This is inconsistent with the regulations’ prohibition on NQTLs that are not “comparable.”

The regulations give an example of a similar situation. In the regulations’ example 1, a plan requires concurrent review for inpatient, in-network MH/SUD benefits but does not require it for any inpatient, in-network medical/surgical benefits. The plan conducts retrospective review for inpatient, in-network medical/surgical benefits. The plan violates the regulations because the concurrent review process is not comparable to the retrospective review process. In similar fashion, the plan in the scenario above applies a concurrent review process to MH/SUD benefits that is not “comparable” to any review process on medical/surgical benefits. Accordingly, the plan in such a situation violates the clear language of the regulations.

Applying a NQTL in MH/SUD while not applying a comparable NQTL in medical/surgical is likewise consistent with the other parts of the underlying Act. The treatment limitations section of the Act states that health plans must ensure that “there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.” Here, the limitation is clearly only applicable to the MH/SUD benefit and, accordingly, is inconsistent with the statute.

d) Question:

A plan has concurrent review requirements for the majority of MH/SUD inpatient (in or out-of-network) care. The plan requires concurrent review for medical/surgical rehabilitation hospital benefits. Rehabilitation hospital spending represents less than ten percent of medical/surgical spending in the inpatient classification. Is this a violation of MHPAEA?

d) Answer:

A plan that applies concurrent review to ten percent of medical/surgical spending is prohibited from applying concurrent review to MH/SUD benefits because the concurrent review is a treatment limitation that does not apply to substantially all medical/surgical benefits.

MHPAEA is clear that MH/SUD treatment limitations must be “no more restrictive than the predominant treatment limitations applied to substantially all” medical/surgical benefits covered by the plan.¹⁷ This phrase contains three discrete tests: (1) is the limitation applied to substantially all medical/surgical

¹⁷ *Id.*

benefits; (2) is it the predominant treatment limitation; and (3) is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit? Importantly, the statute applies this standard to all treatment limitations.¹⁸ Accordingly, the standard can be used here to judge the appropriateness of the plan's action.

The first issue is whether the limitation applies to substantially all medical/surgical benefits. Under the statute, the term "substantially all" is a barrier that prevents plans from applying a treatment limitation to MH/SUD benefits unless that limitation applies to substantially all medical/surgical benefits. Although the statute does not define "substantially all," a treatment limitation applicable to only ten percent of spending cannot reasonably be viewed as applying to substantially all benefits covered by the plan. In this case, the concurrent review applies to only ten percent of inpatient medical/surgical spending. Accordingly, the treatment limitation does not apply to substantially all medical/surgical benefits. Because it does not apply to substantially all medical/surgical benefits it cannot apply to MH/SUD benefits.

The regulations state that a treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in a classification. If a treatment limitation does not apply to at least two-thirds of the medical/surgical benefits in a classification, that type of treatment limitation "cannot be applied to mental health or substance use disorder benefits in that classification."¹⁹ Here, the concurrent review process applies to only ten percent of inpatient medical/surgical benefits. This percentage does not meet the two-thirds threshold required by the regulations. Since the limitation does not apply to at least two-thirds of medical/surgical outpatient benefits, it cannot apply to MH/SUD inpatient benefits.

¹⁸ 29 U.S.C. 1185a(a)(3)(A)(ii).

¹⁹ 75 Fed. Reg. 5414

3. DISCRIMINATION IN REIMBURSEMENT PRACTICES

Introduction

Health plans and MBHOs commonly use reimbursement practices, i.e., fee schedule or usual and customary rate methodologies for out-of-network services, which, when contrasted to the fees paid for medical surgical services are not comparable and are more restrictive. That is, physician specialists providing mental health and substance use services are typically paid less than other physicians relative to recognized fee benchmarks such as Medicare. Health plans also typically restrict the scope of allowable physician services that these specialists' physicians may provide and bill for.

Both reimbursement practices may limit physician network participation or their availability on an out-of-network basis thereby increasing the out-of-pocket spending by consumers of mental health services. The parity regulations recognize these practices as non-quantitative treatment limitations, because they may limit patient access to treatment or otherwise limit the scope or duration of treatment. As such, they are subject to the compliance tests established by the regulations for NQTLs. The analysis presented here describes these commonly occurring situations and discusses compliance.

Patton Boggs Provided the Legal Analysis for the Answers to the following Questions

a) Question:

Do the regulations prohibit using rate calculation methods for in or out-of-network providers that are more stringent for MH/SUD than medical/surgical providers? Would lack of inflation adjusters for MH/SUD providers vs. medical/surgical providers be considered a Non-Quantitative Treatment Limitation?

a) Answer:

The plain language of the regulations prohibits rate calculation methods that are more stringent for MH/SUD providers than medical/surgical providers.

As noted above, a plan may not impose a NQTL with respect to MH/SUD benefits unless the process, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, or are applied no more stringently than, those with respect to medical/surgical benefits. The regulations define both QTLs and NQTLs. QTLs are defined as limitations which are "expressed numerically," such as "50 outpatient visits per year."²⁰ NQTLs, by contrast, are limitations that are not numeric but that "otherwise limit the scope or

²⁰ *Id.*

duration of benefits for treatment under a plan.”²¹ The regulations set forth an illustrative list of NQTLs. One of these NQTLs is “standards for provider admission to participate in a network, *including reimbursement rates*.”²² (Emphasis added). When the language of a regulation is plain, that language governs. **The plain language of the regulation, which specifically includes reimbursement rates as an example of a NQTL, demonstrates that provider rate calculation methods are a NQTL subject to the “comparable” and “no more stringently” standards.** In addition, the list of NQTL examples lists “plan methods for determining usual, customary, and reasonable charges.” This payment-related NQTL further demonstrates that rate calculation methods are a NQTL subject to parity requirements.

Inflation updates, which are tied closely to reimbursement rates and methods for determining charges, would similarly qualify as NQTLs subject to parity requirements. Although inflation updates are not mentioned specifically in the list of NQTL examples, the mention of reimbursement rates would reasonably be interpreted to include such updates. The list of examples is illustrative rather than comprehensive, and can accordingly include other NQTLs. In commenting on the regulations, advocates should note this extension of the term “reimbursement rates” to include inflation adjusters to reimbursement rates. In addition, if a plan regularly denies inflation updates to MH/SUD providers while providing them to medical/surgical providers, the result will be that the underlying reimbursement rates become non-comparable.

b) Question:

A plan refuses to allow a psychiatrist or addiction physician to bill for evaluation and management services for MH/SUD conditions under established E&M CPT physician codes while permitting all other non-psychiatric physicians to use these codes for medical/surgical disorders.

b) Answer:

A plan that prohibits the use of E&M codes for MH/SUD practitioners, while allowing the use of these codes for medical/surgical professionals has implemented a non-comparable treatment limitation that violates the regulations.

Under the parity regulations, the processes, strategies, evidentiary standards, or other factors used in applying a NQTL to a MH/SUD benefit must be comparable and no more stringent than those applied to a medical/surgical benefit. NQTLs are non-numeric plan policies that “limit the scope or duration of benefits for treatment under a plan.”²³ While the illustrative list of NQTL examples does not specifically list coding limitations as an NQTL, it does list several other payment-

²¹ *Id.*

²² 75 Fed. Reg. 5443.

²³ 75 Fed. Reg. 5445.

related policies that qualify as NQTLs. For example, one of these NQTLs is “standards for provider admission to participate in a network, including reimbursement rates.”²⁴ Another listed NQTL is “plan methods for determining usual, customary, and reasonable charges.” Like these examples, coding is closely related to reimbursement. As with these other payment-related examples, coding restrictions can be considered a NQTL.

E&M codes generally pay more than psychiatry CPT codes and many plans preclude psychiatrists from using these codes to bill for services. Both of these factors may ultimately affect a psychiatrist’s willingness or ability to participate in a provider network, which will, in turn, affect the scope of services available to a beneficiary. Additionally, a plan’s decision to prohibit a psychiatrist or addiction specialist physician from using E&M codes will restrict who can provide basic medical management services to persons with MH/SUD. As discussed above, because of the potential effect on the “scope” of services caused by limitations on the use of E&M codes by psychiatrists and addiction specialist physicians, such restrictions likely qualify as an NQTL.

As an NQTL, coding policies are subject to the regulations’ “comparable” standard. The comparable standard clearly prohibits plans from instituting a NQTL in MH/SUD while refusing to institute a “comparable” NQTL in the medical/surgical benefit.²⁵ Here, the plan prohibits the use of E&M codes for MH/SUD practitioners, while allowing the use of these codes for medical/surgical professionals. On its face, such a policy is not comparable. An NQTL is being applied in MH/SUD that does not exist in medical/surgical. This is inconsistent with the regulations’ prohibition on NQTLs that are not comparable.

²⁴ 75 Fed. Reg. 5443.

²⁵ 75 Fed. Reg. 5416

4. APPLICATION OF PARITY (MHPAEA) TO MEDICAID MANAGED CARE PLANS

Introduction

This section addresses Medicaid managed care plans. MHPAEA applies to group health insurers and Medicaid managed care organizations (MCO). No provisions were included in the statute to differentiate the statute's impact on Medicaid managed care organizations or establish a later implementation period.

As is the case with private health insurance plans if a Medicaid MCO (that is providing general health benefits) offers any behavioral benefits within any of the 6 benefit classifications then they are required to be compliant with all of the statutory and regulatory requirements of MHPAEA.

While regulators have suggested additional guidance will be forthcoming on the implementation of MHPAEA in Medicaid managed care organizations, according to Patton Boggs, these organizations are currently covered under the statute and subject to all of MHPAEA's requirements including the Interim Final Regulations. Please see attachments 1 & 2 for 2009 guidance on this topic from CMS and a letter from key legislators and House Committee Chairmen clarifying congressional intent on the application of MHPAEA to Medicaid managed care organizations.

Patton Boggs Provided the Legal Analysis for the Answers to the following Questions

a) Question:

Must Medicaid managed care organizations (MCOs) comply with these regulations, or is CMS permitted to issue separate regulations for these organizations?

a) Answer:

The Medicaid statute requires that Medicaid managed care plans comply with the parity provisions of the Act. Since the regulations implement the Act and do not contain an exemption for Medicaid managed care plans, Medicaid MCOs must comply with the parity requirements as spelled out in the regulations. This conclusion is supported by both the Act, and the regulatory history of previous mental health parity laws.

The Act modified the Public Health Service Act (PHSA) to require that if a group health plan offers both medical/surgical benefits and MH/SUD benefits, the financial requirements and treatment limitations for MH/SUD benefits must be no more restrictive than those imposed in the medical/surgical benefit.²⁶ The Medicaid managed care statute refers to this section and mandates that

²⁶ 42 U.S.C. 300gg-5(a)(3) (2000).

managed care plans “comply” with its provisions. Specifically, Social Security Act Section 1932(b)(8) specifies that “Each Medicaid managed care organization shall comply with the requirements of subpart 2 of Part A of title XXVII of the Public Health Service Act [42 U.S.C.A. 300gg-5 *et seq.*] insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.”²⁷ The statutory reference in the quote refers to the mental health parity provisions as passed in the 1996 Mental Health Parity Act (MHPA) and as modified by the 2008 Act. Thus, **the Medicaid managed care statute requires that Medicaid MCO plans comply with both the 1996 and the 2008 parity requirements.**

This interpretation is consistent with Congressional views on the meaning and application of the Act. The Senate Committee on Health, Education, Labor, and Pensions (HELP) reported its version of the Act out of Committee on April 11, 2007. In the Committee Report accompanying the bill, the Committee stated that “[t]he bill’s requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program.”²⁸ Similar language is included in the Congressional Budget Office (CBO) cost estimate included in the Committee Reports from the House Education & Labor, Energy & Commerce, and Ways & Means Committees.²⁹ Although the Committee-passed legislation was not identical to the bill enacted into law, no changes were made to the bill that would alter this analysis.

The view that Medicaid MCO plans must comply with the parity provisions of the Act is also consistent with past agency interpretation of MHPA. The 1997 Balanced Budget Act (BBA) made a number of changes involving managed care to the Medicaid statute, including adding Section 1932(b)(8), the requirement discussed above that MCO plans comply with mental health parity requirements.³⁰ The Health Care Financing Administration (HCFA), the predecessor agency to CMS, subsequently released a number of letters to State Medicaid Directors explaining the effect of the BBA on Medicaid managed care organizations. In a letter dated January 20, 1998, Sally Richardson, the director of the Center for Medicaid and State Operations, stated that the parity requirements of the 1996 Mental Health Parity Act (MHPA) “apply to Medicaid managed care organizations without exemptions.”³¹ This is so because Section 1932(b)(8) “specifically requires Medicaid managed care organizations to comply with MHPA by treating them, for that purpose, like health insurance issuers

²⁷ 42 U.S.C. 1396u-2(b)(8) (2000).

²⁸ S. REP. NO. 110-53, at 5 (2007) (Sen. Comm. on Health, Educ. & Labor, 2007).

²⁹ H.R. REP. NO. 110-374, pt. 1 (2007) (Educ. & Labor Comm.); H.R. REP. NO. 110-374, pt. 2 (2007) (Ways & Means Comm.); H.R. REP. NO. 110-374, pt. 3 (2007) (Energy & Commerce Comm.).

³⁰ 42 U.S.C. 1396u-2(b)(8) (2000).

³¹ Letter from Sally Richardson, Director of the Health Care Financing Administration, to State Medicaid Directors (January 20, 1998), available at: <http://www.cms.hhs.gov/smdl/downloads/SMD012098d.pdf>.

offering group health insurance coverage.”³² Although this letter was written during implementation of the 1996 Act, its reasoning continues to apply with respect to the 2008 Act. **The 2008 Act simply added a section to the original 1996 parity law. This new section falls within the scope of Section 1932(b)(8)’s requirement that managed care organizations must comply with the parity requirements. Accordingly, Section 1932(b)(8) applies equally to the parity requirements in the 2008 Act. This means that Medicaid MCO plans are subject to the 2008 Act’s requirements.**

The statute, legislative history, and regulatory history demonstrate that the Act applies to Medicaid MCO plans. The regulations state that they are “implementing” the Act. **The regulations do not contain an exemption for MCOs from compliance with the requirements therein. Since the Act’s requirements apply to Medicaid MCOs, and since the regulations that implement the Act give no indication that separate rules apply to MCO plans, MCOs must comply with these regulations.**

³² This is not to say that Medicaid Managed Care plans necessarily meet the requirements of a “group health plan” under the 1996 or 2008 parity acts. However, the statutory language of 42 U.S.C. 1396u-2(b)(8), and the analysis by HCFA demonstrate that MMC plans are treated like group health plans with respect to the parity requirements.

5. DISCRIMINATION IN ANY COST CONTAINMENT PRACTICES

Introduction

The parity statute and regulations not only required parity in utilization review techniques and application of medical management interventions between behavioral and medical but it also required parity in the application of any cost containment efforts and policies.

In this section there are several specific examples given with a legal analysis for each. Many plans have added restrictions in the MH/SUD benefit only, such as requirements that only short term, crisis care will be reimbursed or only those treatments that can show significant clinical improvement will be paid for. As is outlined in these questions and answers, this is non-compliant with MHPAEA.

Further, most insurance plans perform technology reviews on treatments whether medical or behavioral to determine if these treatments meet some minimum level of scientific evidence to prove their effectiveness. Prior to MHPAEA, many managed behavioral health organizations did these reviews on MH/SUD treatments in a vacuum without regard to what criteria were being used on medical procedures and often these companies used scientific criteria that were more restrictive than what was done for most medical treatments. This activity has now been ruled non-compliant with MHPAEA. The specific legal rationale is addressed here in these questions and answers.

Patton Boggs Provided the Legal Analysis for the Answers to the following Questions

Question:

- a) **A plan's coverage policy or medical necessity criteria states it will reimburse only for short term, acute, crisis intervention types of treatment for any MH/SUD condition that the plan covers. The plan has no such restriction on medical/surgical conditions.**

a) **Answer:**

A plan that will reimburse only for short term, acute, crisis intervention types of treatment for any MH/SUD but does not impose such a restriction on medical/surgical conditions is in violation of both the regulations and the underlying statute.

MHPAEA is clear that MH/SUD treatment limitations must be “no more restrictive than the predominant treatment limitations applied to substantially all” medical/surgical benefits covered by the plan.³³ This phrase contains three

³³ *Id.*

discrete tests: (1) is the limitation applied to substantially all medical/surgical benefits; (2) is it the predominant treatment limitation; and (3) is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit?³⁴ Importantly, the statute applies this standard to *all* treatment limitations.³⁵ Accordingly, the standard can be used here to judge the appropriateness of the plan's action. Here, the treatment limitation does not apply at all in the medical/surgical benefit and, therefore, clearly fails to meet the "substantially all" and "predominant" tests above.

The regulations define two types of treatment limitations: QTLs and NQTLs. NQTLs are limitations that are not numeric but that "otherwise limit the scope or duration of benefits for treatment under a plan." Because NQTLs are not expressed numerically, it is often challenging to identify when a NQTL is "more restrictive." Accordingly, the regulations create the comparable and no more stringently standard to put the no more restrictive standard into practice.

The comparable and no more stringently standard states that a plan may not impose a NQTL for MH/SUD benefits unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are "comparable to, and are applied no more stringently than" those used in applying the NQTL to medical/surgical benefits.³⁶ The "comparable to" requirement is the decisive factor in determining plan compliance under the scenario above.

The regulations prohibit plans from instituting a NQTL in MH/SUD while refusing to institute a "comparable" NQTL in the medical/surgical benefit. Here the plan has a very specific coverage limitation in the MH/SUD benefit, but no such limitation in the medical/surgical benefit. Thus, a NQTL is being applied in MH/SUD that does not exist in medical/surgical. This is inconsistent with the regulations' prohibition on NQTLs that are not "comparable."

The regulations give an example of a situation similar to the scenario above. In the regulations' example 5, plan participants are able to access MH/SUD benefits only after exhausting counseling sessions offered under an employee assistance program (EAP). The plan violates the regulations because no similar exhaustion requirement applies with respect to medical/surgical benefits. In similar fashion, the plan in the scenario above applies a restriction to MH/SUD benefits that does not apply to any restriction on medical/surgical benefits. Accordingly, the plan in such a situation violates the clear language of the regulations.

Applying a NQTL in MH/SUD while not applying a comparable NQTL in medical/surgical is likewise consistent with the other parts of the underlying Act. The treatment limitations section of the Act states that health plans must ensure that "there are no separate treatment limitations that are applicable only with

³⁴ More information on this argument can be found in the memo from Patton Boggs to the Parity Implementation Coalition, dated March 26, 2010.

³⁵ 29 U.S.C. 1185a(a)(3)(A)(ii).

³⁶ 75 Fed. Reg. 5436.

respect to mental health or substance use disorder benefits.” Here, the limitation is clearly only applicable to the MH/SUD benefit and, accordingly, is inconsistent with the statute.

In addition, allowing a NQTL in MH/SUD while not imposing any similar limitation in medical/surgical would be inconsistent with the purpose of the Act. The purpose of the Act, as stated by each of the five Committees that considered the bill, was to ensure “parity” between MH/SUD benefits and medical/surgical benefits. Parity is “the quality or state of being equal or equivalent.” It seems clear that a plan with a NQTL for MH/SUD but not for medical/surgical is not “equal or equivalent.” In addition, the legislation was enacted to remedy a specific problem, namely, “the discrimination that exists under many group health plans with respect to mental health and substance-related disorder benefits.” Interpreting the Act to allow the application of a NQTL in MH/SUD while not applying a more restrictive NQTL in medical/surgical perpetuates the discrimination that Congress intended to do away with.

b) Question:

A plan states that it will only reimburse for treatments (for the plan’s covered MH/SUD conditions) that will show significant clinical improvements based on national guidelines that their internal managed mental health and substance care organization has developed. For example, a plan refuses to reimburse for coverage of “mental illnesses that will not substantially improve beyond the current level of functioning or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the mental health/substance abuse designee,” i.e. the plan. No such language is applied to coverage for medical/surgical benefits.

b) Answer:

The Act states that treatment limitations can be “no more restrictive” for MH/SUD benefits than the predominant treatment limitations applied to substantially all medical/surgical benefits covered by the plan. Here, the plan is imposing a restriction to MH/SUD benefits that does not exist for the medical/surgical benefits. It is clear that in such a case the plan is applying a treatment limitation that is “more restrictive” to MH/SUD benefits than in medical/surgical benefits. Indeed, because the limitation does not even exist for the medical/surgical benefits, it is difficult to imagine how the treatment limitation could be applied any more restrictively.

The Act also prohibits “separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.”³⁷ In this case, it is again clear that the plan is imposing a limitation that applies “only with respect to”

³⁷ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A. § 1185a(a)(3)(A)(ii) (2009).

MH/SUD benefits. In so doing, the plan has violated the treatment limitations section of the Act.

Applying this limitation without imposing a similar limitation on medical/surgical benefits also violates the regulations that implement the Act. The regulations state clearly that any “processes, strategies, evidentiary standards, or other factors” used in applying a NQTL to MH/SUD benefits must be “comparable to” the processes, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits.³⁸ The evidentiary standard used by the plan (i.e., whether the treatment will show significant clinical improvements) is not applied in a comparable manner to medical/surgical benefits because it does not exist for the medical/surgical benefits. Accordingly, if this standard is not applied to medical/surgical benefits, it violates the parity regulations

c) Question:

Do the regulations require plans to use the same scientific criteria or standards in both medical/surgical and MH/SUD for determining whether a treatment or diagnostic test is experimental?

c) Answer:

Although the regulations do not require identical scientific criteria or standards for determining whether a treatment or diagnostic test is experimental, such criteria must be comparable and be applied no more stringently in MH/SUD than in medical/surgical.

The first step in determining whether plans must use the same scientific criteria or standards for determining whether a treatment is experimental is to determine whether these criteria qualify as a treatment limitation under the regulations. As noted previously, QTLs are limitations which are “expressed numerically,” while NQTLs are limitations that are not numeric but that “otherwise limit the scope or duration of benefits for treatment under a plan.”³⁹ Since scientific criteria for determining the experimental nature of a treatment or diagnostic test are not expressed numerically, these criteria do not qualify as a QTL. But, since they have the potential to limit or eliminate coverage of a treatment or test that is deemed experimental, these criteria or standards qualify as a NQTL under the regulations. This conclusion is buttressed by the illustrative list of examples provided in the regulations. Example A states that NQTLs include medical management standards limiting or excluding benefits...*based on whether the treatment is experimental or investigative.*⁴⁰ From this example, it seems clear that **scientific criteria that limit or exclude benefits based on whether the**

³⁸ 75 Fed. Reg. 5416.

³⁹ 75 Fed. Reg. 5438.

⁴⁰ 75 Fed. Reg. 5443.

treatment is experimental or investigative are a form of NQTL that is subject to the regulations' requirements.

The NQTL requirements state that any processes, strategies, evidentiary standards, or other factors used in applying a NQTL to MH/SUD benefits in a classification must be comparable to, and be applied no more stringently than those applied with respect to medical/surgical standards. These regulations do not require that the exact same processes, strategies, evidentiary standards, or other factors be used, but they must be comparable and applied no more stringently. Thus, for example, if a plan views medical/surgical treatments as non-experimental based on criteria that only use consensus panels, while only recognizing MH/SUD treatments as non-experimental based on controlled clinical trials, the plan has used standards that are not comparable. In such a case, the plan would not be compliant with the parity regulations.

6. APPLICATION OF PARITY (MHPAEA) TO PSYCHIATRIC AND ADDICTION MEDICATIONS

Introduction

Health plan formulary policies frequently utilize a variety of protocols that govern when and how medications can be accessed. These protocols and their medical necessity criteria, such as fail first on generic drugs and off-label use, are common but are often applied more restrictively to MH/SUD medications.

Pharmacy benefits are defined as a distinct benefit classification by the parity regulations. Pharmacy management protocols are considered non-quantitative treatment limitations (NQTLs). As such, the protocols used for mental health and substance use disorder medications are subject to the tests established by the parity regulations to determine their appropriateness. The examples below provide an analysis as to how the parity tests would apply to a couple of common situations.

Patton Boggs Provided the Legal Analysis for the Answers to the following Questions

a) Question:

Plans develop medical necessity criteria that require a patient to fail first on oral medications for MH/SUD before reimbursing for MH/SUD injectables. However the plan frequently pays for injectables on the medical side without requiring a failed trial of oral medications first. Would this be a MHPAEA violation?

a) Answer:

A plan that requires fail first on oral medications prior to covering injectables for MH/SUD, but does not require fail first on oral medications prior to covering injectables for medical/surgical conditions has violated both the regulations and the statute.

MHPAEA is clear that MH/SUD treatment limitations must be “no more restrictive than the predominant treatment limitations applied to substantially all” medical/surgical benefits covered by the plan.⁴¹ This phrase contains three discrete tests: (1) is the limitation applied to substantially all medical/surgical benefits; (2) is it the predominant treatment limitation; and (3) is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit? Importantly, the statute applies this standard to *all* treatment limitations.⁴² Accordingly, the standard can be used here to judge the appropriateness of the plan’s action. Here, the treatment limitation does not apply at all in the medical/surgical benefit

⁴¹ *Id.*

⁴² 29 U.S.C. 1185a(a)(3)(A)(ii).

and therefore clearly fails to meet the “substantially all” and “predominant” tests above.

The regulations define two types of treatment limitations: QTLs and NQTLs. NQTLs are limitations that are not numeric but that “otherwise limit the scope or duration of benefits for treatment under a plan.” Because NQTLs are not expressed numerically, it is often challenging to identify when a NQTL is “more restrictive.” Accordingly, the regulations create the comparable and no more stringently standard to put the no more restrictive standard into practice.

The comparable and no more stringently standard states that a plan may not impose a NQTL for MH/SUD benefits unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are “comparable to, and are applied no more stringently than” those used in applying the NQTL to medical/surgical benefits.⁴³ The regulations explicitly state that fail-first policies are a form of NQTL. As such, these standards are subject to the regulations’ comparable and no more stringently standards. The “comparable to” requirement is the decisive factor in determining plan compliance under the scenario above.

The regulations prohibit plans from instituting a NQTL in MH/SUD while refusing to institute a “comparable” NQTL in the medical/surgical benefit. Here the plan has a specific coverage limitation in the MH/SUD benefit, but no such limitation in the medical/surgical benefit. Thus, a NQTL is being applied in MH/SUD that does not exist in medical/surgical. This is inconsistent with the regulations’ prohibition on NQTLs that are not “comparable.”

The regulations give an example of a situation similar to the scenario above. In the regulations’ example 5, plan participants are able to access MH/SUD benefits only after exhausting counseling sessions offered under an employee assistance program (EAP). The plan violates the regulations because no similar exhaustion requirement applies with respect to medical/surgical benefits. In similar fashion, the plan in the scenario above applies a restriction to MH/SUD benefits that does not apply to any restriction on medical/surgical benefits. Accordingly, the plan in such a situation violates the clear language of the regulations.

Applying a NQTL in MH/SUD while not applying a comparable NQTL in medical/surgical is likewise consistent with the other parts of the underlying Act. The treatment limitations section of the Act states that health plans must ensure that “there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.” Where a plan imposes fail first policies to MH/SUD injectables but does not apply similar criteria to medical/surgical injectables, it has created a “separate” treatment limitation that applies “only with respect” to MH/SUD. Accordingly, it has acted contrary to the treatment limitations requirements of the statute.

⁴³ 75 Fed. Reg. 5436.

In addition, allowing a NQTL in MH/SUD while not imposing any similar limitation in medical/surgical would be inconsistent with the purpose of the Act. The purpose of the Act, as stated by each of the five Committees that considered the bill, was to ensure “parity” between MH/SUD benefits and medical/surgical benefits. Parity is “the quality or state of being equal or equivalent.” It seems clear that a plan with a NQTL for MH/SUD but not for medical/surgical is not “equal or equivalent.” In addition, the legislation was enacted to remedy a specific problem, namely, “the discrimination that exists under many group health plans with respect to mental health and substance-related disorder benefits.” Interpreting the Act to allow the application of a NQTL in MH/SUD while not applying a more restrictive NQTL in medical/surgical perpetuates the discrimination that Congress intended to eliminate.

b) Question:

A plan reimburses for prescriptions for injectable drugs for medical/surgical disorders, when available, but injectables are not covered on the MH/SUD formulary. Is this a MHPAEA violation?

b) Answer:

A plan that covers injectable drugs for medical/surgical conditions but refuses to cover MH/SUD injectables is in violation of the underlying statute and the regulations’ comparable and no more stringently standards.

MHPAEA is clear that MH/SUD treatment limitations must be “no more restrictive than the predominant treatment limitations applied to substantially all” medical/surgical benefits covered by the plan.⁴⁴ This phrase contains three discrete tests: (1) is the limitation applied to substantially all medical/surgical benefits; (2) is it the predominant treatment limitation; and (3) is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit?⁴⁵ Importantly, the statute applies this standard to all treatment limitations.⁴⁶ Accordingly, the standard can be used here to judge the appropriateness of the plan’s action. Here, the plan has implemented a formulary design that does not allow access to injectable drugs for patients with MH/SUD. This treatment limitation does not apply in the medical/surgical benefit and therefore clearly fails to meet the “substantially all” and “predominant” tests above. Even if the predominant and substantially all standards were met, the treatment limitation here is “more restrictive” because it applies to MH/SUD benefits but not to medical/surgical benefits.

The regulations define two types of treatment limitations: QTLs and NQTLs. NQTLs are limitations that are not numeric but that “otherwise limit the scope or

⁴⁴ *Id.*

⁴⁵ More information on this argument can be found in the memo from Patton Boggs to the Parity Implementation Coalition, dated March 26, 2010.

⁴⁶ 29 U.S.C. 1185a(a)(3)(A)(ii).

duration of benefits for treatment under a plan.” The regulations state specifically that prescription drug formulary design is a form of NQTL. Because NQTLs are not expressed numerically, it is often challenging to identify when a NQTL is “more restrictive.” Accordingly, the regulations create the comparable and no more stringently standard to put the no more restrictive standard into practice.

The comparable and no more stringently standard states that a plan may not impose a NQTL for MH/SUD benefits unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are “comparable to, and are applied no more stringently than” those used in applying the NQTL to medical/surgical benefits.⁴⁷ Here, the plan is likely in violation of both standards.

The regulations prohibit plans from instituting a NQTL in MH/SUD while refusing to institute a “comparable” NQTL in the medical/surgical benefit. Here the plan implements a formulary design that limits access to MH/SUD injectables but presumably does not implement this design in the medical/surgical formulary. This is inconsistent with the regulations’ prohibition on NQTLs that are not “comparable.”

The “no more stringently” standard focuses on the manner in which NQTLs are *applied*. The regulations state that a plan may not impose a NQTL unless the processes, strategies, evidentiary standards, or other factors are “applied” no more stringently in medical/surgical than in MH/SUD.⁴⁸ Under this rule, plans can have the same NQTL in both MH/SUD and medical/surgical and still violate the parity requirements by applying these NQTLs differently.⁴⁹ Here, the plan likely has a formulary design that applies to both medical/surgical and mental health benefits. However, the policies appear to be applied very differently with respect to injectable drugs. The MH/SUD formulary includes a total ban on the use of these medications, while the medical/surgical formula permits them in some instances. This differential application is inconsistent with the regulations because the NQTL is being applied more stringently in the MH/SUD benefit than the medical/surgical benefit.

⁴⁷ 75 Fed. Reg. 5436.

⁴⁸ 75 Fed. Reg. 5412.

⁴⁹ The regulation states explicitly that the no more stringently standard was “included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face are applied in the same manner to medical/surgical and to MH/SUD benefits.” *Id.*

c) Question:

Plan formulary has generic fail-first policy in many classes of drugs for many medical disorders but does not require fail-first on more than one generic drug in order to become eligible for a non-generic drug. The medical management policy for the MH/SUD formulary requires fail first on two or more generic drugs prior to eligibility for a non-generic drug. Is this a MHPAEA violation?

c) Answer:

A plan whose MH/SUD formulary requires that a beneficiary fail first on two or more generic drugs prior to being eligible for a non-generic drug, but only requires fail first on one generic drug in the medical/surgical formulary has acted inconsistently with the statute, regulations, and Congressional intent because a treatment limitation is being applied in a non-comparable and more restrictive manner to MH/SUD benefits.

The parity statute prohibits MH/SUD treatment limitations that are “more restrictive” than those applied to medical/surgical benefits. The statute applies this standard to all treatment limitations.⁵⁰ Given the broad scope of the statute’s treatment limitations language, fail-first policies are a treatment limitation governed by the standard in the statute. Here, the plan’s MH/SUD formulary requires fail-first on two or more generic medications prior to eligibility for a brand drug. The medical/surgical formulary only requires fail first on one generic drug. Because of the higher standard in the MH/SUD formulary, the plan has implemented a more restrictive treatment limitation in violation of the statute.

The fail first policies above also violate the regulations issued to implement the parity statute. According to the regulations, NQTLs are non-numeric plan policies that limit the scope or duration of benefits for treatment under a plan.⁵¹ Under the regulations, the processes, strategies, evidentiary standards, or other factors used in applying a NQTL to a MH/SUD benefit must be no more stringent than those applied to a medical/surgical benefit. The regulations explicitly state that fail-first policies are a form of NQTL.⁵² As such, they are subject to the regulations’ “no more stringently” standards.

⁵⁰ The Act states simply that “treatment limitations” must meet the statute’s requirements. It does not differentiate between types of treatment limitations, but rather applies parity requirements to all types of these limitations. The Act provides guidance as to the meaning of the term when it states that “treatment limitation *includes* limits on the frequency of treatment, the number of visits, days of coverage, or other similar limits on the scope and duration of treatment.” [Emphasis added] Use of the word “includes” shows that the list means that the listed treatment limitations are simply examples, not an exhaustive list of the possible treatment limitation subject to parity. In other words, the list is demonstrative rather than comprehensive. If Congress wanted the treatment limitations section to only apply to a subset of treatment limitations, it could have used stronger, more limiting language. That it did not do so demonstrates that Congress envisioned broad application of the treatment limitations parity requirement.

⁵¹ 75 Fed. Reg. 5412.

⁵² 75 Fed. Reg. 5436.

This standard focuses on the manner in which the processes, strategies, evidentiary standards, and other factors are used in *applying* the NQTL. The regulations state that a plan may not impose a NQTL unless the processes, strategies, evidentiary standards, or other factors “used in *applying*” the NQTL are comparable to and “*applied*” no more stringently in medical/surgical than in MH/SUD.⁵³ [Emphasis added]. Under this rule, plans can have the same NQTL in both MH/SUD and medical/surgical and still violate the parity requirements by applying these NQTLs differently.⁵⁴ Here, the plan has fail-first policies that apply to both MH/SUD and medical/surgical medications. However, the policies are applied very differently. For medical/surgical drugs, the fail-first policy is applied to require fail first on one generic drug. For MH/SUD drugs, the policy is applied to require fail first on two drugs. This differential application violates the regulatory standards because the NQTL is being applied more stringently in the MH/SUD benefit than in the medical/surgical benefit.

⁵³ 75 Fed. Reg. 5412.

⁵⁴ The regulation states explicitly that the no more stringently standard was “included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face are applied in the same manner to medical/surgical and to MH/SUD benefits.” *Id.*

7. NEED FOR COMPLIANCE WITH ALL ASPECTS OF PARITY (MHPAEA) IF AN INSURANCE PLAN PAYS FOR ONE OR MORE MH/SUD TREATMENTS

Introduction

In order for employer or health insurance plan to be regulated by MHPAEA, the employer or plan must provide both medical and behavioral benefits. Medicaid managed care organizations (MCOs) and employers do not have to offer benefits for any specific MH/SUD condition but once a benefit is offered for a disorder then all of those benefits must be compliant with MHPAEA. The parity statute and regulations are clear that if a health plan provides reimbursement for any treatment service for a behavioral disorder then they must pay for all behavioral treatments at parity with the 6 classifications in which medical treatments are provided.

This is true for both private employers and health plans or Medicaid MCOs. So if a plan offers coverage for psychiatric drugs only for a variety of behavioral conditions then they must offer the full scope and range of services for those behavioral conditions that are offered for medical conditions.

Patton Boggs Provided the Legal Analysis for the Answers to the following Questions

a) Question:

If a plan states it is not providing MH/SUD benefits, but reimburses for specific treatment services for one or more MH/SUD disorders, would the plan be subject to MHPAEA and the regulations?

a) Answer:

Plans that provide MH/SUD treatment services are subject to the parity requirements of MHPAEA. Since a plan in such a situation is offering a MH/SUD benefit, the regulations require the plan to offer services in every benefit classification in which medical/surgical benefits are offered.

The Act prohibits financial requirements and treatment limitations applicable to MH/SUD “benefits” that are more restrictive than those applied to medical/surgical “benefits.”⁵⁵ The Act is clear that MH/SUD benefits include some level of treatment services. Mental health benefits are defined in the Act as “benefits *with respect to services* for mental health conditions.”⁵⁶ (Emphasis added). In like manner, the Act defines substance use disorder benefits as “benefits *with respect to services* for substance use disorders.”⁵⁷ (Emphasis

⁵⁵ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C.A. § 1185a(a)(3)(A) (2009).

⁵⁶ § 1185a(e)(4).

⁵⁷ *Id.*

added). Thus, the plain language of the Act demonstrates that treatment services are included as part of MH/SUD benefits.

Conversely, a plan that offers treatment services for a MH/SUD offers a MH/SUD benefit. Because MH/SUD “benefits” are regulated by the Act, a plan in such a situation would be subject to the Act’s parity requirements.

The regulations implement the Act’s parity requirements by dividing the various types of benefits into six classifications.⁵⁸ The regulations require that when a plan “provides [MH/SUD] benefits in any classification of benefits” described in the rule, MH/SUD benefits “must be provided in every classification in which medical/surgical benefits are provided.”⁵⁹ This language demonstrates that if a plan is going to offer one MH/SUD service, it must offer a range of these services across classifications. Accordingly, when a plan offers a MH/SUD treatment service, it must then provide MH/SUD benefits in any classification in which medical/surgical benefits are provided.

An example may help illustrate the operation of these requirements. Imagine a plan that indicates it does not provide MH/SUD benefits, but that reimburses for psychotropic drug treatment for depression. In light of current treatment practices in both the MH/SUD and medical/surgical areas, it seems clear that both medications and the prescription of these medications can be equated with services. Since the plan is providing MH/SUD services, it can be said to be providing MH/SUD benefits. Thus, the plan is subject to parity requirements. “Prescription drugs” is one of the benefit classifications identified in the regulations. Since the plan is offering this classification of benefits, the plan must also provide MH/SUD benefits in every classification in which it provides medical/surgical benefits.

⁵⁸ The classifications include: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. 75 Fed. Reg. 5433.

⁵⁹ *Id.*

8. REQUIREMENT TO USE A NATIONAL CLINICAL STANDARD WHEN USING MORE RESTRICTIVE COST CONTAINMENT PRACTICES

Introduction

Under MHPAEA, the only time health plans are permitted to apply cost containment measures more stringently on MH/SUD than on medical/surgical benefits is when “recognized clinically appropriate standards of care” may permit a difference. Although the parity regulations do not give a precise definition of the “recognized clinically appropriate standards of care,” examples in the regulations and commonly accepted definitions in other healthcare guidelines indicate that, at a minimum, the standards are based on recommendations made by panels of experts “with appropriate training in the fields of medicine involved.” These standards would need to be recognized on a national or international basis and cannot be based only on policies developed internally by a single health plan.

Consumers and providers should request copies of the clinical standards of care or guidelines used in making benefit determinations to assess whether the standards or guidelines meet the generally accepted views of individuals appropriately trained in the field of medicine involved.

Patton Boggs Provided the Legal Analysis for the Answers to the following Questions

a) Question:

What is considered a “recognized clinically appropriate standard of care” in the context of a NQTL?

a) Answer:

Although the regulations do not explicitly define “recognized clinically appropriate standards of care,” the regulations and other government coverage policies give guidance that regulators should heed in construing the term. From a policy perspective, a clear definition of “recognized” is critical to ensure the integrity of the Act and to implement the will of Congress.

The regulations state that NQTLs must be comparable and applied no more stringently in MH/SUD than in medical/surgical. The regulations permit an exception to the comparable and no more stringently standards “to the extent that recognized clinically appropriate standards of care may permit a difference.”⁶⁰ The regulations do not provide a clear definition for the term “recognized clinically appropriate standards of care.”

⁶⁰ 75 Fed. Reg. 5416.

However, both the regulations and other government medical coverage policies provide useful guidance in defining the term. The regulations provide some indications that the standards must meet a general threshold. Example 3 of Section (c)(4) discusses a plan that uses evidentiary standards in determining whether a treatment is medically appropriate.⁶¹ The standards are developed based on “recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved.”⁶² The example notes that the plan complies with parity, in part because “[t]he processes for developing the evidentiary standards” are comparable and applied no more stringently between medical/surgical and MH/SUD benefits.⁶³ Thus, the example demonstrates that “recognized clinically appropriate standards” are those that are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved.

In addition, other parts of the regulations provide a useful guide for how to determine which standards are “recognized.” The regulations state that plan terms defining benefits for MH/SUD conditions must be consistent with “generally recognized independent standards of current medical practice.”⁶⁴ In defining these terms, the regulations state that a plan “may follow the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Diseases (ICD), or a State guideline.”⁶⁵ Although this discussion is not repeated in the NQTL section of the regulations, it demonstrates that there are a number of recognized sources for defining which standards are recognized.

CMS also regularly relies on independent expertise when making its coverage determinations. For example, there is clear precedent for CMS to take a rigorous view of the evidentiary basis for Medicare reimbursement of drugs, devices and procedures. In the National Coverage Determination (NCD) process, CMS evaluates all pertinent data, including the scientific data that requesters submit, peer-reviewed medical, technical and scientific literature, and recommendations from expert panels. CMS also can order a health technology assessment to provide an independent analysis of all of the scientific and clinical evidence available on a particular health care technology.⁶⁶ The Medicare Coverage Advisory Committee (MCAC) also plays a role in assisting the agency in making sound coverage decisions. MCAC provides independent, expert advice based upon the reasonable application of scientific evidence through members who possess the scientific and technical competence to provide these assessments.⁶⁷

⁶¹ 75 Fed. Reg. 5436.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ 75 Fed. Reg. 5412.

⁶⁵ *Id.*

⁶⁶ 68 Fed. Reg. 55626-40.

⁶⁷ 68 Fed. Reg. 55440.

From a policy perspective, **clearly defining “recognized” is critical to ensure the integrity of the Act.** The only exception to the requirement that NQTLs be comparable and applied no more stringently is when “recognized clinically appropriate standards of care” permit a difference. Thus, any attempt to get around the parity requirements will involve finding a “recognized clinically appropriate” standard of care. If adequate requirements for when a standard is recognized are not established, the parity requirements may be circumvented. For example, a plan could trigger the exceptions simply because its own employees or hired consultants deem a standard “recognized”—with no outside verification.

Such a result opens a potential loophole that would weaken Congress’ intended parity protections. Congress’ purpose in passing the Act was to ensure meaningful parity between MH/SUD and medical/surgical benefits by expanding previously-approved mental health parity legislation.⁶⁸ In the Act, Congress was very clear that treatment limitations should be “no more restrictive” in MH/SUD benefits than in medical/surgical benefits. By expanding previous parity legislation, and using clear language in doing so, Congress expressed an intent to ensure strong parity protections. Permitting an exception to parity based on a plan’s internal review alone could weaken this intended strength.

Based on the intent of the Act, other definitions in these regulations and other HHS/CMS practices, the regulators should clearly define “recognized standards of care.” Various best practices exist for developing recognized standards of care, including: (1) gathering input from multiple stakeholders and experts such as academic researchers, senior practicing clinicians, and consumer and advocacy leaders with subject matter expertise; (2) ensuring that the standard has acceptance from multiple provider and national consumer organizations; (3) basing the standard on objective scientific evidence in the field, such as published controlled research trials or expert consensus panels; and (4) approving the standard through accrediting or credentialing organizations.⁶⁹ **To ensure the strong parity protections envisioned by Congress, CMS should adopt these or other recognized best practices in defining “recognized clinically appropriate standards of care.”**

b) Question:

Do the forms of NQTLs include the composition of plan and plan provider panels that are advisory to a managed care organization (MCO) or managed behavioral health organization (MBHO) for the development of clinical standards or for determining what is experimental?

⁶⁸ In 1996, Congress passed and the President signed the Mental Health Parity Act (MHPA). The MHPA equates aggregate lifetime limits and annual limits for MH/SU benefits with aggregate lifetime limits and annual limits for medical/surgical benefits. Thus, the statute gave a measure of protection from the costs of MH services. Legislation to expand mental health parity was introduced in the House from 1997 until the passage of the Mental Health Parity and Addiction Equity Act. It was in this context that the Act was passed.

⁷⁰ 75 Fed. Reg. 5438.

b) Answer:

Because the composition of plan and provider panels could ultimately limit the scope and duration of benefits for MH/SUD treatment under a plan, the composition of these panels would appear to be a form of NQTL subject to the regulations. The regulatory language and the illustrative list of NQTLs provide some substance to this view.

The regulations define both quantitative treatment limitations (QTLs) and NQTLs. QTLs are defined as limitations which are “expressed numerically.”⁷⁰ NQTLs, by contrast, are limitations that are not numeric but that “otherwise limit the scope or duration of benefits for treatment under a plan.”⁷¹ Based on this definition, a limitation that is not numeric, but limits the scope and duration of benefits, is a NQTL. Among other responsibilities, plan and provider panels help establish standards of care or determine whether a procedure is experimental. Indeed, the panel may attempt to create the “recognized clinically appropriate standard of care” that would permit an exception to the NQTL requirements. The determinations made by the plan, especially if these determinations are related to the standard of care mentioned above, would have an effect on the scope and duration of benefits for treatment under the plan. Accordingly, the composition of plan or provider panels should be a NQTL subject to the parity regulations.

Defining plan or provider panel composition as a NQTL is consistent with the NQTL examples listed in the regulation. For example, the regulation states that standards for provider admission to participate in a network, including reimbursement rates, are a NQTL. Although not a direct effect on beneficiaries, the determination of provider rates has the potential to affect the participation of providers in a plan. If rates are too low, certain providers will not participate in the network. Ultimately, the scope and duration of services to the beneficiary will be impacted when the beneficiary is unable to access services. In a similar fashion, decisions related to plan and provider panels do not impact the beneficiary directly. However, to the extent that such decisions result in MH/SUD benefits being disadvantaged as compared to medical/surgical benefits, the scope and duration of services is ultimately impacted. Accordingly, the regulations’ NQTL parity requirements are applicable to the composition of plan and provider panels. In commenting on the regulations, however, this interpretation of the application of NQTLs to plan or provider panel composition should be noted.

⁷⁰ 75 Fed. Reg. 5438.

⁷¹ *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

SHO 09-014
CHIPRA #9

November 4, 2009

Dear State Health Official:

The purpose of this letter is to provide general guidance on implementation of section 502 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, which imposes mental health and substance use disorder parity requirements on all Children's Health Insurance Program (CHIP) State plans under title XXI of the Social Security Act (the Act). This letter also provides preliminary guidance to the extent that mental health and substance use disorder parity requirements apply to State Medicaid programs under title XIX of the Act.

Statutory Basis for CHIPRA Parity Requirement

Section 502 of CHIPRA amended section 2103(c) of the Act to incorporate, by reference, provisions added to section 2705 of the Public Health Service (PHS) Act by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Public Law 110-343. Prior to MHPAEA, the PHS Act required parity in annual or lifetime dollar limits between mental health and medical/surgical benefits (as a result of the Mental Health Parity Act of 1996). MHPAEA expanded the application of the existing mental health parity requirements in section 2705 to substance use disorder benefits, and added new requirements such as:

- Financial requirements (e.g., co-payments) that are applied to mental health or substance use disorder benefits must be no more restrictive than the predominant financial requirements that are applied to substantially all medical/surgical benefits.
- Treatment limitations (e.g., numbers of visits or days of coverage) that are applied to mental health or substance use disorder benefits must be no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- No separate financial requirements or treatment limitations can apply only to mental health or substance use disorder benefits.
- When out-of-network coverage is available for medical/surgical benefits, it also must be available for mental health or substance use disorder benefits.

The MHPAEA was enacted on October 3, 2008, and will be effective for group health plans for plan years beginning after October 3, 2009. The Departments of Health and Human Services (HHS), Labor and the Treasury will jointly publish regulations on the application of MHPAEA to group health plans.

Application to Medicaid

The MHPAEA requirements apply to Medicaid only insofar as a State's Medicaid agency contracts with one or more managed care organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs), to provide medical/surgical benefits as well as mental health or substance use disorder benefits. In this case, those MCOs or PIHPs must meet the parity requirements of MHPAEA, as incorporated by reference in title XIX of the Act, for contract years beginning after October 3, 2009. MHPAEA parity requirements do not apply to the Medicaid State plan if a State does not use MCOs or PIHPs to provide these benefits.

Application to CHIP

The application of MHPAEA to CHIP is somewhat broader. Section 2103(c)(6) of the Act applies the MHPAEA requirements to the entire "State child health plan" including, but not limited to, any MCOs that contract with the State CHIP program. Specifically, section 502 of CHIPRA requires that State child health plans comply with the requirements of section 2705(a) of the PHS Act "in the same manner" as such requirements apply to a group health plan. Therefore, if a CHIP State plan provides both medical/surgical benefits and mental health or substance use disorder benefits, any treatment limitations, lifetime or annual dollar limits or out-of-pocket costs for both types of benefits must comply with the provisions added to the PHS Act by MHPAEA. Section 502 of CHIPRA also specifies that State CHIP plans are deemed to satisfy the mental health and substance use disorder parity requirements if they provide coverage of Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefits (as defined under title XIX of the Act). This requirement was effective as of April 1, 2009.

Implementation of MHPAEA Requirements

States will need to begin to assess their own compliance with the MHPAEA parity requirements prior to the issuance of MHPAEA regulations. For States that use MCOs or PIHPs to provide Medicaid benefits, a review of current contract language with the plans should occur before the next contract year begins to ensure that MHPAEA parity requirements are in place.

Similarly, each State will need to review its CHIP plan to determine if the CHIP State plan imposes more restrictive requirements on mental health or substance use disorder benefits than on medical/surgical benefits. As noted above, any State that either operates its CHIP program as an expansion of its Medicaid program, or which provides coverage of EPSDT benefits as defined under title XIX of the Act in its separate or combination CHIP program, already will be in compliance with these mental health and substance use disorder parity requirements.

Until the MHPAEA regulations are issued or other guidance is provided, States will not have detailed information regarding how specific provisions in MHPAEA will be interpreted. However, section 3(d)(2) of CHIPRA provides that Federal financial participation in both CHIP and Medicaid shall not be denied if States make a good faith effort to comply with the requirements prior to the issuance of any regulations or guidance implementing the provisions in question. Examples of what might be considered a good faith effort could include States providing an assurance in their CHIP State plan that there is no significant difference in cost

sharing, lifetime or annual dollar limits, or treatment limits (e.g. the number of inpatient days) between mental health/substance use disorder benefits and medical/surgical benefits.

In addition, section 3(b) of CHIPRA addresses the situation in which States need to pass legislation in order to bring their CHIP plans into compliance. In that case, a State will not be found to be in violation of the statutory requirements before its next legislative session, as long as it notifies the Secretary of HHS, and she concurs that legislation is needed. If your State requires such legislation, please submit a letter to the Center for Medicaid and State Operations to that effect as soon as possible. The letter should include the provision in question, the reason that State legislation is required for compliance, and the date the State will begin implementing the provision. For States with annual legislative sessions, this date must be no later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after February 4, 2009 (the date CHIPRA was enacted). For States that have a 2-year legislative session, each year of the session is considered a separate regular session for this purpose.

Additional policy guidance will be provided on this issue after the MHPAEA regulation is published. However, in the meantime, we encourage all States to begin a dialogue with their Centers for Medicare & Medicaid Services regional office concerning their timeline for complying with these parity requirements.

If you have any questions on the information provided in this letter, please send an email to CMSOCHIPRAQuestions@cms.hhs.gov or contact Ms. Maria Reed, Deputy Director, Family and Children's Health Programs Group, at 410-786-5647.

Sincerely,

/s/

Cindy Mann
Director

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cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

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Director for Health Policy
Council of State Governments

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Congress of the United States
House of Representatives
Washington, D.C. 20515

May 4, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

The Honorable Hilda Solis
Secretary
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

The Honorable Timothy Geithner
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Ave, NW
Washington, DC 20220

Dear Secretaries Sebelius, Solis, and Geithner:

We are writing to ask you to clarify several important issues as you promulgate a final regulation implementing the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA). Enacted on October 3, 2008, this landmark civil rights legislation is estimated to benefit approximately 140 million Americans and ensure that those who experience mental health and substance use disorders in plans affected by the law will receive health care on par with other medical conditions.

As you know, the final Mental Health Parity Law, MHPAEA, was the result of over 10 years of Congressional deliberation. Members of Congress worked diligently to craft statutory language that satisfied key stakeholders. The final law was a ground-breaking effort intended to lead to changes in the design and operation of health plans in order to end a century of stigma and second class treatment toward mental health and substance use disorders.

The Departments are to be commended for issuing timely and clear rules requiring covered health plans to comply with the MHPAEA. In particular, we are pleased that the Departments' rules correctly prohibited health plans from maintaining separate deductibles for medical and mental health services.

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We believe there are a few areas in which the interim final rules must be clarified to comply with Congressional intent and to provide meaningful benefits to eligible participants and beneficiaries.

Key issues the final regulation must address:

Parity in services: It is the intent of Congress that if a plan offers mental health and substance use disorder benefits, the plan's range and scope of services must be no more restrictive than the plan's range and scope of services for medical/surgical services. While we applaud the Departments' adoption of the six classification system for comparing medical and mental health benefits, further guidance on the classifications are needed. We have heard from many health plans that they often do not believe apples to apples comparisons can be made with regard to medical and mental health benefits within these classifications. This is exactly the type of mythology that MHPAEA was intended to end. The Departments must provide additional guidance elaborating on how the range and scope of services should be comparable in the six categories to ensure that services in MH/SU are offered in parity with medical/surgical in each classification.

Parity in out-of-network services: Similarly, MHPAEA provides that if a plan or coverage provides coverage for medical or surgical benefits by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits by comparable out-of-network providers consistent with the parity rules. The final rules should make clear that access to out-of-network services is fully subject to MHPAEA.

Mental Health Parity Act (MHPA) of 1996 Rules: The Departments' interim rule inappropriately replaces the Departments' rule on MHPA 1996. As you know MHPAEA amended MHPA 1996 and did not replace it. We did so specifically because we supported the 1996 rules and wanted the rules to serve as a starting point to be built upon or changed as required by MHPAEA or subsequent laws.

Application of "predominant and substantially all": As defined in the statute, the "predominant and substantially all" standards apply to all treatment limitations, quantitative and non-quantitative. Some health plans are interpreting the interim rules not to subject non-quantitative treatment limitations to the "predominant and substantially all" standard. This is not correct under the law, and the final rules need to make clear that the statute applies "predominant and substantially all" to all treatment limits, quantitative and non-quantitative.

Medical Management – The final MHPAEA deleted all prior references to medical management. Congress specifically decided not to address medical management practices because there was no consensus on the types of medical management processes that are appropriate based on established medical evidence. Therefore, while the final rules are correct in establishing the principle that health plans must apply medical management practices in parity

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for medical and mental health benefits, the Department should refrain from approving or disapproving specific techniques. The final rules also should not create administrative rules that permit plans to individually create exceptions for self-determined “recognized clinically appropriate standards of care,” this is beyond the scope of the law.

Availability of Plan Information: The Departments’ rule did not specify the manner in which health plans must provide the criteria for medical necessity determinations and reasons for any denial to plan participants. As the Departments well know, this has long been an area of abuse by health plans. The final rule should make clear that health plans must provide all relevant health plan documents to participants and beneficiaries no later than 30 days after a request (earlier for emergencies) at least equal to the Department of Labor’s rules for claims procedures. Further, health plans must provide information sufficient for a participant or beneficiary to determine if the plan is applying the medical necessity criteria and other factors similarly for medical and mental health benefits.

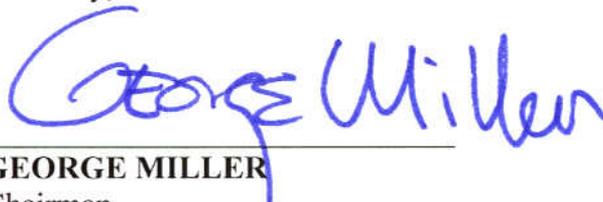
Medicaid Managed Care Plans: The regulations should clarify that Medicaid managed care plans are currently subject to MHPAEA and the Interim Final Regulations. This is consistent with the law and Congressional intent.

Protection of stronger state laws: The final regulations should clearly reflect that the HIPAA preemption rule applies to MHPAEA. Thus, there is no preemption of state laws that do not prevent the applicability of MHPAEA. States and health plans need clear guidance apprising them of the applicability of stronger state laws that provide mental health parity protections.

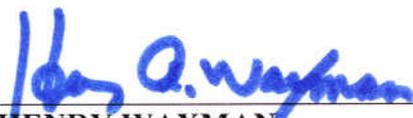
Finally, the above comments illustrate the complexity of the issues surrounding MHPAEA and the current wide lack of awareness of the new law by health plans and participants. The law requires the Department of Labor to provide assistance to stakeholders to help them understand and comply with the law. We look forward to continuing to be kept abreast of plans to educate the public, health plans and states on their rights and obligations under the new law.

We look forward to continuing to work with you on increasing access to equitable mental health services for the millions of Americans who need them.

Sincerely,



GEORGE MILLER
 Chairman
 Committee on Education and Labor

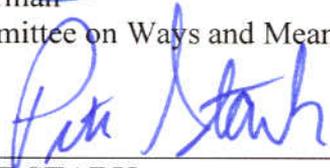


HENRY WAXMAN
 Chairman
 Committee on Energy and Commerce

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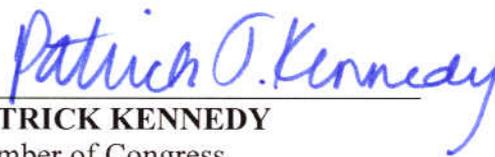
SANDER LEVIN
Chairman
Committee on Ways and Means



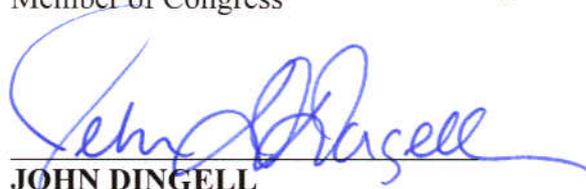
PETE STARK
Chairman
Subcommittee on Health,
Ways and Means Committee



FRANK PALLONE
Chairman
Subcommittee on Health,
Energy and Commerce Committee



PATRICK KENNEDY
Member of Congress



JOHN DINGELL
Member of Congress



ROBERT E. ANDREWS
Chairman
Subcommittee on Health, Employment,
Labor and Pensions,
Education and Labor Committee