



National Association of
State Mental Health
Program Directors



A tax-exempt subsidiary of
The Bowman Family Foundation



ISSUE BRIEF: Behavioral Health Crisis Services Governed by the No Surprises Act and the Federal Parity Law

By Henry T. Harbin, MD and Beth Ann Middlebrook, JD

I. Introduction

Crisis services for a physical health emergency have long been recognized as essential for all Americans. However, behavioral health crises have typically been addressed through inadequate and ineffective approaches such as actions by law enforcement, incarceration, emergency departments focused primarily on physical health, or no care at all. While behavioral health crises and emergency services have been developing for many years, these interventions have been underfunded and are inconsistently reimbursed by many insurers.

This Issue Brief addresses how several federal laws and initiatives:

1. expand access to the full range of behavioral health crisis services (988).
2. recognize that these behavioral health crisis services are similar to physical health emergency services (NSA).
3. clarify the requirement for “on par” reimbursement by insurers regulated by the federal parity law (MHPAEA).

This Issue Brief is intended to provide educational information for use by regulators (both state and federal), insurance purchasers and issuers, and providers (both medical and behavioral). This Issue Brief is made available for informational purposes only and is not intended to and should not be construed as providing legal advice.¹

II. Brief Summary of Key Federal Initiatives and Laws

1. **Federal Expansion of BH Crisis Services (988).** In 2020, Congress designated the new 988 dialing code to be operated through the existing National Suicide Prevention Lifeline. SAMHSA sees 988 as a first step towards a transformed crisis care system in America. As of July 2022, “988 Suicide and Crisis Lifeline” centers are available as a behavioral health counterpart to 911 – intended to offer care that aligns with 911 calls for physical emergencies. In addition to someone to speak with, comprehensive behavioral health crisis care must include someone to come to the individual in need, and provide a safe place for them to receive care. Thus, just as ambulances come to an individual in a physical crisis and hospital emergency departments are available 24/7 for treatment, so too must behavioral health mobile crisis teams and behavioral health crisis “receiving and stabilization” centers be available 24/7 for behavioral health crises. Vital “no-wrong-door” crisis services that deliver real-time access to behavioral health care align with physical health emergency services that provide the same essential care for every person in need.

¹ Please refer to **DISCLAIMER** at the end of this Issue Brief before **Appendix A**.

2. **No Surprises Act (NSA).** The NSA’s recent regulatory guidance recognizes the alignment between physical and behavioral health crisis services and specifically includes behavioral health crisis services within the scope of the NSA’s requirements.

3. **Federal Parity Law (MHPAEA).** In addition, the Mental Health Parity and Addiction Equity Act (MHPAEA) and its governing regulations make clear that behavioral health crisis services are within the scope of services governed by MHPAEA. As such, there can be no separate treatment limitations, in the form of exclusions or otherwise, applied to behavioral health crisis services that are not applied to physical crisis services. There also can be no coverage limitations applied to behavioral crisis services that are non-comparable and/or more stringent than coverage limitations applied to physical health emergency services for MHPAEA regulated plans and issuers.

[T]here can be no separate treatment limitations, in the form of exclusions or otherwise, applied to behavioral health crisis services that are not applied to physical crisis services. There also can be no coverage limitations applied to behavioral crisis services that are non-comparable and/or more stringent than coverage limitations applied to physical health emergency services.

III. Review and Discussion of Key Federal Initiatives and Laws Impacting BH Crisis Services

1. Federal Expansion of BH Crisis Services (including 988)

The Substance Abuse and Mental Health Services Administration’s (SAMHSA) recently published [National Guidelines for Behavioral Health Crisis Care](#) (SAMHSA’s National Guidelines) which provide guidance for what constitutes crisis services:

“Crisis services are for **anyone, anywhere and anytime**. Examples of crisis level safety net services seen in communities around the country include: (1) 911 accepting all calls and dispatching support based on the assessed need of the caller, (2) law enforcement, fire or ambulance dispatched to wherever the need is in the community, and (3) hospital emergency departments serving everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime**.

Similar to medical/surgical emergency services, crisis services for behavioral health care include: (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller [SAMHSA pages 14-17], (2) mobile crisis teams dispatched to wherever the need is in the community [SAMHSA pages 18-21], and (3) crisis receiving and stabilization facilities that serve anyone who comes through their doors from all referral sources [SAMHSA pages 22-24]. These services are for “anyone, anywhere and anytime.” (p. 8).

Behavioral health crisis services are designed to connect individuals to care as quickly as possible through a systemic approach that is comparable to that of the physical healthcare system. While a multitude of other similar and important services contribute to a community’s system of care, these three fundamental components of a crisis system are addressed herein.

- Core Levels of Crisis Services

The National Action Alliance for Suicide Prevention established a Crisis Services Task Force that defined essential levels of care within a crisis system continuum, resulting in the “Crisis Now” model that is defined in detail in SAMHSA’s National Guidelines.

The three core structural elements of the crisis care system defined by the Crisis Services Task Force and SAMHSA are:

- a. *Regional or statewide crisis call centers coordinating in real time;*
- b. *Centrally deployed, 24/7 mobile crisis services; and*
- c. *Short-term, crisis receiving and stabilization facilities/programs*

a. **Regional Crisis Call Services**

Regional behavioral health crisis call centers, also known as “988 Suicide and Crisis Lifeline Centers”, operate 24/7, are staffed with licensed behavioral health professionals and trained call center support workers, and include chat and text support services. The delivery of telehealth support services is planned for the near future.

b. **Mobile Crisis Team Services**

Mobile crisis services are typically comprised of two-person crisis response teams (licensed behavioral health professionals and often peers) that offer outreach and support where people in crisis are, either in the person’s home or a location in the community.

c. **Crisis Receiving and Stabilization Facility Services**

Crisis stabilization services are an immediate and unscheduled behavioral health intervention provided by a facility in response to an individual’s behavioral health issue to prevent imminent harm and to stabilize or resolve an acute behavioral health issue. The 23-hour crisis stabilization service program is staffed with a multidisciplinary team that includes a prescriber (psychiatrist and/or psychiatric nurse practitioner), nurse, therapist, and peer.

2. **No Surprises Act (NSA)**

The [No Surprises Act \(NSA\)](#), which establishes protections for health plan participants from surprise medical billing, was passed in late 2020 as part of the [2021 Consolidated Appropriations Act](#). The NSA protects members of health insurance plans obtained through employers, on the Health Insurance Marketplace®, or directly by individuals from insurance companies, **by banning the following**:

- Surprise bills for emergency services, even if received from out-of-network providers and without approval beforehand (prior authorization).
- Out-of-network cost-sharing (like coinsurance or copayments) for all emergency and some non-emergency services. A member cannot be charged more than in-network cost-sharing for these services, and any cost-sharing paid is counted towards the deductible and maximum out-of-pocket limits for the policy year.
- Out-of-network charges and balance bills for supplemental care (like anesthesiology or radiology) by out-of-network providers who work at certain in-network facilities (like a hospital or ambulatory surgical center).

Air ambulance services, but not ground ambulance services, are included under the NSA protections. In addition to emergency departments that are part of a hospital system, the NSA also applies to a freestanding emergency department, which is defined as a health care facility that is geographically separate and distinct

from a hospital, is separately licensed from a hospital by the state, and provides services for an emergency medical, mental health and/or substance use condition. Such freestanding emergency departments must be covered without regard to network status. The NSA Interim Final Rules provide that this is intended to include any health care facility that is geographically separate and distinct from a hospital and that is licensed by the state to provide emergency services, even if the facility is not licensed under the term “independent freestanding emergency department”.²

Many behavioral health facilities are included in the definition of behavioral health emergency services providers. These providers are licensed to provide behavioral health crisis services, which are analogous to emergency physical health services, given that their function is to assess, stabilize and initiate treatment of individuals experiencing a behavioral health emergency condition.

The Final Rules and FAQs under the NSA were issued on August 19, 2022. **FAQ 10** (see **Appendix A**) clarifies that the NSA surprise billing protections apply to behavioral health emergency services provided by facilities that meet the definition of “emergency department of a hospital” or an “independent freestanding emergency department”, **regardless of whether the facility is licensed as such, or whether the license contains the word “emergency services” to describe its services.**

FAQ 10 clarifies that the NSA surprise billing protections apply to behavioral health emergency services regardless of whether the facility is licensed as such, or whether the license contains the word “emergency services” to describe its services.

3. Federal Parity Law (MHPAEA)

Parity – or equity – should be the expectation. This means that, for individuals experiencing a mental health or substance use crisis, access to timely and effective care based on the person’s needs must be equivalent to that of a person experiencing a physical health emergency. As more fully discussed in the [Sustainable Funding for Mental Health Crisis Services](#) document, establishing universally recognized and accepted billing codes for crisis services is an important step toward delivering on our nation’s promise of parity – moving behavioral healthcare out of the shadows and into mainstream care of the whole person. Unfortunately, access to effective care during a behavioral health crisis is widely considered to be deficient in healthcare settings across the country.

As published in the Forbes article, “[Most ER Doctors Don’t Believe The Mental Health System is Working for Patients](#)”, a national survey of nearly 1,500 emergency room physicians conducted by the American College of Emergency Physicians (ACEP) showed that “[o]ver 80% of emergency physicians believe that the mental systems currently in place in their communities and surrounding regions are not providing optimal care for patients...”. As discussed in [Sustainable Funding for Mental Health Crisis Services](#), thousands of Americans are dying from suicide every month. Many family members of those coping with serious mental illness or loss of loved ones to suicide are experiencing unspeakable pain. Individuals with limited options are getting the wrong care in the wrong place, such as jails, inpatient care in lieu of mental health crisis services, and 911 and/or law enforcement functioning as de facto mobile crisis teams.

² See 86 Fed. Reg. at p. 36879 (July 13, 2021)

The Federal Parity Law, known as the Mental Health Parity and Addiction Equity Act (MHPAEA)³, requires that any financial requirement and quantitative treatment limitation (QTL) applied to mental health and substance use disorder (MH/SUD) benefits can be no more restrictive than such requirements and limitations applied to medical/surgical (med/surg) benefits in any classification of benefits.⁴

MHPAEA also provides that any non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits must be comparable to and applied no more stringently for MH/SUD benefits than for med/surg benefits.⁵ While MHPAEA does not mandate behavioral health coverage under a plan, once a plan covers behavioral health services in any classification of benefits, it must do so at equity with med/surg benefits in all classifications, in compliance with the Federal Parity Law. All insurers cover emergency services for med/surg conditions.

Group health plans and insurance issuers often limit or restrict coverage to behavioral health crisis services in several ways, **including coverage exclusions, experimental vs. non-experimental, how classifications and sub-classifications of benefits are defined, reimbursements and network admission standards and access.**

Behavioral health crisis services could be classified by an insurer as emergency services, or as other benefit classes such as outpatient facility. NQTLs must be applied comparably across the same classification of benefits, and the standards and definitions for each benefit classification must be the same for MH/SUD as compared to med/surg. Typically, med/surg emergency classification of benefits do not require prior authorization. Likewise, to be compliant with parity, behavioral health crisis services in the emergency classification of benefits would not require prior authorization.

As it relates to behavioral health crisis services, under the MHPAEA Final Rules, restrictions or exclusions based on "facility-type" that limit the scope of coverage for services is expressly listed as an NQTL⁶ and must comply with the NQTL rule. The MHPAEA Final Rules provide an example of a non-comparable facility-type restriction or exclusion that violates the NQTL rule under MHPAEA. In **Example 9 (see Appendix A)**, the salient facts are that a plan automatically excluded coverage for inpatient substance use treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For medical/surgical conditions, the plan provided coverage for inpatient treatment outside of a hospital if the inpatient treatment was deemed medically appropriate. The Final Rules conclude that the plan's exclusion of SUD inpatient treatment in any setting outside of a hospital violated MHPAEA, as it was not comparable to the coverage of med/surg inpatient treatment outside of a hospital, so long as it was authorized as medically necessary.⁷

In addition to the NQTL rule requiring comparability and no more stringency between MH/SUD vs. med/surg coverage, any separate NQTL (such as facility-type exclusion or restriction) that applies only to behavioral health benefits within any classification of benefits does not comply with MHPAEA.

As it relates to behavioral health crisis services, under the MHPAEA Final Rules, restrictions or exclusions based on "facility-type" that limit the scope of coverage for services is expressly listed as an NQTL and must comply with the NQTL rule.

³ 29 U.S.C. 1185a(a); 42 U.S.C. 300gg-26(a)

⁴ 29 CFR 2590.712(c)(2); 45 CFR 146.136(c)(2)

⁵ 29 CFR 2590.712(c)(4); 45 CFR 146.136 (c)(4). MHPAEA was amended by The Consolidated Appropriations Act, 2021, to codify requirements that plans and insurance issuers perform and document their comparative analyses of the design and application of NQTLs.

⁶ *Id.*

⁷ Example 9, 78 Fed. Reg. 68283, 68293 (November 13, 2013)

In addition to the NQTL rule requiring comparability and no more stringency between MH/SUD vs. med/surg benefits, any separate NQTLs (such as facility-type exclusions or restrictions) that apply only to behavioral health benefits within any classification of benefits do not comply with MHPAEA.⁸ The [2020 MHPAEA Self-Compliance Tool](#)⁹ provides the example of a plan that classifies medical skilled nursing facilities and behavioral health residential treatment facilities as inpatient benefits, and covers room and board for all medical/surgical inpatient care. The plan imposed a restriction on behavioral health residential care, which was a separate, impermissible limitation only on behavioral health benefits and therefore violated MHPAEA.¹⁰ Thus, any restriction on coverage for behavioral health crisis services where there exists coverage for medical emergency and urgent care services would be in violation of MHPAEA.

Any restriction on coverage for behavioral health crisis services where there exists coverage for medical emergency and urgent care services would be in violation of MHPAEA.

Moreover, in determining the classification in which a particular benefit belongs, a group health plan or group or individual market health insurance issuer must apply the same standards to (med/surg) benefits as to MH/SUD benefits.¹¹ Thus, if a plan classifies certain emergency services as part of the emergency service benefit or as inpatient or outpatient services, it must classify comparable behavioral crisis services as either emergency, inpatient or outpatient in the same manner.

Appendix A hereto contains quoted references to NSA and MHPAEA regulatory guidance that demonstrate how behavioral health crisis services (a) are protected in the same manner as med/surg emergency services, and (b) must be covered at parity with med/surg emergency services. Guidance is included with respect to coverage exclusions, experimental vs. non-experimental, and classifications/sub-classifications of benefits.

About the Authors: Dr. Henry T. Harbin and Beth Ann Middlebrook, J.D. have extensive experience and expertise in the area of MHPAEA compliance, particularly, NQTLs. Select parity-related experience includes:

Dr. Henry T. Harbin and Beth Ann Middlebrook, J.D. have been providing input on MHPAEA regulations and enforcement to DOL/HHS/IRS from 2009 to the present. They have Informed federal agencies on regulatory and sub-regulatory processes with numerous submissions of exemplary FAQs, best practice analyses, consumer parity disclosure templates, and presentations on scope of services and non-quantitative treatment limitation (NQTL) implementation and enforcement. They are co-authors of the "Six Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements, published by the American Psychiatric Association, The Kennedy Forum and Parity Implementation Coalition (Sept. 2017). They are advisors to The Bowman Family Foundation and have assisted in developing the Milliman research reports on claims data disparities in key NQTL operational measures, such as reimbursement rates and out-of-network use. They are currently advising several state insurance regulators on best practices for NQTL examinations, including reviews of carrier NQTL submissions.

Henry Harbin, MD is a psychiatrist and was formerly CEO of two national managed behavioral health care companies (Magellan and Greenspring Health Services). He has no current ties to any health plan.

⁸ 29 U.S. Code Section 1185a(3)(A)(ii)

⁹ The Self-Compliance Tool is updated every two years.

¹⁰ 2020 MHPAEA Self-Compliance Tool, p. 22.

¹¹ See 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).

Beth Ann Middlebrook, JD is a health lawyer with significant experience and expertise in MHPAEA and was Chair of the American Bar Association's Health Law Section Interest Group on Substance Use Disorders and Mental Health from 2013-2016; Advisory Board chair 2017-2020.

This Issue Brief is the opinion of the authors and does not purport to represent the views of state or federal regulators, issuers of insurance or administrators of insurance plans.

About MHTARI and The Bowman Family Foundation: This Issue Brief is part of a series of educational, informational and best practice materials funded by MHTARI for use in the examination and analysis of claims and other data to assist in assessing network adequacy and access to behavioral healthcare services. MHTARI, an independent, tax-exempt subsidiary of The Bowman Family Foundation, supports the development of quantitative data analytics to improve access to and the effectiveness of behavioral health care. The issue briefs, studies and templates funded by MHTARI are made available for public use.

About NASMHPD: The National Association of State Mental Health Program Directors (NASMHPD) represents the \$41 billion public mental health service delivery system serving 7.5 million people annually in all 50 states, 4 territories, and the District of Columbia. It is the only national association to represent state mental health commissioners/directors and their agencies. As a private, not-for-profit 501(c)(3) membership organization, NASMHPD helps set the agenda and determine the direction of state mental health agency interests across the country, historically including state mental health planning, service delivery, and evaluation. The Association also creates a forum for members to exchange diverse views and experiences, learning from one another in areas vital to effective public policy development and implementation. NASMHPD provides a broad array of services designed to identify and respond to critical policy issues, cutting-edge consultation, training, and technical assistance.

About RI International: RI International is a global organization with more than 50 programs located throughout the United States and abroad. We continuously work to strengthen our position as the worldwide leader of mental health and substance use crisis service design, delivery and peer-delivered care. We celebrated our 30 year anniversary in 2020, representing an enduring commitment to continuous innovation that includes over 20 years of delivering peer support services, the creation of the living room model of crisis care, and key contributions to The National Action Alliance for Suicide Prevention's Zero Suicide in Healthcare Framework as well as SAMHSA's National Guidelines for Behavioral Health Crisis Care. We have created innovative tools that help others bring these important services to life throughout the globe by posting them for immediate access by all online; efforts that align with our aspiration to positively impact the lives of individuals faced with acute mental health and substance use challenges.

DISCLAIMER: This Issue Brief is made available for informational purposes only and is not intended to and should not be construed as providing legal advice. Each situation is highly fact specific and requires knowledge of both state and federal laws. Therefore, each reader should receive legal advice from a licensed attorney in the relevant jurisdictions when considering whether the information and opinions in this Issue Brief are relevant to the reader. Each reader assumes all risk from any use of this Issue Brief or any information contained herein. The Bowman Family Foundation, MHTARI, NASMHPD, RI International, and the authors shall have no responsibility or liability for any errors or omissions, and specifically disclaim any and all representations and warranties, express or implied, regarding this Issue Brief and the information contained herein, including without limitation the accuracy, completeness, relevance and applicability of the information and opinions expressed for any specific regulator, provider, issuer of insurance or administrator of an insurance plan. The opinions and views expressed in this Issue Brief are those of the authors based on their experience and activities in the area of NQTL compliance.

APPENDIX A

1. NO SURPRISES ACT (NSA)

FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 55, August 19, 2022

“Q10: How do the surprise billing provisions of the No Surprises Act and its implementing regulations apply to emergency services furnished with respect to a visit to a behavioral health crisis facility?”

“The July 2021 interim final rules made clear that the definition of emergency medical condition includes mental health conditions and substance use disorders that satisfy that definition. [fn 24] The Departments recognize that individuals experiencing behavioral health emergencies may be served most effectively in settings outside of hospital emergency departments and that states, localities, and health care systems are actively exploring alternatives to hospital-based care to respond to behavioral health emergencies, including through services provided in specialized facilities that are staffed by behavioral health providers trained to provide crisis services. To the extent that services provided in response to a behavioral health crisis meet the definition of ‘emergency services,’ and are provided with respect to a visit to a facility that meets the definition of an ‘emergency department of a hospital’ or an ‘independent freestanding emergency department,’ as those terms are defined under the July 2021 interim final rules, these services are subject to the surprise billing protections in the No Surprises Act and its implementing regulations applicable to emergency services [fn 25]. This is true regardless of whether the license issued to the facility uses the term ‘hospital emergency department’ or ‘independent freestanding emergency department’ and regardless of whether the license issued to the facility uses the term ‘emergency services’ to describe the services the facility is licensed to provide. For example, if under state licensure laws, a facility that provides behavioral health crisis response services is permitted to provide emergency services as described in 26 CFR 54.9816- 4T(c)(2), 29 CFR 2590.716-4(c)(2), and 45 CFR 149.110(c)(2), and is geographically separate and distinct from a hospital, then such a facility would fall within the definition of ‘independent freestanding emergency department’ under the July 2021 interim final regulations, and the surprise billing protections would apply with respect to emergency services provided with respect to a visit to the facility.”

2. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) Regulatory Guidance

A. Nonparticipating (Non-Par) Coverage Exclusions Impermissible

Example 9, under the [MHPAEA Final Rules](#), November 2013, the NQTL rule, provides:

(i) *Facts*. A plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) *Conclusion*. In this *Example 9*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits, **the plan's unconditional exclusion of substance**

use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions." (Emphasis added).

This **Example 9** demonstrates that a plan cannot unconditionally exclude services from MH/SUD benefits, if those services are covered, under certain conditions, for med/surg benefits.

B. Exclusions based on Experimental vs. Non-Experimental Treatment Must Comply with NQTL Rule

[FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39](#), Sept. 5, 2019

"Q1. My health plan document states that it excludes coverage for treatment that is experimental or investigative for both medical/surgical benefits and for MH/SUD benefits. For both medical/surgical benefits and MH/SUD benefits, the plan generally follows current medical evidence and professionally recognized guidelines on the efficacy of treatment. With respect to both medical/surgical benefits and MH/SUD benefits, the plan's documents state that the plan excludes coverage for treatment as experimental for a given condition when no professionally recognized treatment guidelines define clinically appropriate standards of care for the condition, and fewer than two randomized controlled trials are available to support the treatment's use with respect to the condition.

The plan defines autism spectrum disorder as a mental health condition. More than one professionally recognized treatment guideline and more than two controlled randomized trials support the use of Applied Behavior Analysis (ABA) therapy to treat certain children with autism spectrum disorder. The plan, in practice, excludes coverage for ABA therapy to treat children with autism spectrum disorder under the rationale that the treatment is experimental or investigative. With respect to medical/surgical conditions, the plan covers treatment when supported by one or more professionally recognized treatment guidelines and two or more controlled randomized trials. Is this permissible under MHPAEA?

No. The plan's application of the NQTL to MH/SUD benefits is not permissible because, in operation, the plan applies the NQTL more stringently to certain MH/SUD benefits than to medical/surgical benefits. **A medical management standard limiting or excluding benefits based on whether a treatment is experimental or investigative is an NQTL under MHPAEA.** [fn 7] A group health plan or group or individual health insurance issuer may impose an NQTL on MH/SUD benefits if, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors used by the plan in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to medical/surgical benefits in the same classification. [Emphasis added].

Although the plan as written purports to exclude experimental or investigative treatment for both MH/SUD and medical/surgical benefits using the same standards, in practice, it imposes this exclusion more stringently on certain MH/SUD benefits, as the plan excludes ABA therapy, despite the fact that professionally recognized treatment guidelines and the requisite number of randomized controlled trials support the use of ABA therapy to treat children with autism spectrum disorder. Accordingly, the plan's exclusion of certain MH/SUD benefits—in this case, for ABA therapy—does not comply with MHPAEA because the plan applies the NQTL more stringently to these MH/SUD benefits than to medical/surgical benefits.

To comply with MHPAEA, the plan must ensure that any processes, strategies, evidentiary standards, and other factors used to impose the exclusion are applied comparably to all medical/surgical and MH/SUD benefits in the relevant classification. This could be accomplished, in practice, by not excluding as experimental or investigative any treatment that has professionally recognized treatment guidelines defining clinically appropriate standards of care for the condition and for which at least two randomized controlled trials are available to support the treatment's use with respect to the condition. To the extent the plan determines any treatment should be excluded after properly applying this standard, the plan should also document the factors relied upon to exclude the treatment on this basis."

"Q2: My health plan documents state that the plan excludes coverage for treatment that is experimental or investigative for both medical/surgical benefits and for MH/SUD benefits. The plan defines experimental or investigative treatments as those with a rating below "B" in the Hayes Medical Technology Directory, with exceptions for certain treatments that have a rating of "C" only where an exception is determined to be medically appropriate. However, in operation, the plan reviews and covers certain treatments for medical/surgical conditions that have a rating of "C" only when an exception is determined to be medically appropriate, while denying all benefits for MH/SUD treatment that have a rating of "C" or below, without reviewing the treatments to determine whether exceptions are medically appropriate. Is this permissible under MHPAEA?

No. A medical management standard that limits or excludes benefits based on whether a treatment is experimental or investigative is an NQTL under MHPAEA. [fn 8] A plan or issuer may impose an NQTL on MH/SUD benefits if, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors used by the plan in applying its NQTL with respect to MH/SUD benefits are comparable to, and applied no more stringently than, those used in applying the NQTL with respect to medical/surgical benefits in the same classification.

Here, although the terms of the plan set forth the same evidentiary standard for MH/SUD benefits and medical/surgical benefits (defining experimental as having a Hayes Medical Technology Directory rating below "B," with exceptions for those with a "C" rating where medically appropriate), the plan applies a different evidentiary standard, and the standard is more stringent for MH/SUD benefits than for medical/surgical benefits because claims for medical/surgical treatments with a "C" rating are reviewed to determine whether an exception is medically appropriate while claims for MH/SUD treatments with a "C" rating are denied without review by the plan to determine whether an exception might be medically appropriate. The fact that the plan ultimately denies some medical/surgical benefits that have a rating of "C" does not justify the total exclusion of treatments with a "C" rating for MH/SUD. Accordingly, the plan's medical management standard does not comply with MHPAEA.

To comply with MHPAEA, the plan must apply the same exception for MH/SUD treatments in the same classification if the plan, in operation, provides an exception based on medical appropriateness for medical/surgical treatments. To ensure that its approach is compliant with MHPAEA and that it will be able to satisfy participants' requests for documents, the plan should document in writing the availability and requirements of its exceptions process, as well as the factors relied upon in determining how the exception process applies to both MH/SUD and medical/surgical benefits."

[2020 MHPAEA Self-Compliance Tool](#)

“ILLUSTRATION 5: A patient with chronic depression has not responded to five different antidepressant medications and therefore was referred for outpatient treatment with repetitive transcranial magnetic stimulation (TMS). This specific treatment has been approved by the FDA and has been the subject of more than six randomized controlled trials published in peer reviewed journals. The plan denies the treatment as experimental. The plan states that it used the same criteria to deny TMS as it does to approve or deny any MH/SUD or medical/surgical benefits under the plan. The plan identifies its standard for both medical/surgical benefits and MH/SUD benefits as requiring that at least two randomized controlled trials showing efficacy of a treatment be published in peer reviewed journals for any new treatment. However, the plan indicates that while more than two randomized controlled trials regarding TMS have been published in peer reviewed journals, a committee of medical experts involved in plan utilization management reviews reviewed the journals and determined that only one of the articles provided sufficient evidence of efficacy. The plan did not identify what specific standards were used to assess whether a peer review had adequately evidenced efficacy and what the qualifications of the plan’s experts are. Lastly, the plan does not impose this additional level of scrutiny with respect to reviewing medical/surgical treatments beyond the initial requirement that the treatment has been the subject of the requisite number and type of trials.

Conclusion: The plan’s exclusion fails to comply with MHPAEA’s NQTL requirements because, in practice, the plan applies an additional level of scrutiny with respect to MH/SUD benefits and therefore applies the NQTL more stringently to mental health benefits than to medical/surgical benefits without additional justification. To come into compliance, the plan could ensure that that any additional levels of scrutiny are imposed on both medical/surgical and MH/SUD benefits comparably, including by establishing standards for when a peer review has adequately evidenced efficacy, and that the qualifications of the plan’s experts are similar for both MH/SUD and medical/surgical benefits.” (Emphasis added).

C. Other Limits such as Visits, Duration, Scope of Services Must Comply with Federal Parity Law

[2020 MHPAEA Self-Compliance Tool](#) (pp. 9 -10)

“Plans and issuers that offer MAT [medication-assisted treatment] benefits to treat opioid use disorder[s] are subject to MHPAEA requirements, including the special rule for multi-tiered prescription drug benefits that applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as appropriate for purposes of MHPAEA. **Plans and issuers should ensure there are NO impermissible QTLs, such as visit limits, or impermissible NQTLs, such as limits on treatment dosage and duration.** For example, a limitation providing that coverage of medication for the treatment of opioid use disorder is contingent upon the availability of behavioral or psychosocial therapies or services or upon the patient’s acceptance of such services would generally not be permissible unless a comparable process was used to determine limitations for the coverage of medications for the treatment of medical/surgical conditions.” (Emphasis added).

“ILLUSTRATION: An issuer did not cover methadone for opioid addiction, though it did cover methadone for pain management. The issuer failed to demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions. The issuer re-evaluated the medical necessity of methadone maintenance treatment programs and developed medical-necessity criteria

that mirrors federal guidelines (including the Substance Abuse and Mental Health Services Administration treatment improvement protocol for medication for opioid use disorder) for opioid treatment programs to replace the methadone-maintenance treatment exclusion.”

“ILLUSTRATION: A plan uses nationally recognized clinical standards to determine coverage for prescription drugs to treat medical/surgical benefits based on the recommendations of a Pharmacy and Therapeutics (P&T) committee. However, the plan deviates from such standards for buprenorphine/naloxone to treat opioid use disorder based on the P&T committee’s recommendations. This deviation should be evaluated for compliance with MHPAEA’s NQTL standard in practice, including the determination of (1) whether the P&T committee has comparable expertise in MH/SUD conditions as it has in medical/surgical conditions, and (2) whether the committee’s evaluation of the nationally-recognized clinical standards and decision processes to deviate from those standards for MH/SUD conditions is comparable to and no more stringent than the processes it follows for medical/surgical conditions.”

D. Same Standards and Definitions Must be Used for Classifying Benefits, Including BH Crisis Services

2020 MHPAEA Self-Compliance Tool (pp.9, 11)

“Classifying benefits. In determining the classification in which a particular benefit belongs, a group health plan or group or individual market health insurance issuer must apply the same standards to medical/surgical benefits as to MH/SUD benefits. See 26 CFR 54.9812- 1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).”

“1. Special rule for outpatient sub-classifications:

- For purposes of determining parity for outpatient benefits (in-network and out-of-network), a plan or issuer may divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules. 26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).
- After the sub-classifications are established, the plan or issuer may not impose any financial requirement or QTL on MH/SUD benefits in any sub-classification (i.e., office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the MHPAEA regulations. See 26 CFR 54.9812-1(c)(3)(i), 29 CFR 2590.712(c)(3)(i), 45 CFR 146.136(c)(3)(i), 45 CFR 146.136(c)(3)(iii).”

2020 MHPAEA Self-Compliance Tool (p. 22)

“NOTE: If a plan classifies covered intermediate levels of care, such as skilled nursing care and residential treatment, as inpatient benefits, and covers room and board for all inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction only on MH/SUD benefits and therefore violates MHPAEA.”