

**ORDER**

BY THE HONORABLE ROGER A. SEVIGNY  
INSURANCE COMMISSIONER OF THE  
STATE OF NEW HAMPSHIRE

IN THE MATTER OF:

Harvard Pilgrim Health Care of New England, Inc., NAIC #96717

TARGETED MARKET CONDUCT EXAMINATION REPORT – SUD BENEFITS  
Docket No.: INS No. 15-073-MC

**WHEREAS**, the New Hampshire Insurance Department (“the Department”) conducted a targeted market conduct examination of the above-referenced insurance company (“the Company”) regarding its handling of substance use disorder (“SUD”) benefits during the period January 1, 2015 through September 30, 2015, and the examination resulted in a Verified Market Conduct Examination Report (“Verified Report”) as of October 28, 2016.

**WHEREAS**, the Verified Report contains the findings and recommendations of the Examiners.

**WHEREAS**, the Company received a copy of the Verified Report, and, by correspondence dated November 28, 2016, December 5, 2016, December 8, 2016, and December 19, 2016, submitted its Rebuttal to the Verified Report to the Department.

**WHEREAS**, by an Order executed by the Commissioner on December 27, 2016, the Department adopted the Verified Report pursuant to RSA 400-A:37, IV (b) (1) with modifications as noted in that Order.

**WHEREAS**, the Company requested a closed meeting with the Commissioner pursuant to RSA 400-A:37, IV (c) (2); the meeting was held on January 12, 2017, and the Company also submitted additional correspondence to the Department, at the Department’s request, on January 13, 2017.

**WHEREAS**, the Department appreciates the information the Company has shared at and after the closed meeting, and will take it into account in any future proceedings that may relate to the findings in the Adopted Report.

**WHEREAS**, the Adopted Report has been modified slightly at the request of examiners to clarify the examiners’ explanation of market conditions with respect to network adequacy, a change which does not alter the examiners’ findings with respect to the Company’s practices.

**NOW THEREFORE**, in accordance with RSA 400-A:37, IV (c)(4), the Adopted Report, as modified, is hereby accepted and filed, and shall be deemed final.

It is **SO ORDERED**

New Hampshire Insurance Department



Date: February 7, 2017

\_\_\_\_\_  
Roger A. Sevigny, Commissioner

STATE OF NEW HAMPSHIRE

COUNTY OF MERRIMACK

Joelien J Atwater, being duly sworn, upon her oath deposes and says:

That she is an examiner employed by the Insurance Department of the State of New Hampshire;

That an examination was made of the affairs of the

**Harvard Pilgrim Health Care f New England**

Organized and authorized under laws of the State of New Hampshire,

Vested by **Roger A. Seigny**, Commissioner of Insurance of the State of New Hampshire;

That she was the examiner-in-charge of said examination and that the attached report of the examination is a true and complete report of the condition of the above named Company as of October 28, 2016 as determined by the examiners.

  
Examiner-In-Charge

Subscribed and sworn to before me this  
27<sup>th</sup> Day of October, A.D. 2016

  
Notary Public/Just's  are EXP 3/25/2020



NEW HAMPSHIRE INSURANCE DEPARTMENT  
MARKET CONDUCT TARGETED EXAMINATION

OF

HARVARD PILGRIM HEALTH CARE OF NEW ENGLAND, INC

650 ELM STREET, SUITE 700

MANCHESTER, NH 03101

NAIC# 96717

FOR THE PERIOD OF JANUARY 1, 2015 THROUGH SEPTEMBER 30, 2015  
REGARDING THE HANDLING OF SUBSTANCE USE DISORDER BENEFITS AND  
MENTAL HEALTH PARITY



**FINAL**

AS OF  
FEBRUARY 7, 2017

# Table of Contents

- Scope ..... 3
  - Phase I ..... 4
  - Phase II ..... 5
- Company Profile ..... 9
- Executive Summary ..... 10
- FINDINGS ..... 18
  - DELEGATED SERVICE CONTRACTS ..... 18
  - NETWORK ADEQUACY ..... 20
  - PRE-AUTHORIZATION ..... 26
  - GRIEVANCES AND APPEALS ..... 30
  - CLAIMS ..... 31
  - MEDICATION ASSISTED TREATMENT ..... 34
    - Formulary Design ..... 34
    - Age Limitations ..... 35
    - Formulary Exception Process ..... 35
    - Dosage and Refill Limits ..... 35
    - Lifetime/Annual Limits ..... 36
    - Pre-authorization for Methadone and Buprenorphine ..... 36
    - Penalties or Exclusions for Failure to Complete a Course of Treatment ..... 36
    - Medical Necessity Standards for Methadone and Buprenorphine ..... 36
  - MENTAL HEALTH PARITY ..... 36
    - Market Review ..... 38
    - Quantitative Treatment Limits ..... 38
    - Non-Quantitative Treatment Limits ..... 39
    - Medical Management Policies and Procedures ..... 40
    - Consumer Medical Management Policy/Guidelines Access ..... 42
    - Consumer Contract Language ..... 43
    - Policy Development and Updates ..... 43
    - Pre-certification/Prior-authorization ..... 44
    - Provider reimbursement rates and fee schedules ..... 45
    - Processes and Procedures for determining Usual and Customary ..... 48

## Scope

Pursuant to RSA Chapter 400-A:37, the New Hampshire Insurance Commissioner (Commissioner) issued an examination warrant for the purpose of examining Harvard Pilgrim Health Care of New England's (Harvard) administration of benefits for Substance Use Disorder and Addiction (SUD) treatment services.

The goal of the examination was to ascertain how carriers regulated by the New Hampshire Insurance Department (Department) are providing coverage for Substance Use Disorder (SUD) treatments and to ensure that benefits are consistently applied within the requirements of state and federal law and are not subject to more stringent requirements than for medical/surgical benefits during the examination period of January 1, 2015 through September 30, 2015.

Specifically, this examination encompassed all regulatory requirements under RSA Title XXXVII that apply to the health carriers' practices for the handling of SUD services under both New Hampshire and federal law, including but not limited to:

1. RSA 417-E:1, V and RSA 420-B:8-b, V, which authorize the Commissioner to enforce the provisions of the federal Mental Health Parity Addiction Equity Act of 2008, codified at 20 U.S.C § 1185a (MHPAEA) that relate to the business of insurance, including federal regulations adopted under MHPAEA 45 CFR Section 146.136, Parity in mental health and substance use disorder benefits (federal parity rule)<sup>1</sup>;
2. RSA 420-N:5, which authorizes the Commissioner to enforce the consumer protections and market reforms set forth in the Affordable Care Act (ACA), including the ACA's amendments to MHPAEA;
3. RSA 415:18-a, requiring coverage for mental or nervous conditions and treatment for chemical dependency under group health plans;
4. RSA 420-B:8-b, requiring that Health Maintenance Organizations (HMOs) provide coverage for mental and nervous conditions and chemical dependency;
5. RSA 417-E:1, requiring coverage for certain biologically-based mental illnesses that is in parity with coverage for physical illness; and
6. Provisions of New Hampshire's Managed Care Law, including RSA 420-J:5 through 5-e, governing appeals; RSA 420-J:7, regarding network adequacy; RSA 420-J:8-a, requirements for prompt pay; RSA 420-J:4 governing provider credentialing and RSA 420-J:6, regarding utilization review.

---

<sup>1</sup> This Examination applied to the federal parity rule rather than New Hampshire's parity rule, N.H. Code of Admin. R. INS Part 2702, as the federal rule is more recent and more comprehensive. As noted below, the Examination applied state law requirements in addition to federal requirements when the state requirements were stricter and/or more protective of the consumer.

The examination was conducted in two phases. Phase I included sending interrogatories to obtain initial information regarding the following areas: Delegated Service Contracts, Network Adequacy, Pre-Authorizations, Grievances/Appeals and Claims. Phase II included a series of interrogatories to verify Medication Assisted Treatment (MAT) practices and overall compliance with both quantitative and non-quantitative requirements of MHPAEA.

For the purposes of this examination, the Department contracted with the following as outside examiners (1) an Independent Review Organization (IRO) that provided the medical expertise of addiction specialists; (2) a mental health parity expert; and (3) a pharmacist to assist with the interpretation of the documentation provided with respect to pharmacy benefits.

### **Phase I**

On December 4, 2015, the Department sent interrogatories and a Behavioral Health Survey to Harvard. Harvard was requested to provide a detailed response to the survey and interrogatory questions as they relate to fully-insured group and individual health benefit plans. When referencing small and large groups, the Department requested that the responses encompass employer/group contracts with a bricks and mortar work location in the state of New Hampshire with one or more New Hampshire employees.

Harvard was required to provide information relative to the following operational areas:

- Delegated Service Contracts
- Network Adequacy
- Pre-authorizations
- Grievances and Appeals
- Claims

Interrogatory responses were requested, received and reviewed by the Department's examiners and contracted examiners. The examiners interacted with the carrier for any follow-up questions or identified deficiencies.

The Department's primary objective in conducting Phase I of the examination was to evaluate whether the carrier is covering SUD benefits no less favorably than medical/surgical benefits. The goals and objectives in conducting the Examination included but were not limited to the following:

1. Evaluate the carrier's delegated service contracts to ensure that if the carrier has delegated SUD utilization or case management reviews, that:
  - The delegated entity has the appropriate expertise to perform SUD reviews;
  - The delegated entity has applied clinically appropriate criteria and guidelines; and,
  - The criteria and guidelines utilized do not impose any limitations on SUD services that are more stringent than those applied to medical/surgical services.
2. Evaluate the carrier's provider network to determine whether there are a sufficient number of providers, including providers that specialize in Behavioral Health/SUD services, and to ensure that consumer access to services is available without unreasonable delay.
  - Review and test the carrier's website for ease of use and accuracy of on-line directory
3. Evaluate the carrier's entire universe of SUD pre-authorization denials during the examination period to ensure that denials were appropriate based on medically sound criteria.
4. Test 100% of the carrier's SUD grievances and appeals during the examination period to determine:
  - If the grievance/appeal determination was made in accordance with clinically appropriate criteria and guidelines, contractual obligations and all applicable state and federal laws; and
  - That all adverse benefit determination letters included information regarding any right to external review and all required contact information.
5. Measure the carrier's claims in order to quantify volumes of claims for SUD services in comparison to claims for medical/surgical services.

## **Phase II**

This phase consisted of two major components: Medication Assisted Treatment (MAT) and carrier compliance relative to MHPAEA and the federal parity rule. This included an in depth review by a contracted pharmacist of Harvard's practices for MAT to establish a baseline for the program.

The Department's primary objective in conducting the examination was to evaluate whether the carrier is covering Behavioral Health benefits no less favorably than Medical/surgical benefits. The goals and objectives in conducting Phase II of the Examination included but are not limited to the following:

1. Identify all market segments that are subject to MHPEA to determine that the carrier is not limiting coverage or benefits inappropriately in any market.
2. Identify any variations for coverage or benefits for these market segments and ensure that any identified variances are in compliance with the appropriate statutes and regulations, including all allowed variances outlined in 45 CFR § 146.136.
3. Determine that the Behavioral Health benefits provided in the classifications identified by 45 CFR §146.136 (a)(c)(2)(ii)(A); in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency and pharmacy, are paid in parity with benefits in the same classification under Medical/surgical.
4. Evaluate the carrier's quantitative and non-quantitative benefit limits to ensure that limitations are consistently applied through Behavioral Health and Medical/surgical benefits and that any quantitative limitations imposed meet the two-thirds threshold of the substantially all requirement outlined in 45 CFR § 146.136 (a)(c)(3)(i).
5. Evaluate the carrier's Medical Necessity policies and procedural requirements to ensure that the carrier is not imposing more restrictive requirements and determinations on Behavioral Health treatments than on Medical/surgical.
  - a. Evaluate the Medical Necessity requirements to determine that the guidelines are clearly outlined and presented to consumers in a format compliant with all applicable statutes and regulations.
6. Evaluate the carrier's Precertification/Pre-authorization policies and procedural requirements to ensure that the carrier is not imposing more restrictive requirements and determinations on Behavioral Health treatments than on Medical/surgical.
7. Evaluate the carrier's reimbursement fee schedule to determine if the reimbursement fees are consistently applied to Behavioral Health and Medical/surgical, and to determine that any fee updates are consistently applied to both Behavioral Health and Medical/surgical providers.
8. Evaluate the carrier's Usual and Customary allowances to determine that benefit reductions are not applied more strictly to Behavioral Health than to Medical/surgical benefits.
9. Measure the carrier's claims to quantify volumes of Behavioral Health claims for services in comparison to Medical/surgical services.

In the MAT portion of Phase I and II, interrogatories were sent to the carrier by the pharmacist and detailed responses were requested. The information received was reviewed by the pharmacist with oversight by the Department's examiners. The examiners and contracted pharmacist worked with the carrier to answer follow-up questions or discuss deficiencies.

In Phase II's area of Mental Health Parity compliance, on May 17, 2016, the contractors acting on behalf of the Department sent interrogatories based on Harvard's responses to the Behavioral Health Survey the carrier had completed as part of the initial phase of the examination. The carrier was requested to provide a detailed response to the interrogatory questions as they relate to fully-insured group and individual health benefit plans. On June 23, 2016, follow-up interrogatories were sent.

Specifically, Harvard was required to provide information relative to the following:

Medication Assisted Treatment (MAT):

- Formularies to determine the number of SUD medications offered
- Documentation to ensure that inappropriate age limitations were not imposed through discriminatory benefit designs for MAT medications
- Processes and policy language presented to the consumer that explain how to request an exception for coverage of medications not covered under the plans formulary
- Documentation regarding the dosage and refill limits for methadone, buprenorphine, buprenorphine/naloxone, naloxone and naltrexone
- Documentation regarding lifetime or annual limits for methadone, buprenorphine, buprenorphine/naloxone, naloxone and naltrexone
- Preauthorization, re-authorization or step therapy processes or any other utilization review requirements specific to methadone and/or buprenorphine
- Information regarding penalties or exclusions of coverage for failure to complete a course of treatment specific to methadone and/or buprenorphine
- Medical necessity standards applied to methadone and/or buprenorphine

Mental Health Parity and Addiction Equity Act (MHPAEA):

- Market segments served by the carrier which are subject to MHPAEA
- Variances in requirements for Medical/surgical benefits and Behavioral Health benefits
- Classification and sub-classification of benefits for both Medical/surgical and Behavioral Health in the following categories

- In-network inpatient
- Out-of-network inpatient
- In-network outpatient
- Out-of-network outpatient
- Emergency
- Pharmacy
- Quantitative and Non-quantitative Treatment limits for both Medical/surgical benefits and Behavioral Health benefits
  - Medical Necessity Requirements including notifications provided to members outlining the Medical Necessity Requirements for both Medical/surgical and Behavioral Health
  - Precertification/Pre-authorization requirements for both Medical/surgical and Behavioral Health including policy language
  - Provider reimbursement rates and fee schedules for both Medical/surgical and Behavioral Health
  - Processes and Procedures for determining Usual and Customary and frequency of updates of such for both Medical/surgical and Behavioral Health; and
  - Claims volume for both Medical/surgical and Behavioral Health

Interrogatory responses were requested, received and reviewed by the Department's examiners and contracted examiners. The examiners interacted with the carrier for any follow-up questions or identified deficiencies.

## Company Profile

Harvard Pilgrim Health Care of New England, Inc. (“Harvard Pilgrim of New England”) was incorporated in 1978 as a Massachusetts not-for-profit corporation under the name MultiGroup Health Plan. It is licensed as an HMO in New Hampshire and Massachusetts. In 1986, MultiGroup affiliated with Harvard Community Health Plan, and changed its name to Harvard Community Health Plan of New England. In 1996, it became Harvard Pilgrim Health Care of New England, following the affiliation of its parent corporation with Pilgrim Health Care (see below). The offices of Harvard Pilgrim of New England are located at 650 Elm Street, Suite 700 Manchester, NH 03101-2596

Harvard Pilgrim Health Care, Inc. (“Harvard Pilgrim”), formerly known as Harvard Community Health Plan, is the parent company of Harvard Pilgrim of New England. As the parent corporation, Harvard Pilgrim provides administrative services and staffing to Harvard Pilgrim of New England. Harvard Pilgrim is a not-for-profit managed care organization. In 1995, Harvard Community Health Plan changed its name to Harvard Pilgrim Health Care. Its corporate headquarters are located at 93 Worcester Street, Wellesley, Massachusetts 02481.

## **Executive Summary**

The following summary of this targeted market conduct examination of the carrier is intended to provide a high-level overview of the examination results. The report includes sections which detail the scope of the examination, tests conducted, findings and observations. Appendices include the Interrogatories and Data Requests sent to Harvard.

One of the most predominant observations Examiners wish to note is the overall shortage in New Hampshire of available SUD and Behavioral Health providers in which to contract.

The examination included the following areas of review: Delegated Service Contracts, Network Adequacy, Pre-Authorizations, Grievances/Appeals, Claims, and Medication Assisted Treatment specific to SUD, as well as Parity between Behavioral Health and Medical/surgical services. Based upon our review of the information received from the carrier, the following is a summary of our findings and observations:

### **Delegated Services**

Harvard has a delegation agreement in place with United Behavioral Health, dba UBH/Optum Behavioral to manage all Behavioral Health and SUD benefits.

Examiners requested but did not receive documentation specific to the compliance audits and examination results of UBH/Optum's records and procedures and performance of delegated functions for 1/1/15 through 9/30/15.

Examiners will require that Harvard produce copies of the compliance audits and examination results of UBH/Optum's records and procedures and performance of delegated functions that were completed in 2015 as indicated in the Master Service Agreement, within 30 days of the final report.

Examiners will recommend that a follow up examination of delegated services and National Committee on Quality Assurance (NCQA) oversight be completed.

### **Network Adequacy**

Deficiencies in the availability of servicing providers were identified, based upon New Hampshire Network Adequacy Standards RSA 420-J:7 and N.H. Code of Admin. R. Ins. Part 2701. These deficiencies are a result of a lack of providers in this area in New Hampshire.

The examiners will be requesting further information including documentation in regards to how the carrier demonstrates it handles requests from members in service areas that do not have adequate contracted providers available.

### **Web-site consumer ease of access**

Examiners will require that Harvard provide a corrective action plan to the Department within 30 days of finalization of the report to address the timelines associated with providing a current listing of all SUD and Behavioral Health providers, as well as update their website and UBH/Optum's website to prominently display an accurate, up-to-date listing of all SUD and Behavioral Health providers.

### **Provider directory accuracy**

As a result of the network adequacy deficiencies, examiners extended their review to carrier website ease-of-use for identification of Behavioral Health providers and to confirm the accuracy of the listing.

The examiners will be requesting that Harvard provide the Department with their policies and procedures for quality oversight of the on-line provider directory which must demonstrate:

- How Harvard ensures accurate listings are published on their website
- Documentation regarding the coordination of provider information between UBH/Optum and Harvard for the directory
- The method and frequency of verification; and
- The most recent verification results and any corrective actions put in place to correct deficiencies

### **Pre-Authorizations**

The Department contracted with a certified independent review organization (IRO) that provided 16 addiction specialists, to conduct a review of all pre-authorization medical necessity denials. This consisted of 100% of all denials for SUD benefits during the examination period of January 1, 2015 through September 30, 2015. Harvard was delayed in submitting the pre-authorization documentation as they redacted information from the files prior to sending them to the IRO for review.

The IRO was unable to provide an opinion on three of the pre-authorization requests due to the lack of sufficient documentation. The IRO also disagreed with Harvard's final determination on three pre-authorization reviews and felt additional benefits should have been provided and would have overturned the denials.

Examiners are recommending follow-up with all six consumers to determine present treatment status and to ensure they have received all appropriate treatment under their benefit contract.

In addition, the medical director of the IRO was asked to review the criteria used for the evaluation of Medical Necessity for SUD treatment and confirm that it is consistent with current medical standards. The medical director stated, "It is my medical opinion that the protocols are medically reasonable."

### **Grievances and Appeals**

A review of all SUD Grievances and Appeals letters for the scope of the exam was conducted for compliance with RSA 420-J:5. Harvard provided a total of 22 grievances and appeals for review. Examiners eliminated six grievances and appeals from the review as they were out of scope for the examination period or were not for SUD services.

No compliance issues for the remaining grievances and appeals were identified.

### **Claims**

Examiners were unable to quantify the overall volume and percentage of SUD claims in relation to Medical/surgical claims due to the multiple versions of data submitted. Several requests were made for data and the examiners were unable to validate what was submitted due to inconsistency in the information provided.

Harvard will be required to address claims data through expanded interrogatories in the overall delegated service and NCQA oversight examination to be scheduled.

### **Medication Assisted Treatment**

The Department contracted with a registered pharmacist to create a set of interrogatories designed to provide a baseline of Harvard's MAT program in New Hampshire.

Medication assisted treatment is defined as any opioid addiction treatment that includes a Food and Drug Administration (FDA) approved medication for the detoxification or maintenance treatment of opioid addiction. The interrogatories that were developed reflect the most up-to-date information on opioid addiction and treatment with an understanding that opioid addiction is a chronic disease.

Examiners will require that Harvard provide information regarding the clinical basis for dosage limitations for Narcan and Evzio as they are contrary to the manufacturer's

dosing guidelines. This documentation must be provided to the Department within 30 days of the final report.

## **Mental Health Parity**

For purposes of this report, this section refers to the services to which the parity laws are applicable interchangeably as either Mental Health or Behavioral Health benefits, categories which also include SUD services. Many documents presented by the carrier uses the term Behavioral Health rather than Mental Health. This term is used as an all-encompassing term that not only includes promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but also has as an aim preventing or intervening in substance abuse or other addictions. However, because the term “Mental Health” is used in MHPAEA, the report does on occasion use the term “Mental Health” rather than “Behavioral Health.” In several areas, the Parity review focuses on concerns of parity with respect to SUD services more narrowly, rather than looking at all areas that would fall under Mental Health or Behavioral Health.

A Mental Health Parity review was completed on the carrier’s internal processes and procedures to determine compliance with NH parity laws as well as the updated federal regulation implementing MHPAEA, 45 CFR §146.136. To complete the review, examiners looked at the responses received to the original Mental Health Parity Survey, follow-up interrogatory responses and the carrier’s documented procedures. This review was performed to identify potential areas where procedures and protocols as well as access to Behavioral Health benefits were less favorable than the procedures and protocols for Medical/surgical considerations.

The following information identifies the areas of review, the determinations, and recommendations for various parity comparisons.

## **Market Review**

Examiners requested information on the markets in which the carrier writes business that is subject to MHPAEA. Examiners then reviewed the markets for both Medical/surgical and Behavioral Health coverage to ensure there were no disparities or gaps in coverage in each market.

Harvard provides Behavioral Health coverage in the Individual, Small Group, and Large Group markets. The same requirements are applied through all three markets.

Harvard’s practices as they relate to each market are consistent and compliant with the identified regulations.

The examiners found no exceptions in terms of inclusion of all relevant markets under parity procedures.

### **Quantitative Treatment Limits**

In accordance with the federal mental health parity rule (45 CFR § 146.136 (a)(3)(i)(A)), examiners reviewed the carrier's policies and procedures in applying quantitative limits. Under the rule, quantitative treatment limitations are those for which the extent of benefits provided are based on accumulated amounts, such as an annual or lifetime day or visit limit.

Examiners reviewed the HPHC Analysis of Quantitative Benefit Limitations which provides a comparative analysis of the quantitative limitations imposed for both Medical/surgical and Behavioral Health benefits, as well as fee schedules presented in the HMO policy language and determined that documents provided show that the carrier meets the 2/3 predominate financial requirement required in 45 CFR §146.136 (c)(3)(i)(A) in the application of quantitative limitations between Mental Health benefits and Medical/surgical benefits. Examiners confirmed that Harvard and UBH/Optum review quantitative limits on an annual basis for both Medical/surgical and Behavioral Health.

### **Non-Quantitative Treatment Limits**

Non-quantitative treatment limits included (but are not limited to) the following:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Network tier design for plans with multiple network tiers (such as preferred providers and participating providers);
- Standards for provider admission to participate in a network, including reimbursement rates;
- Methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and

- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage)

Medical Management standards were reviewed to determine that access to coverage, medical necessity requirements, utilization reviews, and precertification requirements for Behavioral Health and Medical/surgical benefits were consistently applied and did not incorporate more stringent factors for Mental Health benefits that would limit or discourage access for treatment.

### **Medical Management Policies and Procedures**

Medical Management guidelines established for Medical/surgical reviews by Harvard and Behavioral Health by UBH/Optum were determined to be compliant with regulatory requirements and consistently applied.

Examiners will re-address the Optum U.S. Behavioral Health Plan, California dba OptumHealth Behavioral Solutions of California (“OHBS-CA”) document to confirm compliance with New Hampshire law.

### **Consumer Medical Management Policy & Guideline Access**

Medical Management criteria for Behavioral Health policies are provided on the carrier’s website through a link to the UBH/Optum website. This information is in the Provider Tab on the home page; however, it is not presented through the Member Tab.

Examiners will require Harvard to ensure that Medical Necessity information, including Utilization Review policies and Clinical Guidelines are easily accessible to consumers on the carrier’s website.

### **Consumer Contract Language**

Examiners reviewed policy language for Individual, Small Group and Large Group plans.

Examiners found no exceptions.

### **Policy Development and Updates**

Examiners reviewed methodologies that the carrier uses to create, amend or update Medical Management policies and procedures. Harvard retains control of policy development for Medical/surgical benefits and delegates policy development regarding

Behavioral Health to UBH/Optum. Committees consisting of representatives of both Harvard and UBH/Optum are responsible for oversight of policy development.

Examiners requested, but did not receive, documentation relative to the committee oversight activity.

Examiners will include medical management processes for policy and procedure development and oversight into the delegated services and NCQA oversight examination to be scheduled.

### **Pre-certification and Prior-authorization**

To determine parity between pre-certification and prior-authorization requirements for both Behavioral Health and Medical/surgical benefits, examiners reviewed the carrier's internal processes for both areas as well as samples of policy language from a large group, small group and individual plan.

In reviewing policy language, the examiners determined that to be covered by the plan, all Mental Health and drug and alcohol rehabilitation services must be prearranged (pre-certified) through the Behavioral Health Access Center and provided by contracted providers. The same requirement is not imposed on all Medical/surgical benefits.

Examiners will require that Harvard provide the Department with evidence that this is not a parity violation within 30 days of the final report.

### **Provider reimbursement rates and fee schedules**

The examiners reviewed the policies and procedures utilized to update reimbursement rates and fee schedules. Documentation reviewed shows that the carrier reviews its fee schedules utilizing the Centers for Medicare & Medicaid Services (CMS) Resource Based Relative Value Scale (RBRVS) methodology as well as recent trends in services and utilization and employer groups' Ambulatory Payment Classification (APC) methods.

Examiners determined that there are variances in reimbursement rates and fees between Medical/surgical providers and Behavioral Health providers. On the average, Behavioral Health providers are reimbursed at rates approximately 85% of the rates for Medical/surgical providers. However, the documentation provided was titled "2013". When examiners requested clarification, the carrier responded that the documents depicted current reimbursement rates, which would be outside of the scope of the examination period.

Due to the confusion in the documentation provided by the carrier and concerns regarding whether the documentation is reflective of the examination period, Examiners will recommend that reimbursement methodology and rates be re-addressed in the delegated services and NCQA oversight examination to be scheduled.

Examiners will recommend that Harvard provide evidence demonstrating why this is not a parity violation.

### **Processes and Procedures for determining Usual and Customary**

Examiners reviewed the policies and procedures regarding usual and customary reimbursement (UCR) rates and determined Harvard uses the same process for determining usual and customary charges for both Medical/surgical services and Behavioral Health services.

Facility UCR fee schedules for Medical/surgical benefits and Behavioral Health benefits are updated every two years. Non-facility (professional services) UCR fee schedules for Medical/surgical and Behavioral Health services are based on the Fair Health Charge Database in which the rates are updated twice a year, in January and July. Examiners found no concerns.

### **Examiners' Final Recommendation**

Examiners recommend that Harvard Pilgrim be cited for the inability to facilitate the examination in a timely manner.

## FINDINGS

### DELEGATED SERVICE CONTRACTS

#### Standard 6

The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.

*NAIC Market Regulation Handbook – Chapter 16, page 222*

#### Regulatory Authority

#### RSA 402-H:6 Responsibilities of the Insurer.

III. In cases in which an administrator administers benefits for more than 100 certificate holders on behalf of an insurer, the insurer shall, at least semi-annually, conduct a review of the operations of the administrator. At least one such review shall be an on-site audit of the operations of the administrator.

The examiners requested all contract provisions and the supporting documentation of all delegated services to determine the handling of SUD Utilization Management (UM) and operational processes and procedures.

Harvard has a delegation agreement in place with United Behavioral Health, dba UBH/Optum Behavioral to manage all Behavioral Health and SUD benefits.

Examiners reviewed the delegated service contract – Amendment Ninth (9<sup>th</sup>) Effective February 20, 2015.

The examiners requested the supporting documentation of all delegated service contracts to determine the handling of SUD claims processes and procedures as well as documentation to show that Harvard completes the annual compliance audits of UBH/Optum as stated in the Master Services Agreement between the two companies.

As stated in the documentation provided by Harvard, “In accordance with the Ninth amendment to Master Services Agreement between Harvard Pilgrim Health Care, Inc. and United Behavioral Health dba UBH/Optum Behavioral, Exhibit D (4), states Harvard Pilgrim shall, at least annually, evaluate, review and approve the QI and UM plan and programs established by the Delegate’s to ensure that ensure that such plans and programs comply with current Harvard Pilgrim policy and NCQA Standards and any other statutory or regulatory requirements, as applicable. Harvard Pilgrim shall also monitor, in a manner and frequency defined by Harvard Pilgrim, Delegates’ compliance with Harvard Pilgrim operational requirements as they related to QI, UM, Credentialing and Member Rights and Responsibilities.”

The Master Services Agreement , page 7, Section 4 (b)(ii) states that “Harvard Pilgrim shall perform compliance audits and shall examine Delegate’s records and review Delegate’s procedures and performance related to delegated functions no less than once a year.”

Harvard submitted two reports; the Reports & Performance Measures – Q2 2015 and the Semi-Annual JOC (1/1/15 – 6/30/15) report as evidence of the oversight of UBH/Optum. Both of the reports submitted were created by UBH/Optum and did not encompass the entire examination period of January 1, 2015 through September 30, 2015. The information in the reports included data relative to Administrative Only Services (ASO groups which are self-insured) and are therefore out-of-scope for this examination.

Harvard submitted a document that outlines the various committees responsible for oversight of UBH/Optum which included a brief description of each committee and its membership. Examiners requested but did not receive documentation specific to the compliance audits and examination results of UBH/Optum’s records and procedures and performance of delegated functions for 1/1/15 through 9/30/15.

Several discussions were held with the compliance officer for Harvard and examiners have not been able to define Harvard’s compliance for 2015 with its’ delegated service contract.

### **Examiners’ Recommendation**

Examiners will require that Harvard produce copies of the compliance audits and examination results of UBH/Optum’s records and procedures and performance of delegated functions that is completed annually as indicated in the Master Service Agreement, within 30 days of the final report. This documentation must encompass the entire examination period of January 1, 2015 through September 30, 2015.

Examiners will recommend that a follow up examination of delegated services and National Committee on Quality Assurance (NCQA) oversight be completed.

### **Company Response**

Harvard Pilgrim responded to the verified report on November 28, 2016 with the following information;

“Harvard Pilgrim would like the Department to know that it and UBH have been routinely audited by NCQA and both have received exceptionally high marks on their reviews. We have attached for your reference the 2009 and 2015 closing reports. (See Exhibit 1-1).”

## **Examiners' Comment**

Examiners appreciate and understand the value that Harvard Pilgrim has placed on NCQA standards; however, the Examiners were addressing the Delegated Service Contract, as cited in the ninth amendment on page 7. This document expressly states that Harvard Pilgrim will perform, at least annually, compliance audits.

## **Company Response**

Harvard Pilgrim provided an additional response to the verified report on December 19, 2016, and stated the following;

“Harvard Pilgrim will look to revise its delegated services contract with UBH/Optum to clarify that Harvard Pilgrim will conduct compliance audits and examine delegate’s records and review delegate’s procedures and performance related to delegated functions upon its request. This will enable Harvard Pilgrim flexibility in the timing and need of future audits for these specific functions.”

## **NETWORK ADEQUACY**

### **Standard 1**

The health carrier demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers that ensure all services to covered persons will be accessible without unreasonable delay.

*NAIC Market Regulation Handbook – Chapter 20, page 530*

A health carrier shall demonstrate that it monitors its providers, provider groups and intermediaries with which it contracts on an ongoing basis to ensure their ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to covered persons.

*NAIC Market Regulation Handbook – Chapter 20, page 531*

### Regulatory Authority

*RSA 420-J:7 Network Adequacy.*

I. A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay.

IV. Annually, the health carrier shall submit a report to the commissioner demonstrating compliance with the rules for network adequacy.

*Ins 2701.10 Enforcement.* If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered

persons have accessible health care services in a geographic area or that a health carrier's health care certification of compliance report does not assure reasonable access to covered benefits, the commissioner shall issue an order requiring the health carrier to institute a corrective action, or shall use other enforcement powers under RSA 420-J to ensure that covered persons have access to covered benefits.

Specific requirements for Network Adequacy under RSA 420:J and INS 2701.06 Geographic Accessibility are as follows:

For at least 90% of the enrolled population within each county or hospital service area, the travel time interval to a provider of outpatient mental health services shall be no greater than 25 miles or 45 minutes travel time. Within the same service area, access to a general inpatient psychiatric facility, emergency mental health providers and short term facility for substance abuse treatment must be within 45 miles or 60 minutes of travel time.

Exceptions to the geographic requirements may be permitted if a carrier can establish that there are an insufficient number of qualified providers or facilities available in the county or hospital service area, if there is a community mental health program approved by the commissioner of DHHS (Department of Health and Human Services) and the program has been deemed to provide a level of geographic access that is at least equal to the customary practice and travel arrangements and the carrier has taken reasonable steps to mitigate any detriment to their enrollees.

Examiners requested the carrier to provide the following information for review and analysis during this examination:

- A listing of all contracted providers including,
  - The type of services they provide in relation to SUD
  - Which providers are accepting new patients
  - Patient capacity for outpatient and inpatient settings
- Two (2) GEO Access reports
  - One (1) report specific to SUD providers throughout New Hampshire
  - One (1) report specific to all of Harvard's existing membership

Network capability for SUD Inpatient, SUD Intensive Outpatient and SUD Rehabilitation services was reviewed to identify deficiencies in the availability of servicing providers based on New Hampshire Network Adequacy Standards RSA 420-J:7 and Ins. 2701.06. Current NH law does not require that carriers document the availability of specialty care providers including SUD providers. The examiners requested SUD-specific provider availability for the examination period and Harvard reported the following deficiencies:

- SUD Acute Inpatient
- SUD Intensive Outpatient
- SUD Intermediate Facilities

In addition to the detail provided by the carrier for network adequacy during the examination period, in the 2015 Network Adequacy report filed with the Department by Harvard on February 29, 2016, Mental Health Facility deficiencies were noted.

In the waiver request, Harvard states “Involuntary Psychiatric Admissions for Carroll, Coos, Grafton, Cheshire, Sullivan and Belknap Counties. As we have discussed in prior years with our submission there is only one facility in the state that will provide services to members of a health plan. Harvard Pilgrim is requesting a waiver to the standards for involuntary psychiatric admission for Carroll, Coos, Grafton, Cheshire, Sullivan and Belknap Counties, as there are not enough qualified facilities in the area to meet the standard.”

“Short Term Substance Abuse Standard for Coos County. Harvard Pilgrim is requesting a waiver of the short term substance abuse facility standard for Coos County as there are not enough qualified facilities in the area to meet the standard.”

### **Examiners’ Recommendation**

As a result of the current opioid crisis facing New Hampshire and the increasing number of members whose coverage includes SUD treatment services under the ACA and the NH Health Protection Program, the examiners require that Harvard submit further information including documentation, in regards to how the carrier demonstrates it handles requests from members in service areas that do not have adequate contracted providers available. This information must be submitted to the Department for review and approval within 60 days of the final report. Emphasis shall be placed on Behavioral Health and SUD providers.

Examiners’ concerns regarding network deficiencies and current consumer complaints prompted an additional review of the website for ease of access and the network via the on-line provider directory. Although this testing fell outside of the examination period due to the need to complete “live” testing, it was appropriate due to regulatory authority under *CFR Title 45, Part 156 Subpart C §156.230 (b) (2)*.

### **Company Response**

Harvard Pilgrim responded to the verified report on November 28, 2016 with the following comment:

“Harvard Pilgrim objects to the Examiner’s request for a “corrective action plan” in its recommendation related to the deficient number of providers located in New Hampshire.”

### **Examiners’ Comment**

Harvard Pilgrims’ corrective action plan should demonstrate how the carrier handles requests for care from consumers in areas where no contracted facilities are available. This corrective action plan should include policies and procedures for the processing of these types of requests.

### **Website consumer ease of access**

#### Regulatory Authority

*CFR Title 45, Part 156 Subpart C §156.230 (b) (2)* For plan years beginning on or after January 1, 2016 a QHP issuer must publish an up-to-date, accurate and complete provider directory, including information on which providers are accepting new patients, the provider’s location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. A provider directory is easily accessible when –

- (i) The general public is able to view all of the current providers for a plan in the provider directory on the issuer’s public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and
- (ii) If a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.

Examiners expanded the review to include a test of Harvard’s current website, as well as UBH/Optum’s current website, for accessibility and ease of consumer use which resulted in the following observations:

#### Harvard

- There is a separate tab for behavioral health provider directory
- When calling the phone number listed on the website, the user is connected to United Behavioral Health/Optum
  - There is no notice or disclaimer on the website that indicates that UBH/Optum manages Harvard’s behavioral health benefits
- Harvard maintains a provider directory separate from UBH/Optum

## UBH/Optum

- Notice on website to contact UBH if member cannot wait 10 days for an appointment, but no means of contact is listed
- Multiple notices and disclaimers were specific to California residents
- UBH website is liveandworkwell.com – not clear that it is actually UBH.
- Because of the many websites there is a potential added level of confusion for members

### **Examiners' Recommendation**

Examiners will require that Harvard provide a corrective action plan to the Department within 30 days of finalization of the report to address the timelines associated with providing a current listing of all SUD and Behavioral Health providers, as well as update their website and UBH/Optum's website to prominently display an accurate, up-to-date listing of all SUD and Behavioral Health providers.

### **Company Response**

Harvard Pilgrim responded to the verified report on November 28, 2016 with the following information;

“Harvard Pilgrim is currently revising its Web pages that is expected to be completed by December 15, 2016 and will consider other ways to display its Web materials related to provider directories and policies to make it easier for viewers to access.”

### **Examiners' Comment**

No further action is required.

### **Provider directory accuracy**

Examiners reviewed the search results produced and conducted outreach to listed providers with the following outcomes:

- Search results identified individual providers with multiple service locations
- Inaccuracies of data
  - Provider is not at the practice or phone number listed in the directory

In addition to reviewing the on-line directory, examiners reviewed the Harvard on-line Provider Manual; Network Operations and Care Delivery Management – Forms, Provider Change Form and Form Information. This information directs providers to use

the Provider Change Form when submitting changes related to their practice and demographic information.

### **Examiners' Recommendation**

The examiners will require that Harvard provide the Department with their policies and procedures for quality oversight of the on-line provider directory and maintenance of provider demographic changes which must document:

- How Harvard ensures accurate listings are published on their website
- Documentation regarding the coordination of provider information between UBH/Optum and Harvard for the directory
- The method and frequency of review and verification and;
- The most recent verification results and any corrective actions put in place to correct deficiencies

Examiners will request that Harvard provide all supporting documentation of maintenance activity from July 1, 2016 through September 30, 2016, which shall include, but not be limited to:

- Volumes of provider maintenance forms received
- Volumes of provider maintenance forms processed
- Timeliness of provider maintenance forms processed
- Volumes of provider maintenance forms received, but not yet processed

After review of the quality oversight program and the data and documentation provided, examiners will conduct a more extensive test of the on-line provider directory.

### **Examiners' Recommendation**

Examiners recommend that Harvard review and consider the potential adoption of the 2016 National Committee on Quality Assurance (NCQA) provider directory audit process rules effective July 2016.

We further recommend that the carrier consider the DirectAssure™ program from the Council for Affordable Quality Healthcare (CAQH) or a similar program to assist with review and attestation of provider demographic information.

### **Company Response**

Harvard Pilgrim responded to the verified report on November 28, 2016 by stating;

“Harvard Pilgrim and UBH are both NCQA accredited and are working toward adoption of the 2016 NCQA audit processes. Harvard Pilgrim anticipates beginning in the first quarter of 2017 that it will implement a program for outreaching to providers on a

quarterly basis to request that each provider validate its information. Harvard Pilgrim is also in the process of assessing the DirectAssure and other similar programs to assist with the review and attestation of provider demographic information.”

### **Examiners’ Comment**

Based upon Harvard Pilgrim’s response of November 28, 2016, no further action is required.

All supporting documentation submitted will be retained under RSA 400-A:37.

## **PRE-AUTHORIZATION**

### **Standard 1**

The health carrier shall operate its utilization review program in accordance with final regulations established by the US Department of Health and Human Services (HHS), the US Department of Labor (DOL) and the US Department of the Treasury (Treasury).

*NAIC Market Regulation Handbook, Chapter 20A, page 689*

### **Standard 2**

NAIC Standard #2 - The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations.

*NAIC Market Regulation Handbook, Chapter 20, page 565*

### Regulatory Authority

*RSA 415-A:4-a Minimum Standards for Claim Review; Accident and Health Insurance.*  
– Any carrier that offers group health plans and employee benefit plans shall establish and maintain written procedures by which a claimant may obtain a determination of claims and by which a claimant may appeal a claim denial.

It was established as part of the scope of the exam that the Department would require medical expertise to determine the appropriateness of the pre-authorization denials as well as to ascertain whether the protocols used by Harvard meet acceptable standards of care. For the purpose of these reviews, the Department represented the consumers associated with the pre-authorization denials.

An Independent Review Organization (IRO) with medical reviewers specializing in Addiction and SUD was retained by the Department to conduct the reviews of all denied pre-authorizations. This review was undertaken to determine, on a case by case basis, if the carrier issued denials appropriately due to lack of medical necessity or because

the treatment (proposed or provided) would be inconsistent with generally accepted medical protocols.

The IRO provided the Department with a detailed report indicating the number of requests appropriately denied, those that were questionable, and those in which the reviewer disagreed with the carrier rationale for denial. The reviewer provided a description of the reason(s) that a claim denial determination was questionable or inappropriate.

The pre-authorizations under review were transmitted electronically through a secured platform from the Department to the IRO and final determinations were sent back to the Department via secured e-mail.

All data was transmitted by Joellen Atwater, Examiner-in-Charge (EIC) of this examination and returned back to the EIC for confidentiality purposes.

H.H.C. Group, a URAC accredited and NH certified independent review organization was the IRO retained as the medical reviewer for this examination. They are also contracted with the Department to handle consumer external reviews under RSA 420-J:5-a – 5-e.

All records reviewed, including medical information will remain confidential under RSA 400-A:37 Examination Law, and are subject to restrictions as stated in the Business Associates Agreement executed between the Department and H.H.C. Group.

Examiners requested 100% of all pre-authorization requests for SUD services that were denied during the period under examination, January 1, 2015 through September 30, 2015 for a total of 22 pre-authorization denials. It should be noted that 3 of the 22 pre-authorizations submitted for review had insufficient information available for the IRO to conduct an appropriate medical necessity review. In addition, there was a delay in submission of the pre-authorization information to the IRO due to Harvard redacting medical information contained in the files.

The IRO was asked to consider the following questions in their review:

1. Are the medical records and accompanying information sufficient to answer the following questions?
2. Please determine if the recommended or requested health care service is considered medically necessary.
3. Do you agree or disagree with carriers' final determination for denial?

## **Examiners' Recommendation**

Based on H.H.C. Group's determinations, the examiners will require that Harvard immediately perform additional outreach to the consumer to determine the status of any treatment plans for all requests in which the IRO disagreed with the carriers' final determination, or were unable to render an opinion due to lack of medical information provided.

A separate document will be provided to Harvard that will identify the specific pre-authorization case in question. A corrective action plan for each consumer impacted will be required to document resolution of treatment and shall be reported to the Department.

Case #1 – Incomplete – Question #1; “there are insufficient medical records received to make an independent determination of medical necessity.”

Case #2 – Incomplete – Question #1; “there are insufficient medical records received to make an independent determination of medical necessity.”

Case #3 – Incomplete – Question #1; “there are insufficient medical records received to make an independent determination of medical necessity.”

Case #4 – Partial Denial due to multiple requests – Disagree – “Detoxification treatment appropriately denied. Reviewer disagrees with carriers' determination for denial of residential inpatient treatment, partial hospitalization treatment, and intensive outpatient treatment.”

Case #5 – Disagree – “Disagree with carriers' final determination for denial. Given the indicators it does appear that the patient meets criteria for Substance Abuse Residential Detoxification treatment.”

Case #6 – Disagree - “Disagree. It appears that the patient requires the close outpatient monitoring and structure of an intensive outpatient treatment program.”

Examiners also requested a document that depicts the pre-authorization workflow process but did not receive one. Harvard did submit a document for the Grievances and Appeals workflow which was not in scope for the pre-authorization portion of this examination.

Examiners will include a review of the pre-authorization process as part of the delegated services and NCQA oversight examination to be scheduled.

## **Company Response**

On November 28, 2016, Harvard Pilgrim responded with the following information;

“While Harvard Pilgrim understands that the decisions of the IRO are final, we challenge the conclusions reached by the IRO using the ASAM criteria. Harvard Pilgrim will respond to the six cases under separate cover.”

“Because of the dates of service, the member’s continuing eligibility under the Harvard Pilgrim plans, and current treatment needs of the members, Harvard Pilgrim will work with the Department on follow up steps with members as applicable.”

## **Examiners’ Comment**

The Department has reconsidered and withdraws the requirement for any outreach to the consumer for all determinations by the IRO.

In the three cases where the IRO determined there was insufficient information provided to render an opinion, Harvard Pilgrim has indicated that these cases were handled through the peer-to-peer process. It appears that the supporting documentation for the peer-to-peer process was not provided to the IRO for review.

No further action is required; however, Examiners will include a review of the pre-authorization process as part of the delegated services and NCQA oversight examination to be scheduled.

## **Protocol Review**

The Department also asked the IRO to determine whether the protocols used by Harvard for SUD meet acceptable standards of care and are in alignment with The American Society of Addiction Medicine (ASAM) criteria.

H.H.C’s response to the Department’s request is as follows:

“Recent treatment has moved away from diagnosis-based treatment to one that is more holistic. The American Society of Addiction Medicine (ASAM) has some of the most widely respected and followed treatment guidelines. The latest edition of the ASAM Criteria support treatment that is interdisciplinary and individualized according multiple dimensions of factors such as withdrawal risk, biomedical conditions, psychiatric and cognitive conditions, readiness to change, relapse potential, and living environment. Although all three protocols do not draw from the ASAM Criteria verbatim, they either explicitly recommend or allow for a quality of treatment that is in accordance with ASAM. It is my medical opinion that the protocols are medically reasonable”. (sic)

## **Examiners' Comment**

Examiners have determined that no further action is required as protocols are medically reasonable per the IRO review. The Department is encouraged that Harvard will be able to comply with New Hampshire statutory requirements effective 1/1/17 with regards to the implementation of ASAM protocols.

## **GRIEVANCES AND APPEALS**

### **Standard 2**

The health carrier shall comply with grievance procedures requirements, in accordance with final regulations by the US Department of Health and Human Services (HHS), the US Department of Labor (DOL) and the US Department of the Treasury (Treasury).

*NAIC Market Regulation Handbook – Chapter 20A, page 626*

### **Standard 3**

The carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.

*NAIC Market Regulation Handbook – Chapter 20, page 515*

### Regulatory Authority

*RSA 420-J:5 Grievance Procedures.* – Every carrier or other licensed entity shall establish and shall maintain a written procedure by which a claimant or a representative of the claimant, shall have a reasonable opportunity to appeal a claim denial to the carrier or other licensed entity, and under which there shall be a full and fair review of the claim denial. The written procedure filed with the insurance department shall include all forms used to process an appeal.

The examiners requested an excel spreadsheet list and all supporting documentation of all upheld and overturned grievances/appeals for SUD services. The following data points were required:

- Method of receipt (mail, fax, etc.)
- Source of the request (member, provider)
- Date of receipt
- Date of 2<sup>nd</sup> level appeal request (if applicable)
- Date of final determination

A total of 22 grievances and appeals were received and reviewed for compliance with RSA 420-J:5 by the examiners during the examination period of January 1, 2015 through September 30, 2015. Six were eliminated from the review as they were outside of the scope of the examination period or were for services other than SUD. 100% of the appeal determination letters received and reviewed were fully compliant. All the determination letters included a full explanation of the denial along with instructions and the form required for external review.

Examiners observed the following:

- 14 appeals were upheld, but lesser levels of care were offered in each instance
- 2 were overturned
  - One case offered IOP
  - One case offered RTC
- 14.3% were partial or fully overturned
- None of the appeals within the examination period went to external review

### **Examiners' Comment**

The examiners found no exceptions.

## **CLAIMS**

### **Quantitative Analysis**

In order to quantify the SUD claim activity for the time period under examination, the examiners requested data relative to the total number of claims processed and the total billed amount of the claims processed for both SUD and Medical/surgical benefits.

The claims request was split into two separate requests; claims for ICD codes within the 304 (drug dependence, opioid dependence) coding criteria (SUD claims) and non-mental health ICD codes (Medical/surgical claims).

It should be noted that the total billed amount is subject to provider contractual arrangements and the total paid amount is subject to consumer out-of-pocket obligations in accordance with their contract.

### **Summary**

On February 12, 2016 in response to the Department's request, Harvard provided information regarding overall denial rates for SUD claims. The rate originally provided to the Department was 20.4% for full denials, and 1.97% for partial denials. Harvard had included all SUD claims and had not removed duplicate or otherwise non-covered claim

data. Harvard was given the opportunity to resubmit the data with the removal of duplicate claims. With the analysis on the correct data set, Harvard's full and partial SUD claim denials was 12.47% for full denials and 2.34% for partial denials with an overall SUD claim denial rate of 14.87%.

The original data set provided to the examiners did not include a sort of paid versus denied claims. The examiners requested clarification of the data on several occasions. On May 18, 2016, Harvard stated that the SUD claims information for January 1, 2015 through September 30, 2015 was as follows:

- 2,309 total claims
- 1,967 paid claims
- 54 claims paid with partial pay and denial
- 288 fully denied claims

Original claims data submitted by Harvard to the contracted examiners indicated the following:

Type of Claim	Volume	Total Billed	Total Paid
SUD	3,914	\$6,128,724.00	\$2,301,256.09
Medical/Surgical	759,439	\$305,555,160.58	Unable to determine
Total	763,353	\$311,683,884.58	Unable to determine

On October 10, 2016, examiners requested clarification of data that was received from Harvard on May 18, 2016 and May 25, 2016. On October 14, 2016, the carrier responded with the following information:

Type of Claim	Volume	Total Billed	Total Paid
SUD	2,309	\$1,770,345.48	\$1,104,128.91
Medical/Surgical	637,125	\$656,934,272.46	\$206,215,030.94
Total	639,434	\$658,704,617.94	\$207,319,159.85

Harvard also provided the following information, on October 14, 2016:

Type of Claim	Volume	Amount
Total billed amount for SUD claims	2309	\$1,770,345.48
Total paid amount for SUD paid claims	1967	\$1,104,128.91
Total billed amount for partial pay & denial SUD claims	54	\$30,673.83
Total billed amount of denied SUD claims	288	\$635,542.74

Based upon calculations of the data above, examiners were unable to confirm that the billed amount for SUD paid claims was accurate as the total calculation was the same amount as the total paid SUD claims amount.

Carrier was unable to facilitate the examination request.

### **Examiners' Recommendation**

Harvard will be required to address claims data through expanded interrogatories in the overall delegated service and NCQA oversight examination to be scheduled.

### **Company Response**

Harvard's response to the verified report, received on December 5, 2016 is as follows;

"Harvard Pilgrim discussed your questions with UBH/Optum and they subsequently re-reviewed their data. Upon review, they discovered that they had incorrectly calculated the data. As a result they reran the data and we are providing the new information below. In order to clarify the information, we have provided a summary below of separately calculated partially paid and partially denied claims. The summary also references certain tabs within the data and a copy of the data will also be sent to the Department overnight for your review."

#### **Total Universe Paid and Denied**

- Total Claims – 2380
- Total billed – \$1,770,345.48

#### **Fully Paid**

- Total Claims – 1908
- Total billed – \$942,209.41
- Total paid – \$557,105.76

#### **Full Denial**

- Total Claims – 410
- Total billed – \$636,844.49

#### **Partial Paid and Denied**

- Total Claims – 62
- Total billed – \$191,291.58
- **Partial Denied**
  - Total billed - \$29,372.08
- **Partial Paid**
  - Total billed – \$161,919.50

- Total paid – \$77,441.27

### **Examiners' Comment**

Based on the receipt date of the revised data, Examiners have determined they are unable to validate any completeness or accuracy. Therefore, the data provided by Harvard Pilgrim contained within this report has not been analyzed by the Department.

Harvard will be required to address claims data through expanded interrogatories in the overall delegated service and NCQA oversight examination to be scheduled.

### **MEDICATION ASSISTED TREATMENT**

The Department contracted with a registered pharmacist to create a set of interrogatories designed to provide a baseline of Harvard's Medication Assisted Treatment program in New Hampshire.

Medication assisted treatment is defined as any opioid addiction treatment that includes an FDA approved medication for the detoxification or maintenance treatment of opioid addiction. The interrogatories that were developed reflect the most up-to-date information on opioid addiction and treatment with an understanding that opioid addiction is a chronic disease.

The resources used by the pharmacist to complete the evaluation can be found in Appendix F.

### **Formulary Design**

The pharmacist requested documentation regarding the following medications used for Medication Assisted Treatment;

- Methadone
- Buprenorphine
- Buprenorphine/naloxone
- Naloxone
- Naltrexone

Harvard stated in their response to the interrogatory that they cover all of the above medications as part of their Medication Assisted Treatment program.

### **Examiners' Comment**

Examiners found no exceptions.

### **Age Limitations**

Harvard documented in their response to the interrogatory that they do not impose age limits on the coverage of medication assisted treatment programs.

### **Examiners' Comment**

Examiners found no exceptions.

### **Formulary Exception Process**

Harvard documented in their response to a follow-up question to the original interrogatory that members may use the exception process to ask for coverage of a drug that is excluded or limited. Members may also use the exception process to request an exception to a limitation on the coverage of a drug, including a quantity limitation. The member is provided with information on how to initiate an exception request at the time of the denial.

### **Examiners' Comment**

Examiners found no exceptions.

### **Dosage and Refill Limits**

The pharmacist reviewed the documentation submitted by Harvard regarding the dosage and refill limits and observed the following:

- Dosage limits for Evzio would not allow for coverage at the manufacturer recommended dosage
- Narcan dosage limits would not allow for use more than once per month, which would not provide coverage for an individual in the event of multiple overdoses

### **Examiners' Recommendation**

Examiners will require that Harvard provide information regarding the clinical basis for these limitations as they are contrary to the dosing guidelines. This documentation must be provided to the Department within 30 days of the final report.

### **Examiners' Comment**

Harvard Pilgrim responded to the verified report on November 28, 2016 and further clarification of the information provided is required by the contract pharmacist.

**Lifetime/Annual Limits**

Harvard documented in their response to the interrogatory that they do not impose lifetime or annual limits for methadone or buprenorphine.

**Examiners' Comment**

Examiners found no exceptions.

**Pre-authorization for Methadone and Buprenorphine**

Harvard documented in their response to the interrogatory that they do not impose pre-authorization, re-authorization or step therapy processes or any other utilization review requirements specific to methadone and/or buprenorphine.

**Examiners' Comment**

Examiners found no exceptions.

**Penalties or Exclusions for Failure to Complete a Course of Treatment**

Harvard documented in the response to the interrogatory that they do not impose penalties or exclusions of coverage for failure to complete a course of treatment specific to methadone and/or buprenorphine.

**Examiners' Comment**

Examiners found no exceptions.

**Medical Necessity Standards for Methadone and Buprenorphine**

Harvard documented in the response to the interrogatory that there are no medical necessity standards applied to methadone and/or buprenorphine other than the prescriber must be properly licensed to prescribe buprenorphine.

**Examiners' Comment**

Examiners found no exceptions.

**MENTAL HEALTH PARITY****Standard 3**

The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008.

*Market Regulation Handbook, Chapter 20 – page 508*

## Regulatory Authority

29 USC § 1185a parity in mental health and substance use disorder benefits

(a)(1) Aggregate lifetime limits

(a)(2) Annual limits

(a)(3) Financial requirements and treatment limitations

(A) In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that –

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(a)(4) Availability of plan information

(a)(5) Out-of-network providers

45 CFR § 146.136 (c)(3)(iii)(C) states: *Sub-classifications permitted for office visits, separate from other outpatient services.* For purposes of applying the financial requirement and treatment limitation rules of this paragraph (c), a plan or issuer may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this paragraph (c)(3)(iii)(C). After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph (c)(3)(i) of this section. Sub-classifications other than these special rules, such as separate sub-classifications for generalists and specialists, are not permitted. The two sub-classifications permitted under this paragraph (c)(3)(iii)(C) are:

**(1)** Office visits (such as physician visits), and

**(2)** All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

A Mental Health Parity review was completed on the carrier's internal processes and procedures to determine compliance with NH parity laws as well as the updated federal regulation implementing MHPAEA, 45 CFR §146.136. To complete this review, examiners looked at Harvard's response to the Behavioral Health Survey, the Department sent in December of 2015, follow-up interrogatory responses and the carrier's documented procedures. This review was performed to identify areas where procedures and protocols and access to Mental Health benefits were potentially less favorable than the same for Medical/surgical benefits. The following information identifies the areas of review, the determinations, and recommendations for various parity comparisons.

### **Market Review**

Examiners requested information on the markets in which the carrier writes business that is subject to MHPAEA. Examiners then reviewed information to identify the markets for both Medical/surgical and Behavioral Health coverage to ensure there were no disparities or gaps in coverage in a market.

Harvard provides Behavioral Health coverage in the Individual, Small Group, and Large Group markets. The same requirements are applied through all three markets.

Harvard's practices as they relate to each market are consistent and compliant with the identified regulations.

### **Examiners' Comment**

Examiners found no exceptions.

### **Quantitative Treatment Limits**

In accordance with the federal parity rule, (45 CFR §146.136 (a)(3)(i)(A)), examiners reviewed the carrier's policies and procedures in applying quantitative treatment limits. Under the rule, quantitative treatment limits are those for which the extent of benefits provided is based on accumulated amounts, such as annual or lifetime day or visit limits.

The purpose of the review was to determine whether limitations and standards were being applied consistently between Behavioral Health and Medical/surgical benefits and to ensure that the carrier has processes in place to determine all financial limitations met quantitative requirements outlined in 45 CFR §146.136 (a)(3)(i)(A) (e.g., two-thirds/substantially all).

Examiners reviewed the HPHC Analysis of Quantitative Benefit Limitations which provides a comparative analysis of the quantitative limitations imposed for both Medical/surgical and Behavioral Health benefits, as well as fee schedules presented in the HMO policy language, and determined that documents provided show that the carrier meets the 2/3 predominately all financial requirement outlined in 45 CFR §146.136 (c)(3)(i)(A) in the application of quantitative limitations between Mental Health benefits and Medical/surgical benefits. Examiners confirmed that Harvard and UBH/Optum review quantitative limits on an annual basis for both Medical/surgical and Behavioral Health.

### **Examiners' Comment**

Examiners found no exceptions.

### **Non-Quantitative Treatment Limits**

In accordance with the federal mental health parity rule, (45 CFR §146.136 (a)(3)(i)(A)), examiners reviewed the carrier's policies and procedures in applying non-quantitative treatment limits. Under the rule, non-quantitative treatment limits include but are not limited to:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Network tier design for plans with multiple network tiers (such as preferred providers and participating providers);
- Standards for provider admission to participate in a network, including reimbursement rates;
- Methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage)

Examiners reviewed the carrier's policies and procedures regarding non-quantitative limits, including network admissions, reimbursement rates, and tiered benefits.

Documents reviewed included:

- Non-Quantitative Treatment Limitations Compliance Summary Mental Health Parity and Addiction Equity Document;
- HPHC Authorization Request Criteria;
- Harvard Pilgrim's Fraud Waste and Abuse Policy;
- Provider Network Admission Criteria for both Harvard Pilgrim and Optum;
- Provider Reimbursement Fee's; and
- Fail First Requirements for Medical/surgical and Behavioral Health

Medical Management standards were reviewed to determine that access to coverage, medical necessity requirements, utilization reviews, and precertification requirements for Mental Health and Medical/surgical benefits were consistently applied and did not incorporate more stringent factors for Mental Health benefits that would limit or discourage access for treatment.

Examiners also ensured that the requirements outlined in NH RSA 420-J were applied to the Medical Management standards and that Utilization Review requirements established conform to the standards of either the Utilization Review Accreditation Commission or the National Committee for Quality Assurances and are subject to all applicable rules issued pursuant to RSA 420-E:7.

### **Medical Management Policies and Procedures**

Harvard handles Medical Necessity procedures internally for Medical/surgical benefits and outsources all Behavioral Health initial review processes to UBH/Optum. For Behavioral Health, Oversight Committees have been formed to monitor the operations involved in Behavioral Health benefit considerations. These committees consist of representatives from both Harvard and UBH/Optum.

Examiners conducted a comprehensive review of medical necessity guidelines applicable to Behavioral Health and Medical/surgical processes and procedures. The reason for this review was to determine if the carrier was imposing greater requirements for medical necessity determinations on Behavioral Health benefits than were imposed on Medical/surgical benefits. Examiners reviewed Harvard's Medical Policies and Clinical Utilization Management Guidelines and UBH/Optum's Guidelines to determine:

- The criteria used for creating policies and procedures;
- Whether the appropriate expertise from credentialed professionals was taken into consideration in updating and amending policies and procedures;

- Timeliness and accuracy of policy updates based on current medical standards;
- Whether timeframes for reviewing and updating policies and procedures was consistently applied for both Behavioral Health benefits and Medical/surgical benefits.

### Clinical Utilization Management Guidelines

Ten (10) documents were provided outlining Harvard's clinical utilization management guidelines for Medical/surgical reviews. These documents included:

- HPHC Utilization Management Care Management Program Description;
- HPHC Network Operations & Care Delivery Management, Care Delivery Programs: Utilization Management;
- HPHC Referral, Notification and Authorization: Authorization Policy;
- HPHC UMCM Policy Denials Effective Date: April 22, 2015, Subject: Denials;
- HPHC UMCM Policy Documentation Standards Effective Date: March 16, 2016, Subject: Documentation Standards;
- HPHC Utilization and Care Management Policy Medical Review Criteria, Effective Date: March 9, 2016, Subject: Medical Review Criteria;
- HPHC UMCM Policy, Policy Development and Review, Effective Date: March 9, 2016, Subject: Policy Development and Review;
- HPHC UMCM Policy Standard, Timeframes for UM Decisions, Effective Date: April 22, 2015, Updated August 3, 2015, Subject: Standard Timeframes for UM Decisions;
- HPHC UMCM Policy use of Consultants in UM Decision Making Effective Date: May 28, 2015 Subject: Use of Consultants in UM Decision Making; and
- HPHC UM and Care Management Policy Utilization Review Effective Date: March 9, 2016 Subject: Utilization Review.

Examiners reviewed ten (10) documents utilized by UBH/Optum for Behavioral Health Benefits. These documents included:

- Optum U.S. Behavioral Health Plan, California, dba OptumHealth Behavioral Solutions of California ("OHBS-CA");
- Mental Health Parity and Addiction Equity Act Guidelines;
- Non-Qualitative Treatment Limitations Disclosure document-Harvard Pilgrim Health Care;
- Optum Care Advocacy Policy Management of Behavioral Health Benefits Section. Care Advocacy Process, Effective date: September 1987, Revision Date, April 2016, Last Review Date April 2016;
- 2016 Best Practice Guidelines for Behavioral Health;
- American Psychiatric Association including APA New Development;
- Process for Practice Guidelines of the American Psychiatric Association;

- American Academy of Child & Adolescent Psychiatry Practice Parameters;
- Mental Health Parity and Addiction Equity Act-Non-Quantitative Treatment Limitations-Answers to Key Questions dated July, 2015; and
- Optum's Generally accepted standards of Medical Practice

For the Optum U.S. Behavioral Health Plan, California dba OptumHealth Behavioral Solutions of California ("OHBS-CA") document, examiners confirmed with Harvard that this document is utilized by UBH/Optum across the country and would therefore be applicable to New Hampshire.

Medical Management Guidelines established for Medical/surgical reviews by Harvard and for Behavioral Health by UBH/Optum were determined to be compliant with regulatory requirements and consistently applied.

### **Examiners' Comment**

Examiners will re-address the Optum U.S. Behavioral Health Plan, California dba OptumHealth Behavioral Solutions of California ("OHBS-CA") document to confirm compliance with New Hampshire law.

### **Consumer Medical Management Policy/Guidelines Access**

The examiners determined that the carrier has developed multiple internal policies regarding Medical Management criteria for Medical/surgical services. These policies are available through the carrier's website at [www.HPHC.org](http://www.HPHC.org). Medical Management criteria for Behavioral Health policies are also provided on the carrier's website through a link to the UBH/Optum website. This information is in the Provider Tab on the home page, however is not presented through the Member Tab.

### **Examiners' Recommendation**

Examiners will require Harvard to ensure that Medical Necessity information, including Utilization Review policies and Clinical Guidelines are easily accessible to consumers on the carrier's and delegates website.

### **Examiners' Comment**

Examiners reviewed the response provided by Harvard Pilgrim on November 28, 2016 and no further action is required.

## **Consumer Contract Language**

Examiners also reviewed policy language for Individual, Small Group, and Large Group plans regarding prior authorization requirements.

## **Examiners' Comment**

Examiners found no exceptions.

## **Policy Development and Updates**

Examiners also reviewed methodologies that the carrier utilizes to create, amend, or update policies and procedures to ensure that the carrier is developing procedures consistently with NH RSA 420-J:6 VI. The clinical review criteria used by the health carrier or its designee utilization review entity shall be:

- a) Developed with input from appropriate actively practicing practitioners in the health carrier's service area;
- b) Updated at least biennially and as new treatments, applications and technologies emerge;
- c) Developed in accordance with the standards of national accreditation entities;
- d) Based on current, nationally accepted standards of medical practice; and
- e) If practicable, evidence-based;

and ensure that the policies and procedures for Behavioral Health are updated as frequently, if not more frequently than, the policies and procedures established for Medical/surgical benefits.

It was determined that the carrier retains control of policy development internally for Medical/surgical guidelines, and delegates policy development relating to Behavioral Health to UBH/Optum. Harvard's guidelines are updated at least annually, and in some cases every six months. The carrier retains the appropriate expertise to update policies. Committees consisting of representatives from both Harvard and UBH/Optum provide oversight and ensure the appropriate measures of consideration are being implemented in regards to Behavioral Health.

Harvard submitted a document that outlines the various committees responsible for oversight of UBH/Optum which included a brief description of each committee and its membership.

Examiners requested but did not receive documentation specific to the compliance audits committee minutes, workplans and activities relative to the oversight of policies, procedures and performance of medical necessity reviews and guidelines. Harvard stated "The group may meet more frequently as issues arise and as needed to prepare for mandatory parity compliance certifications and/or filings. To the extent data is

needed for a filing or an employer request, the group members may solicit such information from the parties involved (i.e., actuarial, product administration). As this is an informal group setting, minutes are not taken.”

### **Examiners’ Recommendation**

Examiners will incorporate a medical management policy and procedure review into the delegation and NCQA examination to be scheduled.

### **Pre-certification/Prior-authorization**

A prior-authorization requirement means that the carrier will not pay for a service unless the provider (a physician or hospital, usually) gets permission to provide the service. Sometimes this permission is to ensure that a patient has benefit dollars remaining (for example, a carrier may limit a patient to 12 chiropractor visits in a calendar year), other times it is to ensure that a specific kind of service is eligible for payment under the patient's contract. Authorization can be also granted retroactively, for example, a patient or hospital may have a 24-hour window to notify a carrier after receiving emergency care.

A pre-certification requirement means that a carrier must review the medical necessity of a proposed service and provide a certification number before a claim will be paid. This is often true with services such as elective surgeries. Usually, a representative with the carrier must review a physician's order and the medical record to agree that a proposed procedure is medically appropriate.

In order to determine parity between pre-certification and prior-authorization requirements for both Behavioral Health and Medical/surgical benefits, examiners reviewed the carrier’s internal processes for both areas as well as samples of policy language from a large group, small group and individual plan.

Examiners determined that Harvard handles pre-certification and prior-authorization procedures internally for Medical/surgical benefits and outsources all Behavioral Health prior-authorization procedures to UBH/Optum.

In reviewing preauthorization and pre-certification policy language for: The Elevatehealth HMO for Individual Members-New Hampshire Policy (effective date 01/01/2016), The Harvard Pilgrim HMO New Hampshire Employer Group Plan (Small)(effective date 01/01/2016), and The Harvard Pilgrim HMO-New Hampshire (Large Group) (effective date 01/01/2016), the examiners determined that to be covered by the plan, all Mental Health and drug and alcohol rehabilitation services must be prearranged through the Behavioral Health Access Center and provided by contracted providers.

The same requirement is not imposed on all Medical/surgical benefits.

### **Examiners' Recommendation**

Examiners will require that Harvard provide the Department with evidence that the preauthorization requirement for all Mental Health and drug and alcohol rehabilitation services is not a parity violation within 30 days of the final report.

### **Examiners' Comment**

Examiners reviewed the response provided by Harvard Pilgrim on November 28, 2016 and no further action is required.

### **Provider reimbursement rates and fee schedules**

In response to the Behavioral Health Survey, Harvard states that “the factors that contribute to establishing the reimbursement rate include: AMA Relative Value Units, the education level of the providers such as Physicians and Nurse Practitioners, geographic scarcity, market domination, and participation with provider groups, Patient Centered Medical Homes or Accountable Care Organizations.”

Documentation reviewed by the examiners shows that the carrier reviews its fee schedules utilizing the Centers for Medicare & Medicaid Services (CMS) Resource Based Relative Value Scale (RBRVS) methodology as well as recent trends in services and utilization and employer groups' Ambulatory Payment Classification (APC) methods.

*Medical/surgical benefits:*

#### In Network

Examiners determined that for inpatient facility reimbursement the carrier primarily utilizes industry standard diagnosis-related group (DRG) versions with negotiated base rates. Other inpatient reimbursement methods may be negotiated, including per diem and percentages of billed charges. All methods consider various market factors, including relativity to Medicare. The plan also utilizes varied reimbursement methods for different types of providers, such as MD's, PHD's, Physicians Assistants, and Nurse Practitioners.

Outpatient services, whether practitioner or facility, are reimbursed primarily according to fee schedules. Practitioner fee schedules are based on the resource-based relative value scale (RBRVS) system and facility outpatient fees are based upon CMS' Ambulatory Payment Classification (APC) methods. Other reimbursement methods may

be negotiated, such as percentages of billed charges or case rates. The methodology presented considers various market factors, including relativity to Medicare.

The carrier utilizes varied reimbursement methods for different types of outpatient and physician MD services. In addition, physician groups may be reimbursed according to capitation or risk type arrangements. Provider and facility contracts include pay-for-performance programs that include quality and efficiency measures.

### Out of Network

Examiners determined that the minimum, maximum and medium reimbursement rates for in-area facilities are based on the normal range of charges in Boston, Massachusetts for the same or similar services. Normal ranges of charges are determined using average billed charges by DRG (inpatient) or CPT (outpatient). Reimbursement for in-area professional services is based on the normal range of charges in the geographic area for the same or similar services. Normal ranges of charges are determined using the FairHealth dataset at the 85th percentile.

For out-of-area services, the plan uses 150% of published rates by the CMS for the same or similar services within the geographic marked area. When a rate is not published by CMS for the service and no industry standard methodology applies to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or an industry standard methodology, the Allowed Amount will be 50% of the provider's billed charge.

### *Behavioral health benefits:*

#### In Network:

Examiners reviewed documents presented for reimbursement rates as they relate to Behavioral Health benefits. Behavioral network reimbursement methodology is a fee for service model. Inpatient per diems are negotiated on a facility by facility basis. Schedules are reviewed annually with several factors being taken into consideration in the rate-setting process, including CMS guidelines, as well as regional market dynamics and current business needs.

Network clinician contracts include a state or region specific fee schedule of procedure codes and fee maximums to be applied to provider claims based on clinician licensure level. Network fee schedules are reviewed annually with several factors being taken into consideration in the rate-setting process, including local Usual, Customary, and Reasonable (UCR) and RBRVS methodologies as well as regional market dynamics and current business needs.

### Out of Network:

There are 2 ways non-network clinicians for inpatient and outpatient facility based care is reimbursed. The determination of which methodology is used depends on the product.

- Methodology 1: A distribution of billed charges is derived by geography and by service type. This distribution is ranked and used to determine the allowable amount
- Methodology 2: Using a percent of CMS published Medicare pricing rates to determine the maximum allowable for non-network services.

For outpatient professional services: There are 2 ways non-network providers are reimbursed:

- Methodology 1: Reimbursement based on Usual and Customary Rates (UCR). Calculations are determined by the percentile adopted by the customer (e.g. 85<sup>th</sup> Percentile). UCR is calculated based on the type of service and the provider's geographic area/zip code. The FH Benchmarks database from FAIR Health Inc. is used to determine reimbursement for out-of-network claims.
- Methodology 2: Using a percent of CMS published Medicare pricing rates to determine the maximum allowable for non-network services.

### **Examiners' Comments**

The carrier presented documents showing the reimbursement rates for MDs, PhDs, MSW and RNx for the top psychiatric procedure codes including: 90791 (Psychiatric Diagnostic Evaluation without Medical Services), 90792 (Psychiatric Diagnostic Evaluation with Medical Services), 90832 (Psychotherapy, 30 min), 90834 (Psychotherapy, 45 min), 90837 (Psychotherapy, 60 min), 90839 (Psychotherapy for Crisis, first 60 min), 90846 (Family Psychotherapy, without pt present), 90847 (Family/Couple Psychotherapy), 90849 (Multiple Family Group Psychotherapy), and 90853 (Group Psychotherapy). The rates outlined for these fees indicate that on average a PhD is reimbursed at approximately 85% of the reimbursement rate for MDs. The document provided however, is for 2013 rates.

Examiners requested clarification from Harvard regarding the 2013 documents that were provided as they are out-of-scope for the examination period. Harvard responded by indicating "that the fee schedules provided to you are current. I can understand that the naming of the document could be confusing but are current for 2016." The documents in question are entitled UBH FS 107 NH MD 2013 and UBH FS 207 PhD 2013 respectively.

Current fee schedules would be out-of-scope for the examination period of 1/1/15 through 9/30/15. Examiners are unable to determine whether the documents provided show the fee schedule in effect during the examination period.

### **Examiners' Recommendation**

Due to the confusion in the documentation provided by the carrier and concerns regarding whether the documentation is reflective of the examination period, Examiners will recommend that reimbursement methodology and rates be re-addressed in the delegated services and NCQA oversight examination to be scheduled.

Examiners will recommend that Harvard provide evidence demonstrating why this is not a parity violation.

### **Processes and Procedures for determining Usual and Customary**

Examiners reviewed the policies and procedures regarding usual and customary reimbursement rates by reviewing the HPHC Benefits Handbook which defines allowed amounts, including usual and customary, and the Non-Quantitative Treatment Limits Disclosure Documents. Through reviewing these documents examiners determined Harvard uses the same process for determining usual and customary charges for both Medical/surgical services and Behavioral Health services.

Facility usual and customary fee schedules for Medical/surgical benefits and Behavioral Health benefits are updated every two years. Non-facility (professional services) usual and customary fee schedules for Medical/surgical and Behavioral Health services are based on the Fair Health Charge Database in which the rates are updated twice a year, in January and July.

### **Examiners' Comment**

Examiners found no exceptions.

## APPENDIX A: INTERROGATORIES

The New Hampshire Insurance Department requested each carrier provide a detailed response to the following questions as they relate to full-insured group and individual health benefit plans. When referencing small and large groups, the employer/group contract must be situated in the state of New Hampshire with one or more New Hampshire employees.

1. List all markets in which you currently write business subject to MHPAEA (individual/small group/large group).
  - a. Do you have the same or different requirements for MHPAEA compliance within each market?
  - b. If the requirements are different between markets, describe the difference.
  
2. The MHPAEA final rule 1 differentiates between six different classifications of benefits:
  - (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. MHPAEA requires that services within a particular classification be treated the same for mental illness and substance use disorders as they would be for medical and surgical conditions.
    - a. How do you determine into which classification a particular benefit belongs?
    - b. Please provide a detailed description of the process you utilize in categorizing benefits into the six different classifications.
  
3. To comply with MHPAEA's general parity requirement, a plan may not apply any "financial requirement" or treatment limitation" to mental health or substance use disorder benefits in any classification that is more restrictive than the "predominant" financial requirement of treatment limitation of that type applied to "substantially all" medical/surgical benefits in the same classification.
  - a. Please describe the process that you use to determine whether the "substantially all" test is met.
  - b. Please describe the process that you use when developing a plan design to determine the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits in each classification. Include an explanation of how you ensure that financial limitations and treatment limitations are not more restrictive for mental health/substance use disorder benefits than limitations for medical/surgical benefits in the same classification.

- c. Provide a detailed example of your process using your plan with the most enrollees in New Hampshire (please specify market).
4. Under MHPAEA, a plan may not impose a non-quantitative treatment limitation (NQTL) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification. Under MHPAEA, NQTL's include:
  - a. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
  - b. Formulary design for prescription drugs;
  - c. For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
  - d. Standards for provider admission to participate in network, including reimbursement rates;
  - e. Plan methods for determining usual, customary, and reasonable charges;
  - f. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
  - g. Exclusions based on failure to complete a course of treatment; and
  - h. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.
- a. Provide a description of how you develop NQTLs applicable to mental health and substance use disorders. Include in this description a demonstration of how the processes, strategies, evidentiary standards and other factors used in applying an NQTL to mental health/substance use disorder benefits are comparable to and applied no more stringently than medical/surgical benefits in each classification.
  - b. How do you provide the policyholder with information pertaining to NQTLs?
5. Medical Necessity Criteria

- a. Do you use a Private Review Agent (PRA) to determine the medical necessity or appropriateness of mental health/substance use disorder benefits? If so, what carrier do you use?
- b. Is that carrier different than the PRA you use for medical/surgical benefits? If so, what steps does your carrier take to ensure that the medical necessity or appropriateness criteria used by your PRA for mental health/substance use disorder benefits is consistent with the necessity or appropriateness criteria used by your PRA for medical/surgical benefits?

## 6. Formulary Design for Prescription Drugs

- a. Describe your process for placing mental health/substance use disorder and medical/surgical medications into tiers.
- b. Explain how you determine when to apply each NQTL to mental health/substance use disorder and medical/surgical medications.
- c. Explain your process for grievance and appeals related to mental health/substance use disorder claims.

## 7. Provider Networks

- a. Provide a description of your network admission, credentialing, and network closure standards for mental health/substance use disorder providers and medical/surgical providers.
- b. Provide a description of your process for determining the fee schedule and reimbursement rates for mental health/substance use disorder providers and medical/surgical providers.
- c. Provide information regarding accessibility issues with in-network providers to include options for members when an in-network provider for mental health/substance use disorders is not available.

## APPENDIX B: INTERROGATORIES - PARITY

1. Harvard Pilgrim states “The policies and procedures, plan terms, definitions, evidentiary standards, and processes applicable to each NQTL utilized by Optum and Harvard Pilgrim were reviewed to determine if the two were comparable. If any such policies and procedures, plan terms, definitions, evidentiary standards and processes were determined not to be comparable or to be applied more stringently to mental health/substance use disorder benefits than to medical surgical benefits in any classification, Harvard Pilgrim recommends changes and required that such changes were made to ensure compliance with MHPAEA related guidance.”
  - Through this review process, in what instances were the policies and procedures, plan terms, definitions, evidentiary standards and processes determined to not be comparable?
  - What recommendations were established?
  - How was it ensured that all recommendations were incorporated accordingly?
  - What was the timeframe for all of the recommendations being made, and subsequent implementation?
  - What measures did Harvard Pilgrim take to ensure that additional benefits were not due based on the non-comparable determinations?  
If additional benefits were determined appropriate, how did Harvard Pilgrim ensure that policyholders were made whole?
2. Harvard Pilgrim further states “A task force from Harvard Pilgrim meets regularly to monitor developments under MHPAEA to ensure continued MHPAEA compliance.”
  - How frequently does the task force from Harvard Pilgrim meet?
  - How are the findings from the task force disseminated?
  - If the task force determines that MHPAEA compliance is not met, what steps and actions are taken?
  - Please provide the minutes of the last six meetings from the Task Force
3. Please provide examples of information and disclosures presented to the policyholder regarding Non Quantitative Treatment Limitations (NQTL’s), including a username and password to access the on-line consumer portal, and a copy of the non-quantitative limitations disclosure document.
4. How does Harvard Pilgrim provide access to corresponding Formulary Drugs if the lower tier drugs are not available or determined to not be appropriate? Are the same requirements imposed for Mental Health/Substance Use Disorder

drugs as for Medical/Surgical drugs? If the requirements are different, please provide both sets of standards?

5. Harvard Pilgrim states “Harvard Pilgrim has a written policy regarding the development of reimbursement rates that defines the parameters used by Optum and Harvard Pilgrim to determine whether the network should be expanded and to develop reimbursements for services. In terms of reimbursement, the factors that contribute to establishing the reimbursement rate include: AMA Relative Value Units, the education level of providers, such as Physicians and Nurse Practitioners, geographic scarcity, market domination, and participation in provider groups, Patient Centered Medical Homes, or Accountable Care Organizations.”
  - How frequently are the fee schedules reviewed, and how often are they updated? Are the rates consistent between Mental Health/Substance Use Disorder and Medical/Surgical benefits? Please provide the last date of reimbursement rate updates.
6. Harvard Pilgrim states “When an in-network provider of either medical/surgical services or mental health services is not available due to geographic or expertise limitations, an out-of-network provider will be approved.”
  - Is the reimbursement paid at an in-network, or out-of-network rate? Is this the same consideration for Mental Health and Medical/Surgical benefits? Explain any differences.
7. Harvard Pilgrim presented the “Harvard Pilgrim Health Care Federal Mental Health Parity Testing Model” in their survey response. Please provide the methodology and modeling utilized for this testing to show that Harvard Pilgrim passed the 2/3 threshold of the substantially all requirement established by the regulation.
8. Please provide a list of all services requiring “Fail First” treatment requirements and include detailed explanation of the processes for Mental Health/Substance Use Disorder Treatments, Medical/Surgical and Pharmacy benefit considerations.
9. Do you currently use ASAM screening and assessment tools for prevention of, or early intervention in addiction? If so, please provide your policies and procedures for incorporating the tools, and provide four-six exhibits of the utilization of the tools.

For Medical Management Standards, please provide the following information:

1. Medical Necessity Requirements:
  - Including all documented processes and procedures, manuals and criteria utilized in determining Medical Necessity

- Additionally, please include all notifications that are provided to members outlining the Medical Necessity Requirements when requested;
2. Precertification/Preauthorization requirements:
    - Including processes and procedures, and criteria for both Medical/Surgical and Mental Health.
    - Additionally, please include policy language regarding Precertification/Preauthorization for Medical/Surgical and Mental Health for the most popular Large Group, Small Group and Individual Plans;
  3. Provider reimbursement rates, and fee schedules for both Medical/Surgical and Mental Health reimbursements;
  4. Usual and Customary (U&C) fee schedule;
    - Processes and procedures for determining U&C and the frequency of U&C updates for both Medical/Surgical and Mental Health services; and,
  5. Utilization Management Practices:
    - Including the Utilization Program's Proof of Registration with the Department of Insurance as required by RSA 420-E:7 and Chapter 2001.04 of the New Hampshire Code;
    - Advisement of Appeal Rights due to an adverse Utilization Review determination.

## APPENDIX C: DATA REQUESTS

The following data was requested from each Carrier:

### Delegated Service Contracts

- Please provide a copy of all Third Party Administrator contracts and Service agreements in effect as of January 1, 2015 for all Utilization Review, pre/post authorizations, claims processing or any support functions presently delegated to other entities relative to Substance Use Disorder (SUD).
- Please provide a brief summary of each contract defining the delegated service.
- If services are provided by the carrier, please provide a diagram/flow chart of the internal process associated with the handling of SUD.
- If the process differs for SUD from the standard process, please provide a full explanation of any deviations from the standard process.

### Network Access

- Please provide a list of all contracted providers, and the type of service they provide that are presently utilized within your network to perform SUD services to include (hospitals, rehabilitations centers, specialists, etc.) Also, document availability of each provider by indicating which providers are presently accepting patients and patient capacity within inpatient and outpatient settings.
- Please provide (2) two separate GEO Access reports. One report should demonstrate network providers for SUD treatment throughout New Hampshire and the other report should show all of your existing membership.

### Pre-authorizations

- Please provide a list of all services requiring a pre-authorization for SUD and Medical Surgical requests.
- Please provide an Excel spreadsheet listing all Inpatient and Outpatient pre-authorizations to include any/all SUD requests for services received for in and out of network from January 1, 2015 through September 30, 2015 that were full or partial denials for SUD.
- Please include the following data within the Excel spreadsheet provided:
  - Patient ID#
  - Procedure/Service Type
  - Provider Name
  - Date Received (20YY/MM/DD)
  - Type of Request – urgent, expedited, standard, etc.
  - Type of Review – pre-authorizations, reconsideration, etc.
  - Date(s) of Service (20YY/MM/DD)

- Type of Service
- Place of Service
- Method of Receipt – physician/specialty provider, patient or other
- Date of Request (20YY/MM/DD)
- Date of Clinical Request for additional information (20YY/MM/DD)
- Date of Clinical Information Received (20YY/MM/DD)
- Date of Medical Director Review (20YY/MM/DD)
- Date of Final Determination (20YY/MM/DD)
- Type of Adverse Determination – Full or Partial Denial
- Method of Notification
- Explanation of the final adverse determination

### Appeals/Grievances

- Please provide an Excel spreadsheet reporting all upheld/reversed and overturned appeals/grievances for SUD. (Include how it was requested – mail, fax, telephonic or other). Identify who made the request – provider, consumer, lawyer, etc.
- Date Request Received (20YY/MM/DD)
- Dates for second level appeal or grievance if applicable (20YY/MM/DD)
- Date Final Determination was initiated (20YY/MM/DD)
- Date Final Determination was completed (20YY/MM/DD)
- Also attach the following:
  - An electronic copy of the initial request to include any subsequent request.
  - An electronic copy of the final determination letter to include any relevant supporting documentation
- Please provide within the Appeals/Grievance spreadsheet an indicator of those appeals that an external review was requested. Include the final status of the external review and the final notification letter(s).
- If a separate report on external reviews is available, please provide a copy.

### Claims

- Please provide an Excel spreadsheet of all denied claims for ICD codes within the 304 coding criteria (ICD Code 204 is classified as Dependency)
- Please provide an excel spreadsheet of all paid claims for ICD codes within the 304 coding criteria.
- The following data should be included within each spreadsheet:
  - Member ID#
  - Date of Birth (20YY/MM/DD)
  - Date of Service (20YY/MM/DD)

- ICD Code
- CPT Code
- Date Received (20YY/MM/DD)
- Date Processed (20YY/MM/DD)
- Date Denied/Partial Denial/Paid (20YY/MM/DD)
- Amount Billed
- Amount Paid
- Coinsurance amounts applied
- Denial Code (disposition code)
- Explanation of Denial Code(s)

Behavioral Health Parity Survey

A Behavioral Health Parity Survey was also requested.

## APPENDIX D: INTERROGATORIES – MAT

1. Does the Company cover the following medications used for MAT:
  - a. Methadone
  - b. Buprenorphine
  - c. Buprenorphine/Naloxone
  - d. Naloxone
  - e. Naltrexone
  
2. For what FDA approved indications does the Company cover for the following FDA approved medications:
  - a. Methadone
  - b. Buprenorphine
  - c. Buprenorphine/Naloxone
  - d. Naloxone
  - e. Naltrexone
  
3. What are the dose and/or refill limits applied to the covered medications?
4. Does the Company impose any lifetime or annual limits on MAT for methadone and/or buprenorphine?
5. Are there preauthorization, reauthorization or step therapy processes or other utilization management requirements (limitations on drug screenings, requirements that a physical examination be performed, etc.) applicable for MAT for methadone and/or buprenorphine?
6. Does the Company impose any penalty or exclusion of coverage for the failure to complete a course of treatment applicable to MAT for methadone and/or buprenorphine?
7. What medical necessity or medical appropriateness standard is applied to the coverage of MAT for methadone and/or buprenorphine?

## APPENDIX E: DATA REQUEST – MAT

Please provide electronic files for all non-Mental Health and Substance Use Disorder denied claims received by the Company during the examination period (01/01/15 through 09/30/15). The following data should be included within the files:

- Claim Number
- Member ID Number
- Date of Birth (20YY/MM/DD)
- Date of Service (20YY/MM/DD)
- Type of Service
- ICD Code
- CPT Code (all code categories)
- HCPCS Level II Code
- Date Received
- Date Processed
- Date Denied/Partial Denial
- Amount billed
- Amount paid
- Coinsurance amounts applied
- Denial Code (disposition code)
- Explanation of Denial Code(s)
- Data dictionary describing each field abbreviation and the format of the field (column).

Separately list each line item. In addition, provide separate listings for Professional, Hospital and RX claims. When providing the data, please ensure the data is provided in delimited or fixed length ASCII text.

## **APPENDIX F: – Reference material for Medication Assisted Treatment Review**

CDC.gov

A Treatment Improvement Protocol (TIP 43): Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs -U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (HHS, SAMHSA).

DATA 2000- Title XXXV, Section 3502 of the Children's Health Act.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

## APPENDIX G: MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

### 45 CFR § 146.136 Parity in mental health and **substance use disorder benefits**.

**(a) Meaning of terms.** For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

*Aggregate lifetime dollar limit* means a dollar limitation on the total amount of specified benefits that may be paid under a group health **plan** (or **health insurance coverage** offered in connection with such a plan) for any **coverage unit**.

*Annual dollar limit* means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health **plan** (or **health insurance coverage** offered in connection with such a plan) for any **coverage unit**.

*Coverage unit* means **coverage unit** as described in **paragraph (c)(1)(iv)** of this section.

*Cumulative financial requirements* are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or **annual dollar limits** because these two terms are excluded from the meaning of financial requirements.)

*Cumulative quantitative treatment limitations* are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

*Financial requirements* include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

*Medical/surgical benefits* means benefits with respect to items or services for **medical conditions** or surgical procedures, as defined under the terms of the **plan** or **health insurance coverage** and in accordance with applicable Federal and **State** law, but does not include mental health or **substance use disorder benefits**. Any **condition** defined by the **plan** or coverage as being or as not being a medical/surgical **condition** must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or **State** guidelines).

*Mental health benefits* means benefits with respect to items or services for mental health conditions, as defined under the terms of the **plan** or **health insurance coverage** and in accordance with applicable Federal and **State** law. Any **condition** defined by the **plan** or coverage as being or as not being a mental health **condition** must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or **State** guidelines).

*Substance use disorder benefits* means benefits with respect to items or services for substance use disorders, as defined under the terms of the **plan** or **health insurance coverage** and in accordance with applicable Federal and **State** law. Any disorder

defined by the [plan](#) as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or [State](#) guidelines).

*Treatment limitations* include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a [plan](#) or coverage. (See [paragraph \(c\)\(4\)\(ii\)](#) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular [condition](#) or disorder, however, is not a treatment limitation for purposes of this definition.

**(b) Parity requirements with respect to aggregate lifetime and annual dollar limits.** This paragraph (b) details the application of the parity requirements with respect to aggregate lifetime and annual dollar limits. This paragraph (b) does not address the provisions of [PHS Act](#) section 2711, which prohibit imposing lifetime and annual limits on the dollar value of essential health benefits. For more information, see § [147.126](#) of this subchapter.

**(1) General -**

**(i) General parity requirement.** A group health [plan](#) (or [health insurance coverage](#) offered by an [issuer](#) in connection with a group health plan) that provides both [medical/surgical benefits](#) and mental health or [substance use disorder benefits](#) must comply with paragraph (b)(2), (b)(3), or (b)(5) of this section.

**(ii) Exception.** The rule in [paragraph \(b\)\(1\)\(i\)](#) of this section does not apply if a [plan](#) (or [health insurance coverage](#)) satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for [small employers](#) and for increased cost).

**(2) Plan with no limit or limits on less than one-third of all medical/surgical benefits.** If a [plan](#) (or [health insurance coverage](#)) does not include an aggregate lifetime or [annual dollar limit](#) on any [medical/surgical benefits](#) or includes an aggregate lifetime or [annual dollar limit](#) that applies to less than one-third of all [medical/surgical benefits](#), it may not impose an aggregate lifetime or [annual dollar limit](#), respectively, on mental health or [substance use disorder benefits](#).

**(3) Plan with a limit on at least two-thirds of all medical/surgical benefits.** If a [plan](#) (or [health insurance coverage](#)) includes an aggregate lifetime or [annual dollar limit](#) on at least two-thirds of all [medical/surgical benefits](#), it must either -

**(i)** Apply the aggregate lifetime or [annual dollar limit](#) both to the [medical/surgical benefits](#) to which the limit would otherwise apply and to mental health or [substance use disorder benefits](#) in a manner that does not distinguish between the [medical/surgical benefits](#) and mental health or [substance use disorder benefits](#); or

**(ii)** Not include an aggregate lifetime or [annual dollar limit](#) on mental health or [substance use disorder benefits](#) that is less than the aggregate lifetime or [annual](#)

dollar limit, respectively, on **medical/surgical benefits**. (For cumulative limits other than aggregate lifetime or annual dollar limits, see **paragraph (c)(3)(v)** of this section prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.)

**(4) Determining one-third and two-thirds of all medical/surgical benefits.** For purposes of this paragraph (b), the determination of whether the portion of **medical/surgical benefits** subject to an aggregate lifetime or **annual dollar limit** represents one-third or two-thirds of all **medical/surgical benefits** is based on the dollar amount of all **plan** payments for **medical/surgical benefits** expected to be paid under the **plan** for the **plan year** (or for the portion of the **plan year** after a change in **plan** benefits that affects the applicability of the aggregate lifetime or annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the **plan** will constitute one-third or two-thirds of the dollar amount of all **plan** payments for **medical/surgical benefits**.

**(5) Plan not described in paragraph (b)(2) or (b)(3) of this section -**

**(i) In general.** A group health **plan** (or health insurance coverage) that is not described in paragraph (b)(2) or (b)(3) of this section with respect to aggregate lifetime or **annual dollar limits** on **medical/surgical benefits**, must either -

**(A)** Impose no aggregate lifetime or **annual dollar limit**, as appropriate, on mental health or **substance use disorder benefits**; or

**(B)** Impose an aggregate lifetime or **annual dollar limit** on mental health or **substance use disorder benefits** that is no less than an average limit calculated for **medical/surgical benefits** in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of **medical/surgical benefits**. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost **conditions** (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(5)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated dollar limit under the **plan** are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a **plan** may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the **plan**.