IDOI Letter to Issuers For Plan Year 2023

Timeline For Plan Year 2023

- Single Risk Pool Rate and Form Filing (Individual and Small Group) Deadline: June 13, 2022 at 12:00pm EST.
    - Filings must be filed in **BOTH** HIOS and SERFF **at the same time.**
        - Please note that there will be a gateway between SERFF and the Unified Rate Review (HIOS URR) module.
        - This applies only to the URR module.
        - All other templates must appear in both databases and any updates must be made at the same time.
    - Filings must include all forms and rates.[1]
    - A completed filing must include a completed IDOI ACA Checklist and Attestations for Plan Year 2023 document.[2]
    - All updates to rates and forms must be submitted to the IDOI by August 5, 2022 at 5:00pm EST.
        - All QHP issuers **MUST** have final and active URLs completed by this date.
        - An attestation will be required as part of your final changes that a thorough plan preview has been completed.
    - The IDOI will complete its review of single risk pool filings by August 16, 2022.
- Qualified Dental Plan (QDP) Filing Deadline: June 13, 2022 at 12:00pm EST.
    - Filings must be filed in **BOTH** HIOS and SERFF **at the same time**.
    - Filings must include all forms and rates and all applicable templates.[3].
    - All updates to rates and forms must be submitted to the IDOI by August 5, 2022 at 5:00pm EST.
        - All QDP issuers **MUST** have final and active URLs completed by this date.
        - An attestation will be required as part of your final changes that a thorough plan preview has been completed.
    - The IDOI will complete review of QDP filings by August 16, 2022.
- SERFF response requirement from Issuers:

Date Range	Number of Days to Response to Objection
June 13, 2022 to July 1, 2022	10
July 2, 2022 to July 15, 2022	4
July 16, 2022 to August 3, 2022	2

- All data change requests must be provided to the IDOI 2 days PRIOR to the due date of the submission.
    - Change requests must be emailed to the following email addresses with the

[1] See Attachment 1.
[2] See Attachment 5.
[3] See Attachment 1.

subject line "Data Change Request from Issuer XXXX HIOS ID XXXX."
    - Sshover@idoi.in.gov
    - Ghockwalt@idoi.in.gov
    - Compliance@idoi.in.gov
  - Emails without the above subject line will not be considered.

Essential Health Benefits 2023

- Indiana is retaining the current 2017 essential health benefit benchmark plan for the 2023 calendar year:
  - Anthem BCBS Blue 5 Blue Access PPO Medical Option 6 Rx Option G
  - Pediatric Oral (FEDVIP)
  - Pediatric Vision (FEDVIP)
- Substitutions between benefit categories are not permitted.
- Additional information may be obtained by visiting http://www.in.gov/idoi/2812.htm.

Actuarial Value (AV) De Minimis Ranges

- HHS proposes de minimis ranges at §156.140(c) of +2/-2 percentage points for all individual and small group plans subject to the AV requirements under the EHB package.
- For expanded bronze plans, HHS proposes a de minimis range of +5/-2 percentage points.
- For QHP certification, HHS proposes to limit the de minimis range to +2/0 percentage points for individual market silver QHPs and +1/0 percentage points for income-based CSR plan variations.

Maximum Annual Limitation on Cost Sharing for Plan Year 2023

- HHS proposes to make the 2023 maximum annual limitation on cost sharing $9,100 for self-only coverage and $18,200 for other than self-only coverage.
- This represents an approximately 4.6 percent increase above the 2022 parameters of $8,700 for self-only coverage and $17,400 for other than self-only coverage.

Maximum Annual Limitation on Cost Sharing for 2023

Category	Self-Only	Other Than Self-Only
100 – 150 percent of FPL	$3,000	$6,000
151 – 200 percent of FPL	$3,000	$6,000
201 – 250 percent of FPL	$7,250	$14,500

SERFF Plan Management Instructions

- Binder submissions and Form/Rate filing submissions are required by Indiana for all ACA compliant non-grandfathered plans that are part of the single risk pool as well as Stand Alone Dental Plans (SADPs).[4]
- Form/Rate Filing Changes
  - On the Rate Review Detail (RRD) in SERFF, carriers should report the min,

[4] See Attachment 1 or http://www.in.gov/idoi/2812.htm.

max, and weighted average for the annualized PMPM as premiums to cover one month of coverage.
    - This is a change for QDPs who have traditionally entered annual premiums in this section.

Network Adequacy Review Updates

- For Plan Year 2023, the IDOI has made the following updates to check for adequate networks for all single risk pool products:[5]
    - The IDOI's network adequacy standards closely follow the federal standards listed in the Letter to Issuers and Benefit and Payment Parameters documents for Plan Year 2023.
    - Carriers will design and provide exhibits that clearly demonstrate compliance with the IDOI's network adequacy standards.
    - Carriers will provide:
        - The ECP/Network Adequacy template;
        - Maps demonstrating compliance with distance standards by specialty; county designation, and network;
        - Summary tables of counts of providers by network; **and**
        - Various attestations and any needed justifications.
- HHS has stated ECP provider participation standard be set at 35 percent of available ECPs based on the applicable PY HHS ECP list, including approved ECP write-ins that would also count toward a QHP issuer's satisfaction of the 35 percent threshold.

Formulary Review Updates

- The IDOI has updated the IDOI Clinical Appropriateness Tool's drug lists for Plan Year 2023.
- This is an Indiana specific formulary review for all single risk pool major medical plans and is in addition to all formulary reviews done using the Plan Management Tools designed by CMS.

Nondiscrimination Standards Updates

- Sexual Orientation and Gender Identity: Nondiscrimination protections would explicitly prohibit discrimination based on sexual orientation and gender identity.
- Benefit Design: The design should be clinically based, that incorporates evidence-based guidelines into coverage and programmatic decisions.
- Prescription Drug Tiers: Issuers may not place most or all drugs that treat a specific condition on highest cost tiers.

MHPAEA[6]

- MHPAEA Tab of the EHB Verification Template:
    - The IDOI requires that the classifications be listed separately on the template and must remain separate for the determination of "substantially all" and "predominant" level tests.

[5] See Attachment 2.

[6] See Attachment 3.

    - It is now IDOI policy that Outpatient Office Visits (In-Network) for Medical/Surgical must use the same cost-sharing type (copay/coinsurance) as Mental Health/Substance Use Disorder.
    - Plans that do not comply with this standard will not be approved.
- Insurers **must** submit a completed federal Self-Compliance Toolkit.

No Surprises Act

- The IDOI will require language addressing the changes brought forth by the No Surprises Act to be part of **BOTH** the certificate of coverage and renewal notification documents to be sent to policyholders.
- An example of language may be found in Attachment 4.

Product Discontinuance/Renewal Notifications

- Notification must be sent to policyholders at least 90 calendar days in advance before the date the coverage will be discontinued.[7]
    - Carriers must also send written notice of the product discontinuance to the Commissioner.
    - Notification to policyholders must be approved by the IDOI prior to sending to policyholders.
- Notification requirements are applicable for both grandfathered and non-grandfathered coverage in the large group, small group, and individual market on and off Marketplace.

Definition of Guaranteed Availability (Past Debt)

- HHS proposes to revise interpretation of the guaranteed availability requirement to prohibit issuers from applying a premium payment to an individual's or employer's past debt owed for coverage and refusing to effectuate enrollment in new coverage.

Exchange Reenrollment Hierarchy

- HHS proposes to incorporate the net premium, maximum out-of-pocket (MOOP), deductible, and annual out-of-pocket costs (OOPC) of a plan into the Exchange re-enrollment hierarchy.

Monthly Special Enrollment

- A new monthly SEP will be available to individuals who are eligible for APTC and whose household income does not exceed 150 percent of FPL.
- Individuals who do not meet these requirements will not be eligible for the SEP.
- SEP eligibility will not consider whether someone who is APTC eligible chooses to apply some, all, or none of her PTC to her monthly health insurance plan premiums.

[7] See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Updated-Federal-Standard-Notices-and-Enforcement-Safe-Harbor-for-Discontinuation-Notices-PY2020.pdf.

End of Public Health Emergency – Covid-19 Medicaid Changes

- On August 13, 2021, the Biden administration published guidance to help states prepare to wind down their special Medicaid program operations after the end of the federal Covid-19 public health emergency.[8]
- The IDOI requests insurers consider any impact the this may have on your filings.

Exchange User Fees

- The proposed federal-facilitated Exchange user fee is 2.75%.

Standardized Plan Options (for QHP Issuers Only)

- CMS proposes to require standardized QHP options in FFE at every product network type to include:
  - One bronze plan, one bronze plan that meets the requirements to have an AV up to 5 points above the 60 percent standard as specified in §156.140 (c) (known as expanded bronze plan), one silver plan, one version of each of the three income-based silver CSR plan variations, one gold plan, and one platinum plan.

State Legislative Considerations

- The following legislation should be reviewed for impact on your filings:
  - HB 1001 COVID-19 Immunizations
  - HB 1158 Health and Human Services Matters
  - HB 1238 Insurance Matters
  - HB 1254 Newborn Screening Requirements
  - HB 1373 Ambulance Services
  - SB 88 Prescription Drug Rebates and Pricing
  - SB 95 Coverage for Living Organ Donors
  - SB 136 Dental Plans
  - SB 249 Health Insurance Transparency
  - SB 268 Colorectal Cancer Screening Coverage

Reference Documents

- The IDOI Rate and Form Review will encompass information contained within the following reference documents/rules:
  - 2023 Proposed Notice of Benefit and Payment Parameters https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023
  - 2023 Draft Letter to Issuers https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf
  - 2023 Plan Management/CMS Templates https://www.qhpcertification.cms.gov/s/Application%20Materials
  - No Surprises Act https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills

[8] See https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf.

https://www.cms.gov/nosurprises

Attachment 1
SERFF Plan Management Instructions for Plan Year 2023

Overview

Both Binder submissions and Form/Rate Filing submissions are required by Indiana for all ACA compliant non-grandfathered plans (non-QHPs & QHPs) (Dental and Major Medical) (Small Group and Individual) (On and/or Off Exchange). **This is required even if there are no changes to the rates or forms.** If there are any changes to the forms approved during a previous filing season, carriers are required to submit redline version of the forms to adequately highlight such changes. Each Binder submission should be submitted at the same time as the associated Form/Rate Filing.

Indiana is a Federally Facilitated State for Plan Management. QHP Applications (submissions) need to be submitted in HIOS, as CMS will be reviewing and approving for the federal Marketplace. Additionally, a duplicate QHP submission is required by Indiana and should be submitted through the SERFF Binder process. **Submissions must be submitted in both SERFF and HIOS simultaneously and must contain identical versions of each template at all times**.

State Essential Health Benefits And Mandates

To view Indiana's Essential Health Benefits (EHBs) please visit:
http://www.in.gov/idoi/2812.htm
To view Indiana's Insurance Code, Title 27 please visit:
http://iga.in.gov/legislative/laws/2017/ic/titles/027

Submission Window And Deadlines

For Plan Year 2022, all Plan Management submissions (as well as Form/Rate Filings) for **individual QHP, small group filings, and stand alone dental plan (SADP) filings** need to be submitted by 12:00pm EST on June 13, 2022 including all related rates, documents, and templates. Note that this deadline is several days before the federal deadline. These filings and binders will have a preliminary posting date of June 14, 2022, and a final posting date of August 16, 2022. The last day for carriers to submit changes to the IDOI is August 5, 2022 by 5:00pm EST. The IDOI will begin approving/disapproving plans and closing Binders for both Major Medical and Dental plans on August 15, 2022. Additionally, responses to objections will be expected within:

- 10 business days for objections submitted on June 13, 2022 – July 1, 2022;
- 4 business days for objections submitted on July 2, 2022 – July 15, 2022; and
- 2 business days for objections submitted after July 16, 2022.

Stand Alone Dental Plans (SADPs)

In addition to submitting a Binder and a Form/Rate filing through SERFF, carriers seeking SADP certification for use on or off Marketplace will also need to submit an SADP application through HIOS.

Actuarial Value Calculations

You must provide the IDOI with an actuarial value calculator screen shot for every plan and plan

variant. If you are submitting a plan with a unique benefit design, please remember that EHB requirements must be met, substitutions are not allowed, and a non-discriminatory benefit design is required.

Submission Fees

There is no fee in Indiana for Binder submissions. Normal fees apply for Form/Rate filings in SERFF.

Contacting The Marketplace

All inquiries regarding the QHP application, the QHP application process, the federal templates, the federal review tools should be addressed to the XOSC Help Desk via email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515.

Benefits And Service Areas

Indiana does not allow any EHB substitution of benefits or partial county service areas. Additionally, all carriers offering Small Group Major Medical plans must offer at least one product whose plans all cover morbid obesity surgery. **IC 27-8-14.1-4**

Indiana Specific Templates

State specific templates can be found at http://www.in.gov/idoi/2813.htm or as requirements under Supporting Documentation when creating a Binder.

- IDOI Rate and Crosswalk Template
- IDOI EHB Verification Template: This template must be completed including any and all limits and exclusions on benefit coverage.
- IDOI Active Individual Providers Template

State Specific Formulary Review

Major medical formularies must comply with all requirements reviewed using all of the federal review tools available at https://www.qhpcertification.cms.gov/s/Review%20Tools. Additionally, Indiana conducts the state specific IDOI Clinical Appropriateness Review. This tool is available to carriers on our website.

Network Adequacy

The Essential Community Providers (ECP)/Network Adequacy Template is required for all Binder submissions. The ECP tabs only apply to carriers wishing to sell on the Marketplace. However, all carriers are expected to fully list and categorized their pharmacies, facilities, and providers using all applicable specialty types. If more than one specialty type applies to the pharmacy/facility/provider then multiple specialty types should be listed and separated by commas. The IDOI will conduct a variety of network adequacy checks at the network and specialty type level. Carriers can only receive credit for the coverage that is entered into the template and only plans that meet our standards will be certified. This template takes a significant amount of work to complete, and it is essential for it to be complete, accurate, and fully categorized. Please see the IDOI Network Adequacy Standards for Plan Year 2023 for further details and to learn more about the new IDOI Active Individual Providers Template.

Expanded Bronze Plan Review

Part of the Cost-Sharing Review Tool checks the cost-sharing requirements for expanded bronze plans. As shown below, the state is responsible for setting copay thresholds that will be considered roughly equivalent to 50% coinsurance for the purposes of this review. Below are the copay thresholds that have been chosen for Plan Year 2023.

4d.

Expanded Bronze Plan Review

This review checks that each plan with an Expanded Bronze metal level meets the applicable requirements. The plan must **either:**

1. Meet the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2).

OR

2. Pay for at least one major service before the deductible with reasonable cost sharing.
   -*Major services* are defined as the below list of benefits.
   -*Reasonable cost sharing* is defined as a coinsurance less than or equal to 50% or a copay less than or equal to a benefit-specific copay limit defined by the state. The values are set to default to $0 and states may update the values below.

BEFORE RUNNING THIS REVIEW: The Expanded Bronze review is **NOT** intended to be run with the default copay parameters below. As stated above, states are responsible for setting copay amounts that are roughly equivalent to 50% coinsurance. The tool will not produce meaningful results if run without updating the copay values.

	Copay	Coins
Primary Care Visits	$55	50%
Specialist Visit	$100	50%
Emergency Room Services	$750	50%
Inpatient Hospital Services (e.g., Hospital Stay)	$625	50%
Generic Drugs	$30	50%
Preferred Brand Drugs	$70	50%
Specialty Drugs	$110	50%

Table 1: Required Templates on "Templates" Tab in Binder

Table 1 contains templates found on the Templates tab of Plan Management Binders in SERFF. We expect a carrier to choose a column based on the total single risk pool submission. For example, if you write plans for sale both on and off the Marketplace, and write other plans offered exclusively off the Marketplace, then you would submit all templates shown in column A for all plans in that single risk pool, including plans not sold on the Marketplace.

		A	B	C
Template Name	Template Description	Indiv/SG Both On/Off Marketplace Major Medical Submission	Indiv/SG Only Off Marketplace Major Medical Submission	Exchange Certified Indiv/SG Stand Alone Dental On/Off Marketplace Submission
ECP/Network Adequacy Template	Collects information on providers, hospitals, and pharmacies in the carrier's networks.	Required (ECP tabs apply to Major Medical Marketplace plans only)	Required (ECP tabs may be left blank)	Required (ECP tabs may be left blank)
Plans & Benefits Template	Collects plan and benefit data for medical and dental.	Required	SERFF Plan and Benefits Light Template only	Required
Prescription Drug Template	Collects comprehensive formulary data for plans.	Required	Required	N/A
Network ID Template	Lists a carrier's network IDs and network URLs.	Required	Required	Required
Service Area Template	Information identifying a plan's geographic service area.	Required	Required	Required
Rate Data Template	Rating Tables	Required	N/A	Required
Business Rule Template	Supporting business rules	Required	N/A	Required
Transparency in Coverage Template	Collects data on the number of claims submitted and denied.	Required	N/A	Required

Table 2: Required Templates on "Supporting Documentation" tab in Binder

Table 2 contains templates found on the Supporting Documents tab in SERFF.

Template Name	Indiv/SG Both On/Off Marketplace Major Medical Submission	Indiv/SG Only Off Marketplace Major Medical Submission	Exchange Certified Indiv/SG Stand Alone Dental On/Off Marketplace Submission
Formulary - Inadequate Category/Class Count Supporting Documentation and Justification As Needed	Required	Required	N/A
Discrimination - Cost Sharing Outlier Supporting Documentation and Justification As Needed	Required	N/A	N/A
Discrimination - Language Supporting Documentation and Justification As Needed	Required	N/A	N/A
Discrimination - Formulary Outlier Review Supporting Documentation and Justification As Needed	Required	Required	N/A
Discrimination - Formulary Clinical Appropriateness Supporting Documentation and Justification As Needed	Required	Required	N/A
Plan ID Crosswalk Template	Required	N/A	Required (Marketplace plans only)
IDOI Network Adequacy Documents – IDOI Active Individual Providers Template, Counts of Specialties by Network, Justifications and Attestations	Required	Required	N/A
IDOI Rate and Crosswalk Template	Required	Required	N/A
IDOI ACA Checklist and Attestations	Required	Required	N/A
IDOI EHB Verification Template	Required	Required	N/A

IDOI Network Adequacy Standards for Plan Year 2023

Summary
For Plan Year 2023, the IDOI will use the distance standards provided in CMS's 2023 Letter to Issuers. However, since Indiana has small counties, the IDOI will only use three county type designations (Large Metro, Metro, and Rural) rather than the five designations used by CMS. The IDOI will use a few other simplifications of the requirements as well. Carriers will be responsible for designing and submitting exhibits that clearly demonstrate how all criteria are met. Most criteria are evaluated at the network/county level. For this reason, the information entered into ECP/Network Adequacy template must be complete and accurate, especially regarding the county that is listed. There are also criteria that a provider, facility, or pharmacy must meet in order to be listed in the ECP/Network Adequacy template and be counted towards satisfying network adequacy standards.

Terminology:
The term "provider" refers to individual provider, facility, or pharmacy.

The term "county designation" refers to the designations of Large Metro, Metro, or Rural.

A provider is assumed to meet the "criteria to count towards network adequacy".

Criteria to Count Towards Network Adequacy:
Only providers that meet all the following standards can be entered into the network adequacy tabs (as opposed to the ECP tabs) of the ECP/Network Adequacy template, be listed in the IDOI Active Individual Providers Template, or be shown on any of the network adequacy maps or tables. Providers must:

- Be in-network,
- Be covered at the lowest cost-sharing level (tier),

Required Network Adequacy Documents:
Carriers must submit the following information:

- A complete and accurate ECP/Network Adequacy template listing all provider locations that meet CMS's criteria to count towards network adequacy;
- An IDOI Active Individual Providers Template;
- A table showing the count of unique providers (facilities and individual) by specialty and network;
- Separate maps for each county designation, network, and specialty showing compliance with the distance standards;
    - The maps for individual provider specialties should be made using only the locations listed in the Active Individual Provider Template
- Attestation of compliance with the appointment wait time standards;
- Air ambulance maps to demonstrate coverage for in-network air ambulance services by network; and
- Justifications when a standard was not met.

IDOI Active Individual Providers Template

This is an Excel workbook, separate from the ECP/Network Adequacy template that lists active individual providers at locations that meet the following additional criteria:

- Individual providers in this workbook will still need to be in-network and be covered at the lowest cost-sharing level or tier.
- By default, individual providers may only be listed at a single primary location. However, providers may be listed at additional locations if the carrier has paid major medical claims for care provided in-person at that location for that specialty during or after 2021. The goals for this restriction are as follows:
    - To reduce the number of outdated or incorrect entries;
    - To account for the fact that an individual can only provide a limited amount of care; and
    - To more accurately identify where care is being provided.
- The IDOI may provide additional leniency for carriers that are entering the market and thus would not have any claims in 2021 or 2022.
- The layout and fields in this workbook match the layout and fields of the "IndividualProviders" tabs in the ECP/Network Adequacy template but have the addition of two final columns labeled "Default/Active" and "Date of Recent Service"
    - The Default/Active column should be populated with either "Default" or "Active" to designate which location is being used as the default location.
    - The Date of Recent Service field should be populated with the date the care was provided in-person, by the provider, at that location, for that specialty.
- Carriers should be prepared to provide additional information to support the use of any non-default locations listed.

Count of Providers by Specialty and Network

For each network, carriers should provide the total number of providers of each specialty. These counts must only include providers listed in the ECP/Network Adequacy template on the non-ECP tabs. There should also be a column indicating the percentage of providers in each specialty and for each network that has billed the carrier for care they provided in that specialty at that location since November 1, 2021.

Distance Standards and Maps

County Designations:

The IDOI uses the three county type designations of Large Metro, Metro , and Rural.

County Designation	Population
Large Metro (Marion County Only)	> 900,000
Metro (Metro and Micro)	50,000 – 900,000
Rural (Rural and CEAC)	< 50,000

Distance Standards:

The IDOI will use the specialties and distance (but not time) standards defined by CMS in their final 2023 Letter to Issuers.

Required Maps:
For each network and for each specialty, carriers must provide three maps: Large Metro, Metro, and Rural. The maps must demonstrate that all policy holders will have access to at least one provider of each specialty within the distance standard of their county's designation by plotting each provider location in that network of that specialty type statewide and drawing semi-transparent circles, centered at the provider locations, with radii equal to the map's distance standard. For each map, all providers of that specialty and in that network should be plotted and should have their circles drawn, even if they are in counties of a different county designation than the map. Counties that have the same county designation as what is being shown on the map should be colored in a way to make them easy to identify. It must also be easy to identify which counties do not have plans with the map's network. Each of these counties are expected to be fully covered. Counties that have a less stringent distance standard than that being shown on the map are not expected to be fully covered.

Maps must include the following:

- All Indiana county boundaries,
- All county names,
- County Designation being mapped,
- The distance standard in miles,
- The Network ID,
- The provider specialty,
- The date made,
- Colorings of counties that make it easy to identify which counties match the county designation of the map and which counties offer plans with the map's network.

Appointment Wait Time Standards
Carriers must attest to meeting the appointment wait time standards listed in the Final Notice of Benefit and Payment Parameters for Plan Year 2023 or provide a justification for why this standard was not able to be met. Carriers will need to provide a plan for continuing to monitor that this standard is met throughout the year.

Air Ambulance Standards and Maps
Carriers must have at least one air ambulance provider in their network for each network. For each network, carriers should map the locations where these in-network air ambulances reside when not in use and show the standard service area where these air ambulances can provide prompt responses to emergencies.

Justifications
Carriers must demonstrate a sufficient number of each provider type, in each network, for each county in which that network is used. If a carrier is unable to meet this requirement, the carrier must supply a justification of why the carrier was unable to meet this requirement. This justification will need to be reviewed and deemed adequate by the IDOI for the carrier to receive credit for meeting that standard for that network/county.

Attachment 3

Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)

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About This Tool

The goal of this self-compliance tool is to help group health plans, plan sponsors, plan administrators, group and individual market health insurance issuers, state regulators, and other parties determine whether a group health plan or health insurance issuer complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) and additional related requirements under the Employee Retirement Income Security Act of 1974 (ERISA) that apply to group health plans. The requirements described in this tool generally apply to group health plans, group health insurance issuers, and individual market health insurance issuers. However, requirements that do not apply as broadly are so noted.

This tool does not provide legal advice. Rather, it gives the user a basic understanding of MHPAEA to assist in evaluating compliance with its requirements. For more information on MHPAEA, or related guidance issued by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments), please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

Furthermore, as directed by Section 13001(a) of the 21st Century Cures Act, this publicly available tool is a compliance program guidance document intended to improve compliance with MHPAEA. DOL will update the self-compliance tool biennially to provide additional guidance on MHPAEA's requirements, as appropriate.

MHPAEA, as a federal law, sets minimum standards for group health plans and issuers with respect to parity requirements. However, many states have enacted their own laws to advance parity between mental health and substance use disorder benefits and medical/surgical benefits by supplementing the requirements of MHPAEA. Insured group health plans and issuers should consult with their state regulators to understand the full scope of applicable parity requirements.

This tool provides a number of examples that demonstrate how the law applies in certain situations and how a plan or issuer might or might not comply with the law. Additional examples are included in the Appendix I. The fact patterns used as examples are intended to help group health plans and health insurance issuers identify and address important MHPAEA issues.

Examples of MHPAEA enforcement actions that the DOL has undertaken are included in the MHPAEA Enforcement Fact Sheets, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity. Examples of MHPAEA enforcement actions that HHS has taken are included in the Department of Health and Human Services' MHPAEA Reports at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#mental-health-parity.

Introduction

MHPAEA, as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans and group and individual health insurance issuers that provide coverage for MH/SUD benefits in addition to medical/surgical benefits. DOL has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans, while HHS has primary enforcement authority over non-federal governmental group health plans, such as those sponsored by state and local government employers. HHS also has primary enforcement authority for MHPAEA over issuers selling products in the individual and fully insured group markets in states that have notified HHS' Centers for Medicare & Medicaid Services that they do not have the authority to enforce or are not otherwise enforcing MHPAEA. In all other states, generally the state is responsible for directly enforcing MHPAEA with respect to issuers.

Unless a plan is otherwise exempt, MHPAEA generally applies to both grandfathered and non-grandfathered group health plans and large group health insurance coverage. Also, the Affordable Care Act requires all issuers offering coverage in the individual and small group markets to cover certain essential health benefits (EHB), including MH/SUD benefits. Final rules issued by HHS implementing EHB requirements specify that MH/SUD benefits must be consistent with the requirements of the MHPAEA regulations. *See 45 CFR 156.115(a)(3).*

Under the MHPAEA regulations, if a plan or issuer provides MH/SUD benefits in any classification described in the MHPAEA final regulation, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. Under PHS Act section 2713, as added by the Affordable Care Act, non-grandfathered group health plans and group and individual health insurance coverage are required to cover certain preventive services with no cost-sharing, which include, among other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening. However, the MHPAEA regulations do not require a group health plan or a health insurance issuer that provides MH/SUD benefits only to the extent required under PHS Act section 2713, to provide additional MH/SUD benefits in any classification. *See 29 CFR 2590.712(e)(3)(ii), 45 CFR 146.136(e)(3)(ii), 26 CFR 54.9812-1(e)(3)(ii).*

Definitions

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 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 for any coverage unit.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on certain accumulated amounts, and they 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 certain 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 not including MH/SUD 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).

NOTE: If a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits for purposes of MHPAEA. For example, if a plan defines autism spectrum disorder (ASD) as a mental health condition, it must treat benefits for ASD as mental health benefits. Therefore, for example, any exclusion by the plan for experimental treatment that applies to ASD should be evaluated for compliance as a nonquantitative treatment limitation (NQTL) (and the processes, strategies, evidentiary standards, and other factors used by the plan to determine whether a particular treatment for ASD is experimental, as written and in operation, must be comparable to and no more stringently applied than those used for exclusions of experimental treatments of medical/surgical conditions in the same classification). *See FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century*

Cures Act Part 39, Q1, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf. Additionally, if a plan defines ASD as a mental health condition, any aggregate annual or lifetime dollar limit or any quantitative treatment limitation (QTL) imposed on benefits for ASD (for example, an annual dollar cap on benefits for Applied Behavioral Analysis (ABA) therapy for ASD of $35,000, or a 50-visit annual limit for ABA therapy for ASD) should also be evaluated for compliance with MHPAEA.

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 QTLs, which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

SECTION A. APPLICABILITY

Question 1. Is the group health plan or group or individual health insurance coverage exempt from MHPAEA? If so, please indicate the reason (e.g. retiree-only plan, excepted benefits, small employer exception, increased cost exception, HIPAA opt-out).

Comments:

If a group health plan or group or individual health insurance coverage provides either MH/SUD benefits, in addition to medical/surgical benefits, the plan may be subject to the MHPAEA parity requirements. However, **retiree-only group health plans**, self-insured non-federal governmental plans that have elected to exempt the plan from MPHAEA, and group health plans and group or individual health insurance coverage offering only **excepted benefits**, are generally not subject to the MHPAEA parity requirements. (***Note***: if under an arrangement(s) to provide medical care benefits by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and MH/SUD benefits, the MHPAEA parity requirements apply separately with respect to each combination of medical/surgical benefits and MH/SUD benefits and all such combinations are considered to be a single group health plan. *See 26 CFR 54.9812-1(e), 29 CFR 2590.712(e), 45 CFR 146.136(e)*).

Under ERISA, the MHPAEA requirements do not apply to **small employers**, defined as employers who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employ at least 1 employee on the first day of the plan year. *See 26 CFR 54.9812-1(f)(1), 29 CFR 2590.712(f)(1), 45 CFR 146.136(f)(1).* However, under HHS final rules governing the Affordable Care Act requirement to provide EHBs, non-grandfathered health insurance coverage in the individual and small group markets must provide all categories of EHBs, including MH/SUD benefits. The final EHB rules require that such benefits be provided in compliance with the requirements of the MHPAEA rules. *45 CFR 156.115(a)(3); see also ACA Implementation FAQs Part XVII, Q6, available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xvii.pdf.* In practice, this means that employees in group health plans offered by small employers who purchase non-grandfathered health insurance coverage in the small group market (within the meaning of section 2791 of the PHS Act) that must provide EHBs have coverage that is subject to the requirements of MHPAEA.

MHPAEA also contains an **increased cost exemption** available to group health plans and issuers that meet the requirements for the exemption. The MHPAEA regulations establish standards and procedures for claiming an increased cost exemption. *See 26 CFR 54.9812-1(g), 29 CFR 2590.712(g), 45 CFR 146.136(g).*

Sponsors of self-funded, non-federal governmental plans are permitted to elect to exempt those plans from certain provisions of the PHS Act, including MHPAEA. An exemption election is commonly called a "HIPAA opt-out." The HIPAA opt-out election was authorized under section 2722(a)(2) of the PHS Act (42 USC § 300gg-21(a)(2)). *See also* 45 CFR 146.180. The

procedures and requirements for self-funded, non-federal governmental plans to opt out may be found at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#Self-Funded%20Non-Federal%20Governmental%20Plans.

Question 2. If not exempt from MHPAEA, does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in addition to providing medical/surgical benefits?

Comments:

Unless the group health plan or group or individual health insurance coverage is exempt from MHPAEA or does not provide MH/SUD benefits, continue to the following sections to examine compliance with requirements under MHPAEA.

SECTION B. COVERAGE IN ALL CLASSIFICATIONS

Question 3. Does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in every classification in which medical/surgical benefits are provided?

Comments:

Under the MHPAEA regulations, if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulation, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).*

Under the MHPAEA regulations, the six classifications* of benefits are:

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.

See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).

**See special rules related to the classifications discussed below.*

> ***NOTE***: If a plan or coverage generally excludes all benefits for a particular mental health condition or substance use disorder, but nevertheless includes prescription drugs for treatment of that condition or disorder on its formulary, the plan or coverage covers MH/SUD benefits in only one classification (prescription drugs). Therefore, the plan or coverage would generally be required to provide mental health or substance use disorder benefits with respect to that condition or disorder for each of the other five classifications for which the plan also provides medical/surgical benefits. However, if a prescription drug that may be used for a particular MH/SUD condition and may also be used for other unrelated conditions is included on a plan's or coverage's formulary, the drug's inclusion on the formulary alone would not be considered to override the plan or coverage's general exclusion for a particular mental health condition or substance use disorder unless the plan or coverage covers prescription drugs specifically to treat that condition.

ILLUSTRATION: A Plan provides for medically necessary medical/surgical benefits as well as MH/SUD benefits. While the Plan covers medical/surgical benefits in all benefit classifications, it does not cover outpatient services for MH/SUD benefits for either in-network or out-of-network providers. In this example, since the Plan fails to provide MH/SUD benefits in outpatient, in-network and outpatient, out-of-network classifications in which medical/surgical benefits are provided, the Plan fails to meet MHPAEA's parity requirements. The Plan could

come into compliance by covering outpatient services for MH/SUD benefits both in- and out-of-network in a manner comparable to covered medical/surgical outpatient in- and out-of-network services.

Classifying benefits. In determining the classification in which a particular benefit belongs, a group health plan or group or individual market health insurance issuer must apply the same standards to medical/surgical benefits as to MH/SUD benefits. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).* This rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must assign covered intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) to the existing six classifications in the same way that they assign intermediate medical/surgical benefits to these classifications. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well. A plan or issuer must also comply with MHPAEA's NQTL rules, discussed in Section F, in assigning any benefits to a particular classification. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4).*

Medication Assisted Treatment (MAT) is subject to MHPAEA

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

ILLUSTRATION: An issuer did not cover methadone for opioid addiction, though it did cover methadone for pain management. The issuer failed to demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions. The issuer re-evaluated the medical necessity of methadone-maintenance treatment programs and developed medical-necessity criteria that mirrors federal guidelines (including the Substance Abuse and Mental Health Services Administration treatment improvement protocol 63 for medication for opioid use disorder) for opioid treatment programs to replace the methadone-maintenance treatment exclusion.

ILLUSTRATION: A plan uses nationally recognized clinical standards to determine coverage for prescription drugs to treat medical/surgical benefits based on the recommendations of a Pharmacy and Therapeutics (P&T) committee. However, the plan deviates from such standards

for buprenorphine/naloxone to treat opioid use disorder based on the P&T committee's recommendations. This deviation should be evaluated for compliance with MHPAEA's NQTL standard in practice, including the determination of (1) whether the P&T committee has comparable expertise in MH/SUD conditions as it has in medical/surgical conditions, and (2) whether the committee's evaluation of the nationally-recognized clinical standards and decision processes to deviate from those standards for MH/SUD conditions is comparable to and no more stringent than the processes it follows for medical/surgical conditions.

Treatment for eating disorders is subject to MHPAEA

Eating disorders are mental health conditions, and treatment of an eating disorder is a "mental health benefit" as that term is defined by MHPAEA. *See ACA Implementation FAQs Part 38, Q1, available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf*. Section 13007 of the 21st Century Cures Act provides that if a plan or an issuer provides coverage for eating disorders, including residential treatment, they must provide these benefits in accordance with MHPAEA requirements. For example, an exclusion under a plan of all inpatient, out-of-network treatment outside of a hospital setting for eating disorders would generally not be permissible if the plan did not employ a comparable process to determine if a similar limitation on treatment outside hospital settings for medical/surgical benefits warranted. *See FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q8, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf*.

Compliance Tips

- If the plan or issuer does not contract with a network of providers, all benefits are out-of-network. If a plan or issuer that has no network imposes a financial requirement or treatment limitation on inpatient or outpatient benefits, the plan or issuer is imposing the requirement or limitation within classifications (inpatient, out-of-network or outpatient, out-of-network), and the rules for parity will be applied separately for the different classifications. *See 26 CFR 54.9812-1(c)(2)(ii)(C), 29 CFR 2590.712(c)(2)(ii)(C), 45 CFR 146.136(c)(2)(ii)(C) Example 1.*
- If a plan or issuer covers the full range of medical/surgical benefits (in all classifications, both in-network and out-of-network), beware of exclusions on out-of-network MH/SUD benefits.
- Benefits for intermediate services (such as non-hospital inpatient and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

***NOTE*: Special rules related to classifications**

1. **Special rule for outpatient sub-classifications:**

   - For purposes of determining parity for outpatient benefits (in-network and out-of-network), a plan or issuer may divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules. *26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*

     - After the sub-classifications are established, the plan or issuer may not impose any financial requirement or QTL on MH/SUD benefits in any sub-classification (*i.e.*, office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the MHPAEA regulations. *See 26 CFR 54.9812-1(c)(3)(i), 29 CFR 2590.712(c)(3)(i), 45 CFR 146.136(c)(3)(i), 45 CFR 146.136(c)(3)(iii).*

   - Other than as explicitly permitted under the final rules, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, separate sub-classifications for generalists and specialists are not permitted.

2. **Special rule for prescription drug benefits:**

   - There is a special rule for multi-tiered prescription drug benefits. Multi-tiered drug formularies involve different levels of drugs that are classified based primarily on cost, with the lowest-tier (Tier 1) drugs having the lowest cost-sharing. If a plan or issuer applies different levels of financial requirements to different tiers of prescription drug benefits, the plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for medical/surgical or MH/SUD benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. *See 26 CFR54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*

3. **Special rule for multiple network tiers:**

   - There is a special rule for multiple network tiers. If a plan or issuer provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan or issuer may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or MH/SUD

benefits. After the tiers are established, the plan or issuer may not impose any financial requirement or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

***NOTE*:** As explained in the Introduction to this section, nothing in MHPAEA requires a non-grandfathered group health plan or health insurance coverage that provides MH/SUD benefits only to the extent required under PHS Act section 2713 to provide additional MH/SUD benefits in any classification.

SECTION C. LIFETIME AND ANNUAL LIMITS

Question 4. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding lifetime and annual dollar limits on MH/SUD benefits?

Comments:

A plan or issuer generally may not impose a lifetime dollar limit or an annual dollar limit on MH/SUD benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. *See 26 CFR 9812-1(b), 29 CFR 2590.712(b), 45 CFR 146.136(b).* (This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged.) If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits, or it includes one that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. *26 CFR 54.9812-1(b)(2), 29 CFR 2590.712(b)(2), 45 CFR 146.136(b)(2).*

ILLUSTRATION: Plan Z limits outpatient substance use disorder treatments to a maximum of $1,000,000 per calendar year. With the exception of a $500,000 per year limit on chiropractic services (which applies to less than one-third of all medical/surgical benefits), Plan Z does not impose such annual dollar limits with respect to other outpatient medical/surgical benefits. In this example, Plan Z is in violation of MHPAEA since the outpatient substance use disorder dollar limit is not in parity with outpatient medical/surgical dollar limits.

Compliance Tip

- There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at **Question 6.** A plan or issuer may impose annual out-of-pocket dollar limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.

***NOTE*:** These provisions are affected by section 2711 of the PHS Act, as amended by the Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime and annual dollar limits on EHB, which includes MH/SUD services. Accordingly, the parity requirements regarding lifetime and annual dollar limits apply only to the provision of MH/SUD benefits that are not EHBs.

Note also that, for plan years beginning in 2021, the annual limitation on an individual's maximum out-of-pocket (MOOP) costs in effect under the Affordable Care Act is $8,550 for self-only coverage and $17,100 for coverage other than self-only coverage. The annual limitation on out-of-pocket costs is increased annually by the premium adjustment percentage described under Affordable Care Act section 1302(c)(4), and this updated amount is detailed each year in regulations issues by the Department of Health and Human Services.

SECTION D. FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

Question 5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding financial requirements or QTLs on MH/SUD benefits?

Comments:

- A plan or issuer may not impose a financial requirement or QTL applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of that type that is applied to substantially all medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(2), 29 CFR 2590.712(c)(2), 45 CFR 146.136(c)(2).*
    - Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
    - Types of QTLs include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
- The six classifications and the sub-classifications outlined in Section B, above, are the only classifications that may be used when determining the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits. *See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).* A plan or issuer may not use a separate sub-classification under these classifications for generalists and specialists. *See 26 CFR 54.9812-1(c)(3)(iii)(C), 29 CFR 2590.712(c)(3)(iii)(C), 45 CFR 146.136(c)(3)(iii)(C).*

Compliance Tips

- Ensure that the plan or issuer does not impose financial requirements or QTLs that are applicable only to MH/SUD benefits.
- Identify all benefit packages and health insurance coverage to which MHPAEA applies.

Detailed steps for applying this rule:

To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification. *See 26 CFR 54.9812-1(c)(2)(i), 29 CFR 2590.712(c)(2)(i), 45 CFR 146.136(c)(2)(i).* Coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions, for example, self-only, family, or employee plus spouse. *See 26 CFR 54.9812-1(c)(1)(iv), 29 CFR 2590.712(c)(1)(iv), 45 CFR 146.136(c)(1)(iv).* If a plan applies different levels of a financial requirement or QTL to different coverage units in a classification of medical/surgical benefits (for example, a $15 copayment for self-only and a $20 copayment for family coverage), the predominant level is determined separately for each coverage unit. *See 26 CFR 54.9812-1(c)(3)(ii), 29 CFR 2590.712(c)(3)(ii), 45 CFR 146.136(c)(3)(ii).*

- **STEP ONE ("substantially all" test):** First determine if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits.

    - Generally, a financial requirement or QTL is considered to apply to substantially all medical/surgical benefits if it applies to at least two-thirds of the medical/surgical benefits in the classification. *See 26 CFR 9812-1(c)(3)(i)(A), 29 CFR 2590.712(c)(3)(i)(A), 45 CFR 146.136(c)(3)(i)(A).* This two-thirds calculation is generally based on the dollar amount of plan payments expected to be paid for the plan year within the classification. *See 26 CFR 54.9812-1(c)(3)(i)(C), 29 CFR 2590.712(c)(3)(i)(C), 45 CFR 146.136(c)(3)(i)(C).* Any reasonable method can be used for this calculation. *See 26 CFR 54.9812-1(c)(3)(i)(E), 29 CFR 2590.712(c)(3)(i)(E), 45 CFR 146.136(c)(3)(i)(E).*

- **STEP TWO ("predominant" test):** If the type of financial requirement or QTL applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or QTL that applies to the medical/surgical benefits that are subject to that type of financial requirement or QTL in that classification of benefits. (***Note*:** If the type of financial requirement or QTL does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to MH/SUD benefits in that classification.)

    - Generally, the level of a financial requirement or QTL that is considered the predominant level of that type is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or QTL. *See 26 CFR 54.9812-1(c)(3)(i)(B)(1), 29 CFR 2590.712(c)(3)(i)(B)(1), 45 CFR 146.136(c)(3)(i)(B)(1).* If there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or QTL in the classification. In that case, the least restrictive level within the combination is considered the predominant level. *See 26 CFR 54.9812-1(c)(3)(i)(B)(2), 29 CFR 2590.712(c)(3)(i)(B)(2), 45 CFR 146.136(c)(3)(i)(B)(2).* For a simpler method of compliance, a plan may treat the

least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.

Compliance Tip: Book of Business

- When performing the "substantially all" and "predominant" tests for financial requirements and QTLs, basing the analysis on an issuer's entire book of business is generally not a reasonable method if a plan or issuer has sufficient claims data regarding a specific plan for a reasonable projection of future claims costs for the substantially all and predominant analysis. However, there may be insufficient reliable claims data for a group health plan, in which case the analyses will require utilizing reasonable data from outside the group health plan. A plan or issuer must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice. *See ACA Implementation FAQs Part 34, Q3, available at* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf.

ILLUSTRATION: Plan Z requires copayments for out-patient, in-network MH/SUD benefits. In order to determine if the plan meets the parity requirements, take the following steps:

1. **STEP ONE: Determine if the particular type of financial requirement applies to substantially all (that is, 2/3 of) medical /surgical benefits in the relevant classification**.

   Based on its prior claims experience, Plan Z expects $1 million in medical/surgical benefits to be paid in the outpatient, in-network classification and $700,000 of those benefits are expected to be subject to copayments. Because the amount of medical/surgical benefits expected to be subject to a copayment, which is $700,000, is at least 2/3 of the $1 million total medical/surgical benefits expected to be paid, a copayment can be applied to outpatient, in-network MH/SUD benefits.

2. **STEP TWO: Determine what level of the financial requirement is predominant (that is, the level that applies to more than half the medical/surgical benefits subject to the financial requirement in the relevant classification).**

   In the outpatient, in-network classification where $1 million in medical/surgical benefits is expected to be paid, $700,000 of those benefits are expected to be subject to copayments. Out of the $700,000, Plan Z expects that 25 percent will be subject to a $15 copayment and 75 percent will be subject to a $30 copayment. Since 75 percent is more than half, the $30 copayment is the predominant level.

   CONCLUSION: Plan Z cannot impose a copayment on MH/SUD benefits in this classification that is higher than $30.

Warning Sign: If a plan or issuer applies a specialist copayment requirement for all MH/SUD benefits within a classification but applies a specialist copayment only for certain medical/surgical benefits within a classification, this may be indicative of noncompliance and warrant further review. See "Compliance Tips" below for further guidance on specialist copay requirements.

Compliance Tips

- Ensure that when conducting the predominant/substantially all tests, the dollar amount of all plan payments for medical/surgical benefits expected to be paid in that classification for the relevant plan year are analyzed.
- A plan may be able to impose the specialist level of a financial requirement or QTL to MH/SUD benefits in a classification (or an office visit sub-classification) if it is the predominant level that applies to substantially all medical/surgical benefits within the office visit sub-classification. For example, if the specialist level of copay is the predominant level of copay that applies to substantially all medical/surgical benefits in the office visit, in-network sub-classification, the plan may apply the specialist level copay to MH/SUD benefits in the office visit, in-network sub-classification. *See 26 CFR 54.9812-1(c)(3), 29 CFR 2590.712(c)(3).*

SECTION E. CUMULATIVE FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS

Question 6. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding cumulative financial requirements or cumulative QTLs for MH/SUD benefits?

Comments:

- A plan or issuer may not apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(3)(v), 29 CFR 2590.712(c)(3)(v), 45 CFR 146.136(c)(3)(v).* For example, a plan may not impose an annual $250 deductible on medical/surgical benefits in a classification and a separate $250 deductible on MH/SUD benefits in the same classification.

- 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 (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements). *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*

- Cumulative QTLs 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. *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*

ILLUSTRATION: A plan offers three benefit options, all of which provide medical/surgical as well as MH/SUD benefits. For all three benefit options, the plan provides for in-network treatment limitations of 30 days per year with respect to inpatient mental health services, and in-network treatment limitations of 20 visits per year with respect to outpatient mental health services. No such limitations are imposed on outpatient or inpatient, in-network medical/surgical benefits in any of the three benefit options.

In this example, the plan improperly imposes cumulative treatment limitations on the number of visits for outpatient and inpatient, in-network and out-of-network mental health benefits in all three benefit options. The plan could come into compliance by removing the day and visit limits for mental health services.

SECTION F. NONQUANTITATIVE TREATMENT LIMITATIONS

Question 7. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding NQTLs on MH/SUD benefits?

Comments:

An NQTL is generally a limitation on the scope or duration of benefits for treatment. The MHPAEA regulations prohibit a plan or an issuer from imposing NQTLs on MH/SUD benefits in any classification unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(4)(i), 29 CFR 2590.712(c)(4)(i), 45 CFR 146.136(c)(4)(i).*

The following is an illustrative, non-exhaustive list of NQTLs:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization or ongoing authorization requirements;
- Concurrent review standards;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or issuer 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 of specific treatments for certain conditions;
- Restrictions on applicable provider billing codes;
- Standards for providing access to out-of-network providers;
- 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.

See 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), 45 CFR 146.136(c)(4)(ii). For additional examples of plan provisions that may operate as NQTLs see *Warning Signs, available at* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf.

While NQTLs are generally defined as treatment limitations that are not expressed numerically, the application of an NQTL in a numerical way does not modify its nonquantitative character. For example, standards for provider admission to participate in a network are NQTLs because such standards are treatment limitations that typically are not expressed numerically. *See 29 CFR 2590.712 (c)(4)(ii), 45 CFR 146.136(c)(4)(ii).* Nevertheless, these standards sometimes rely on numerical standards, for example, numerical reimbursement rates. In this case, the numerical expression of reimbursement rates does not modify the nonquantitative character of the provider admission standards; accordingly, standards for provider admission, including associated reimbursement rates to which a participating provider must agree, are to be evaluated in accordance with the rules for NQTLs.

A group health plan or issuer may consider a wide array of factors in designing medical management techniques for both MH/SUD benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these or other factors in a comparable fashion, an NQTL, such as prior authorization, may be required for some (but not all) MH/SUD benefits, as well as for some (but not all) medical/ surgical benefits. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4), Example 8.*

> ***NOTE*** – To comply with MHPAEA, a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network and out-of-network providers for both medical/surgical and MH/SUD benefits. For example, if reimbursement rates for medical/surgical benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule. Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, or market need or availability (demand) must be comparable and applied no more stringently to MH/SUD benefits than medical/surgical benefits.
>
> ***NOTE*** - Plans and issuers may attempt to address shortages in medical/surgical specialist providers and ensure reasonable patient wait times for appointments by adjusting provider admission standards, through increasing reimbursement rates, and by developing a process for accelerating enrollment in their networks to improve network adequacy. To comply with MHPAEA, plans and issuers must take measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers, even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan's network. The Departments note that substantially disparate results—for example, a network that includes far fewer MH/SUD providers than medical/surgical providers—are a red flag that a plan or issuer may be imposing an impermissible NQTL. *See FAQs Part 39, Q6 and Q7, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf.*

Warning Signs: The following plan provisions related to provider reimbursements may be indicative of noncompliance and warrant further review:

1. *Inequitable reimbursement rates established via a comparison to Medicare:* A plan or issuer generally pays at or near Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for medical/surgical benefits. For assistance comparing a plan or coverage's reimbursement schedule to Medicare, see the PROVIDER REIMBURSEMENT RATE WARNING SIGNS in Appendix II.

2. *Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes:* A plan or issuer reimburses psychiatrists, on average, less than medical/surgical physicians for the same E&M codes.

3. *Consideration of different sets of factors to establish reimbursement rates*: A plan or issuer generally considers market dynamics, supply and demand, and geographic location to set reimbursement rates for medical/surgical benefits, but considers only quality measures and treatment outcomes in setting reimbursement rates for MH/SUD benefits.

In order to determine compliance with MHPAEA, the following analysis should be applied to each NQTL identified under the plan or coverage:

Step One:

- Identify the NQTL.

Comments:

Identify in the plan documents all the services (both MH/SUD and medical/surgical) to which the NQTL applies in each classification.

NOTE: NQTLs may also be included in other documents, such as internal guidelines or provider contracts.

Compliance Tips

- Ask for information about what medical/surgical benefits are also subject to these requirements or restrictions.
- If a benefit includes multiple components (*e.g.*, outpatient and prescription drug classifications), and each component is subject to a different type of NQTL (*e.g.*, prior authorization and limits on treatment dosage or duration), each NQTL must be analyzed separately.
- Find out how these requirements are implemented, who makes the decisions, and what the decision-maker's qualifications are.

Determine which benefits are treated as medical/surgical and which are treated as MH/SUD, and analyze the NQTLs under each benefit classification. Plans and issuers should clearly define which benefits are treated as medical/surgical and which benefits are treated as MH/SUD under the plan. Benefits (such as inpatient treatment at a skilled nursing facility or other non-hospital facility and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

Compliance Tip

- Any separate NQTL that applies to only the MH/SUD benefits within any particular classification does not comply with MHPAEA.

NOTE: If a plan classifies covered intermediate levels of care, such as skilled nursing care and residential treatment, as inpatient benefits, and covers room and board for all inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction only on MH/SUD benefits and therefore violates MHPAEA.[1] The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment.

[1] See 29 CFR 2590.712(c)(iii) Ex. 9.

Step Two:

- Identify the factors considered in the design of the NQTL.

Comments:

Examples of factors include but are not limited to the following:

- Excessive utilization;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- Lack of adherence to quality standards;
- Claim types with high percentage of fraud; and
- Current and projected demand for services.

Compliance Tips

- If only certain benefits are subject to an NQTL, such as meeting a fail-first protocol or requiring preauthorization, plans and issuers should have information available to substantiate how the applicable factors were used to apply the specific NQTL to medical/surgical and MH/SUD benefits.
- Determine whether any factors were given more weight than others and the reason(s) for doing so, including evaluating the specific data used in the determination (if any).

Step Three:

- Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified above to design the NQTL.

Comments:

Examples of sources of factors include, but are not limited to, the following:

- Internal claims analysis;
- Medical expert reviews;
- State and federal requirements;
- National accreditation standards;
- Internal market and competitive analysis;
- Medicare physician fee schedules; and
- Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

If these factors are utilized, they must be applied comparably to MH/SUD and medical/surgical benefits.

NOTE: Plans and issuers have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ a particular source or evidentiary standard), as long as they are applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits. For example, a plan utilizes a panel of medical experts, with equivalent expertise in both medical/surgical and MH/SUD benefits, to assess whether preauthorization (an NQTL) is appropriate to apply to certain services, based on the factors of cost and safety. The panel recommends that the plan require preauthorization for electroconvulsive therapy (ECT), because ECT is high cost and its use presents legitimate safety concerns. The plan does not require documentation or studies to support these concerns and instead relies on established medical best practices. As long as the plan similarly relies on established medical best practices to define high cost, identify legitimate safety concerns, and impose preauthorization requirements on medical/surgical benefits in the same classification, then the NQTL is applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits.

Compliance Tips

- Evidentiary standards and processes that a plan or issuer relies upon may include any evidence that a plan or issuer considers in developing its medical management techniques, including recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials), and published research studies.
- If there is any variation in the application of a guideline or standard being relied upon by the plan or issuer, the plan or issuer should explain the process and factors relied upon for establishing that variation.
- If the plan or issuer relies on any experts, the plan or issuer should assess the experts' qualifications and the extent to which the expert evaluations in setting recommendations are ultimately relied upon regarding both MH/SUD and medical/surgical benefits.

NOTE: When identifying the sources of the factors considered in designing the NQTL, also identify any threshold at which each factor will implicate the NQTL. For example, if high cost is identified as a factor used in designing a prior authorization requirement, the threshold dollar amount at which prior authorization will be required for any service should also be identified. You may also wish to consider the following:

- What data, if any, are used to determine if the benefit is "high cost"?
- How, if at all, is the amount that is to be considered "high cost" or the calculation for determining that amount different for MH/SUD benefits as compared to medical/surgical benefits, and how is the difference justified?

Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to, the following:

- Excessive utilization as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care.
- Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased 10 percent or more per year for two years.
- Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30 percent of the time based on clinical chart reviews.
- High level of variation in length of stay may be considered as a factor when claims data shows that 25 percent of patients stayed longer than the median length of stay for acute hospital episodes of care.
- High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period.
- Lack of clinical efficacy may be considered as a factor when more than 50 percent

of outpatient episodes of care for specific diseases are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12-month sample of claims data.

Step Four:

- Are the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical/surgical benefits, both as written and in operation?

Comments:

Plans and issuers should demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD services and medical/surgical services.

Compliance Tips

- If utilization review is conducted by different entities or individuals for medical/surgical and MH/SUD benefits provided under the plan or coverage, ensure that there are measures in place to ensure comparable application of utilization review policies.
- Determine what consequences or penalties apply to the benefits when the NQTL requirement is not met.

These are examples of methods/analyses substantiating that factors, evidentiary standards, and processes are comparable:

- Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and medical/surgical benefits subject to the NQTL.
- Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL.
- A consistent methodology for analyzing which MH/SUD and medical/surgical benefits had “high cost variability” and were therefore subject to the NQTL.
- Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and medical/surgical benefits were the same, both as developed and applied.
- Internal Quality Control Reports showing that the factors, evidentiary standards, and processes regarding MH/SUD and medical/surgical benefits are comparable and no more stringently applied to MH/SUD benefits.

- Summaries of research or peer-reviewed medical journal articles, if considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was utilized similarly for both MH/SUD and medical/surgical benefits.

Compliance Tips

- Look for compliance as written **AND IN OPERATION**.
- Determine whether there are exception processes available and when they may be applied.
- Determine how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and medical/surgical benefits claims.
- Determine who makes denial determinations and if the decision-makers have comparable expertise with respect to MH/SUD and medical/surgical benefits.
- Check sample claims to determine whether a particular NQTL warrants additional review. A plan may have written processes that are compliant on their face, but those processes may not be compliant in practice.
- Determine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/surgical benefits.
- Document your analysis, as a best practice.

NOTE: While outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational MHPAEA parity noncompliance. For example, if a plan has a 34 percent denial rate on concurrent reviews of psychiatric hospital stays in a 12-month period and a 5 percent denial rate on concurrent review for medical hospital stays in that same 12-month period, the concurrent review process for both psychiatric and medical hospital stays should be carefully examined to ensure that the concurrent review standard is not being applied more stringently to MH/SUD benefits than to medical/surgical benefits in operation.

Warning Signs: The following plan provisions related to NQTLs may be indicative of noncompliance and warrant further review:

1. *Prior authorization for medication for opioid use disorder*: A plan or issuer imposes prior authorization for medications for opioid use disorder but does not require prior authorization for comparable medications for medical/surgical conditions.

2. *Different medical necessity review requirements*: A plan or issuer imposes medical necessity review requirements on outpatient MH/SUD benefits after a certain number of visits, despite permitting a greater number of visits before requiring any such review for outpatient medical/surgical benefits.

Compliance Tip

- **Do not focus solely on results.** Look at the **underlying processes and strategies** used in applying NQTLs. Are there arbitrary or discriminatory differences in how the plan or issuer is applying those processes and strategies to medical/surgical benefits versus MH/SUD benefits? While results alone are not determinative of noncompliance, measuring and evaluating results and quantitative outcomes can be helpful to identify potential areas of noncompliance.

SECTION G. DISCLOSURE REQUIREMENTS

Question 8. Does the group health plan or group or individual health insurance issuer comply with the MHPAEA disclosure requirements?

Comments:

- The plan administrator or health insurance issuer must make **available the criteria for medical necessity determinations** made under a group health plan or group or individual health insurance coverage with respect to MH/SUD benefits to any current or potential participant, beneficiary, enrollee, or contracting provider **upon request**. *See 29 CFR 2590.712(d)(1), 45 CFR 146.136 (d)(1).*

  The plan administrator (or health insurance issuer) must make available **the reason for any denial** under a group health plan or group or individual health insurance coverage of reimbursement or payment for services with respect to MH/SUD benefits to any participant, beneficiary, or enrollee, and may do so in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the DOL claims procedure rule) and 29 CFR 2590.715-2719 (internal claims and appeals and external review processes).

  - Pursuant to the internal claims and appeals and external review rules under the Affordable Care Act applicable to all non-grandfathered group health plans and to all non-grandfathered group and individual health insurance coverage, claims related to medical judgment (including MH/SUD) are eligible for external review. The **internal claims and appeals** rules include the right of claimants (or their authorized representatives) to be provided **upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits**. This includes documents with information about the **processes, strategies, evidentiary standards, and other factors used to apply an NQTL** with respect to medical/surgical benefits and MH/SUD benefits under the plan. *See 26 CFR 54.9812-1(d)(3), 29 CFR 2560.5301- 2590.712(d)(3), 45 CFR 146.136(d)(3), 147.136(b).*

- With respect to group health plans that are subject to ERISA, if coverage is denied based on medical necessity, **medical necessity criteria** for the MH/SUD benefits at issue and for medical/surgical benefits in the same classification must be provided **within 30 days of the request** to the participant, beneficiary, provider, or authorized representative of the beneficiary or participant. *See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).*

- If a plan or a plan administrator or health insurance issuer fails to provide these documents, a court may hold it liable for up to $110 a day from the date of failure to provide these documents. *See ERISA Sec. 502(c)(1).*

Compliance Tips

- The reasons for benefit denials include applicable medical necessity criteria as applied to that participant, beneficiary, or enrollee.
- Under ERISA, plans and issuers cannot refuse to disclose information necessary for the parity analysis on the basis that the information is proprietary or has commercial value.
- Under ERISA, plans and issuers can provide summary descriptions of the medical necessity criteria in a layperson's terms.

Make Showing Compliance Simple

Documents or Plan Instruments Participants and Beneficiaries or DOL may Request Include the following:

Under ERISA section 104(b), participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with MHPAEA, and copies must be furnished within 30 days of the request. These documents and plan instruments may include documentation that illustrates how the health plan has determined that any financial requirement, QTL, or NQTL complies with MHPAEA. For example, participants and beneficiaries may request the following:

- An analysis showing that the plan meets the predominant/substantially all tests. The plan may need to provide information regarding the amount of medical/surgical claims subject to a certain type of financial requirement, such as a co-payment, in the prior year for a classification or the plan's basis for calculating claims expected to be subject to a certain type of QTL in the current plan year for a classification, for purposes of determining the plan's compliance with the predominant/substantially all tests;
- A description of an applicable requirement or limitation, such as preauthorization or concurrent review, that the plan applies for MH/SUD benefits and medical/surgical benefits within the relevant classification (for example, in- or out-of-network, or in- or outpatient). These might include references to specific plan documents: for example provisions as stated on specified pages of the summary plan description (SPD), or other underlying guidelines or criteria not included in the SPD that the plan has consulted or relied upon;
- Information regarding factors, such as cost or recommended standards of care, that are relied upon by a plan for determining which medical/surgical or MH/SUD benefits are subject to a specific requirement or limitation. These might include references to specific related factors or guidelines, such as applicable utilization review criteria;
- A description of the applicable requirement or limitation that the plan believes has been used in any given MH/SUD service adverse benefit determination (ABD) within the relevant classification; and
- Medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.

Compliance Tips

- Find out how the plan administrator handles general information requests about coverage limitations as well as specific information or disclosure requests with respect to denied benefit claims.
- Review a sample of appeals files and examine what was disclosed to participants, including the criteria for medical necessity determinations and reasons for claim denials.
- Determine how long it took the plan or the plan administrator to furnish requested documents to participants.

As directed by the 21st Century Cures Act, and in response to comments received from the regulated community, the Departments continue to issue additional guidance regarding disclosures, in particular with respect to NQTLs. Based on requests from various stakeholders for model MHPAEA disclosure forms and for guidance on processes for requesting disclosures in a more uniform, streamlined, or otherwise simplified way, the Departments issued a model disclosure request form (available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template.pdf). For the most current version of the form please visit the DOL's dedicated MH/SUD parity webpage, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

This form can, but is not required to, be used to request MHPAEA-related information from group plans and group and individual health insurance issuers, including general information about coverage limitations or specific information that may have resulted in denial of MH/SUD benefit claims.

Compliance Tips

- Participants, beneficiaries, enrollees, dependents, and contracting providers may request information to determine whether benefits under a plan are being provided in parity even in the absence of any specific ABD.
- Group health plans may need to work with insurance issuers providing coverage on behalf of an insured group health plan or with third party administrators administering the plan to ensure that such service providers either directly or in coordination with the plan are providing participants and beneficiaries any documents or information to which they are entitled.
- If a group health plan or group or individual health insurance issuer uses MH/SUD vendors and carve-out service providers, the plan must ensure that all combinations of benefits comport with MHPAEA. Therefore, vendors and carve-out providers should provide documentation of the necessary information to the plan to ensure that all combinations of benefits comport with parity.

NOTE: Compliance with the disclosure requirements of MHPAEA is not determinative of compliance with any other provision of other applicable federal or state law. Be sure that the plan or issuer, in addition to these disclosure requirements, is disclosing all information relevant to medical/surgical, mental health, and substance use disorder benefits as required pursuant to other applicable provisions of law. For example, if a plan document states it covers benefits consistent with generally accepted standards of care (for both medical/surgical and MH/SUD benefits), and the plan has developed internal guidelines that are more restrictive than the generally accepted standards of care for both medical/surgical and MH/SUD benefits, the plan might comply with MHPAEA but fail to comply with Part 4 of ERISA, which requires that the plan be administered in accordance with its plan documents. Plans should be prepared to disclose their medical necessity criteria and should ensure that, to the extent the plan document specifies a specific treatment guideline, it follows that as well.

Compliance Tip

- Under ERISA, ERISA-covered plans must provide an SPD that describes plan provisions related to the use of network providers and describe the composition of the provider network (*i.e.*, a provider directory). The provider directory may be distributed as a separate document from the SPD and, in many circumstances, may be provided electronically. However, the provider directory must be up-to-date, accurate, and complete (using reasonable efforts). *See e.g., 29 CFR 2520.102-3; FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q10, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf; ERISA Secs. 102, 104, and 404(a).*

SECTION H. ESTABLISHING AN INTERNAL MHPAEA COMPLIANCE PLAN

Although not required by MHPAEA, an internal compliance plan that promotes the prevention, detection, and resolution of potential MHPAEA violations can help plans and issuers improve compliance with the law. Compliance plans for group health plans or issuers may differ, but many successful compliance plans share the following characteristics:

1. **Conducting effective training and education**. Successful compliance programs provide ongoing training and education to all individuals responsible for ensuring MHPAEA compliance, including those who are responsible for making decisions related to medical/surgical and MH/SUD benefits on behalf of the plan or issuer (such as claims reviewers). EBSA provides many educational materials, webcasts, and in-person compliance assistance events that may assist in these trainings and can also be made available to participants and beneficiaries to inform them of their parity protections under MHPAEA.[2]

2. **Ensuring retention of records and information.** ERISA Section 107 requires the retention of certain documents. These documents should be retained for at least six years after the Form 5500 for the relevant plan year has been filed.

3. **Conducting internal monitoring and compliance reviews on a regular basis.** A plan or issuer may monitor compliance on an ongoing basis by conducting internal reviews for potential non-compliance and identification of problem areas related to MHPAEA and by auditing samples of adverse benefit determinations to assess the application of medical necessity criteria, the level of detail provided to claimants, and the correctness of determinations. Plans and issuers may wish to establish an internal consumer ombudsmen program to assist participants and beneficiaries in navigating their benefits and for elevating complaints of noncompliance. Plans and issuers that delegate management of MH/SUD benefits to another entity should have clear protocols to ensure that the service providers for both medical/surgical and MH/SUD benefits provide documentation of the necessary information to the plan or issuer (and to the entity that adjudicates MH/SUD benefit claims, if necessary) to ensure that all combinations of benefits that a participant or beneficiary can elect comport with MHPAEA and to ensure that plans and issuers are able to comply with disclosure requirements.

4. **Responding promptly to detected offenses and developing corrective action.** If a plan or issuer discovers a violation of MHPAEA, it should take steps to correct the violation promptly, including providing retroactive relief and notice to potentially affected participants and beneficiaries. EBSA Benefits Advisors may be able to assist plans and issuers in voluntarily complying with MHPAEA. They can be contacted at (866) 444-3272.

[2] See https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

If a group health plan is audited by DOL investigators for MHPAEA compliance, DOL may ask for at least the following, among other items:

1. Plan materials related to the plan's compliance with MHPAEA, including the following:

    a) Information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the plan or coverage.

    b) Records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under state law. Such records may also be helpful to plans and issuers in responding to inquiries from participants, beneficiaries, enrollees, and dependents regarding benefits under the plan or coverage.

    c) Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer has relied upon as the basis for determining its compliance with the requirement that any NQTL applicable to MH/SUD benefits be comparable to and applied no more stringently than the NQTL as applied to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or issuer to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits. If the standards that are applied to MH/SUD benefits are more stringent than those in nationally recognized medical guidelines, but the standards that are applied to medical/surgical benefits are not, plans and issuers should include any applicable explanation of the reason(s) for the application of the more stringent standard for MH/SUD benefits.

    d) Samples of covered and denied MH/SUD and medical/surgical benefit claims.

    e) Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of MH/SUD benefits to another entity).

    f) Any applicable MHPAEA testing completed by the plan or the issuer for financial requirements or QTLs applied to MH/SUD benefits.

In addition to this Self-Compliance Tool, the National Association of Insurance Commissioners (NAIC) has developed tools (such as a Data Collection Tool, which includes a Non-Quantitative Treatment Limitations Chart) to assist issuers in evaluating MHPAEA compliance. For more information regarding NAIC compliance assistance efforts, please visit its website at https://content.naic.org/.

APPENDIX I: ADDITIONAL ILLUSTRATIONS

ILLUSTRATION 1: A Plan covers neuropsychological testing but excludes such testing for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing, for example, clinical efficacy of such testing for different conditions and the degree to which such testing is used for educational purposes with regard to different conditions. Does the plan rely on criteria and evidence from comparable sources with respect to medical/surgical and mental health conditions? Does the plan have documentation indicating the criteria used and evidence supporting the plan's determination of the diagnoses for which the plan will cover this service and the rationale for excluding certain diagnoses? The result may be that the plan permissibly covers neuropsychological testing for some medical/surgical or mental health conditions, but not for all.

Conclusion: This outcome may be permissible to the extent the plan has based the exclusion of this testing for certain conditions on clinical efficacy and/or other factors if the factors are designed and applied in a comparable manner with respect to the conditions for which testing is covered and those for which it is excluded.

ILLUSTRATION 2: A Plan uses diagnosis related group (DRG) codes in their standard utilization review process to actively manage hospitalization utilization. For all non-DRG hospitalizations (whether due to an underlying medical/surgical condition or a MH/SUD condition), the plan requires precertification for hospital admission and incremental concurrent review. The precertification and concurrent review processes review unique clinical presentation, condition severity, expected course of recovery, quality, and efficiency. The evidentiary standards and other factors used in the development of the concurrent review process are comparable across medical/surgical benefits and MH/SUD benefits, and are well documented. These evidentiary standards and other factors are available to participants and beneficiaries free of charge upon request.

Conclusion: In this example, it appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its precertification and concurrent review of hospitalizations are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

ILLUSTRATION 3: A Plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical conditions as inpatient benefits and likewise treats any covered care in residential treatment facilities for MH/SUD as an inpatient benefit. In addition, the plan treats home health care as an outpatient benefit and treats intensive outpatient and partial hospitalization for MH/SUD services as outpatient benefits.

Conclusion: In this example, the plan assigns covered intermediate MH/SUD benefits to the six classifications in the same way that it assigns comparable intermediate medical/surgical benefits to the classifications.

ILLUSTRATION 4: Master's degree training and state licensing requirements often vary among provider types. The plan consistently applies its standard that any provider must meet the most

stringent licensing requirement standard in the applicable state related to supervised clinical experience requirements in order to participate in the network. Therefore, the plan requires master's-level therapists to have post-degree, supervised clinical experience in order to join its provider network. There is no parallel requirement for master's-level general medical providers because their licensing requires supervised clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD level psychologists since their licensing already requires supervised training.

Conclusion: The requirement that master's-level therapists must have supervised clinical experience to join the network is permissible, as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers whose state licensing does not require this experience.

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

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

ILLUSTRATION 6: A plan imposes prior authorization for certain MH/SUD and medical/surgical services. The medical/surgical outpatient services that require prior authorization include habilitative and rehabilitative services such as physical therapy. Physical therapy services were selected for prior authorization because of findings that physical therapists' documentation of medical necessity is often inadequate. In addition, there has been an increase in litigation regarding physical therapy claims. Prior authorization is conducted telephonically and authorization determinations are reviewed by a physician in consultation with

a licensed physical therapist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of sessions authorized is tailored to the specific medical/surgical condition treated, consistent with generally accepted national clinical guidelines. Determinations to approve or deny coverage are made by physicians with consultation from a licensed physical therapist.

Psychological testing also requires prior authorization. Psychological testing was selected for prior authorization because of recent Medicare fraud schemes and consistent with the Medicare Improper Payment Reports, which found improper payments with respect to psychological testing claims because of inadequate documentation from psychologists. Prior authorization is conducted telephonically and reviewed by a licensed psychologist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of hours authorized for psychological testing are tailored to the age of the client and type of evaluation requested and range from two to five hours for an average evaluation (on the basis of the average number of hours for evaluation as included in generally accepted national clinical guidelines). Determinations to approve or deny coverage are made by licensed psychologists with at least five years of experience in psychological testing.

Conclusion: In this example, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its preauthorization requirements, particularly the use of prior authorization to detect fraud and abuse, are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

APPENDIX II:

PROVIDER REIMBURSEMENT RATE WARNING SIGNS

The Departments have noted that, while outcomes are not determinative of a MHPAEA violation, they can often serve as red flags or warning signs to alert the plan or issuer that a particular provision may warrant further review. With respect to provider reimbursement, comparing a plan or issuer's average reimbursement rates for both medical/surgical and MH/SUD providers against an external benchmark of reimbursement rates, such as Medicare, may help identify whether the underlying methodology used to determine the plan's or issuer's reimbursement rates warrants additional review for compliance with MHPAEA. Furthermore, evaluating how medical/surgical and MH/SUD providers are reimbursed for the same or similar services may also help a plan or issuer determine if the plan's or issuer's underlying methodology for provider reimbursement warrants further review.

Accordingly, the following framework for comparison may assist plans and issuers in identifying information they might consider when comparing reimbursement rates for certain MH/SUD and medical/surgical services based on Current Procedural Terminology (CPT) codes. This is not the only framework for analyzing provider reimbursement rates, and it is not determinative of compliance. This framework utilizes Medicare reimbursement rates as its benchmark for comparison. If a plan's or issuer's comparison of reimbursement rates indicates that the reimbursement rate is lower for MH/SUD providers, either as compared to medical/surgical providers or as compared to an external benchmark, such as Medicare, the plan or issuer should consider further review to ensure that the processes, strategies, evidentiary standards, and other factors used with respect to provider reimbursement for MH/SUD benefits are comparable to, and applied no more stringently than, those used with respect to provider reimbursement for medical/surgical benefits. Please see Section F. Nonquantitative Treatment Limitations for information on how to further evaluate provider reimbursement rates for compliance with MHPAEA.

Specialty	CPT Code	Average Plan rate for [insert locality]	Medicare rate for [insert locality]	Plan rate as a percentage of Medicare
Orthopedic Surgery	99203 99213	$ xx.xx $	$ xx.xx $	xx.x%
Cardiologists	99203 99213	$ $	$ $	
Internists MD	99203 99213	$ $	$ $	
Endocrinologists	99203 99213	$ $	$ $	
Gastroenterologist	99203 99213	$ $	$ $	

Specialty	CPT Code	Average Plan rate for [insert locality]	Medicare rate for [insert locality]	Plan rate as a percentage of Medicare
Neurologists	99203 99213	$ $	$ $	
Pediatrician	99203 99213	$ $	$ $	
Dermatologists	99203 99213	$ $	$ $	
Psychiatrists	99203 99213	$ $	$ $	
Psychologists	90832 (based on 1 hr) 90791 (based on ½ hour)	$ $	$ $	
LCSW	90832 (based on 1 hr) 90791 (based on ½ hour)	$ $	$ $	
Podiatrists	99203 99213	$ $	$ $	
Chiropractor	99203 99213	$ $	$ $	
Occupational Therapy	97165 97166 97167 97168	$ $	$ $	
Physical Therapy	97161 97162 97163 97164	$ $	$ $	
Speech Therapy	Initial Office Visit Codes do not exist. Analysis of specific tests or follow- up may be useful to consider.			

Attachment 4
No Surprises Act

New Protections for Consumers

If you receive care from an out-of-network provider or facility, your health plan may not cover the entire cost. As a result, you may be left with higher costs than if you received care from an in-network provider or facility. In the past, in addition to any out-of-network cost sharing you may owe, the out-of-network provider or facility could bill you for the part of the bill that your health plan did not pay, resulting in a balance bill. An unexpected balance bill from an out-of-network provider or facility is also called a surprise medical bill.

Starting in January 2022, new rules went into effect to protect you from surprise medical bills. These rules are sometimes called the "No Surprises" rules. These rules:

- Ban surprise medical bills for emergency services, even if you get them out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for all emergency and some non-emergency services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for supplemental care (like anesthesiology or radiology) by out-of-network providers who work at an in-network facility.
- Require that health care providers and facilities give you an easy-to-understand notice explaining that getting care out-of-network could be more expensive and options to avoid balance bills. You're not required to sign this notice or get care out-of-network.

Also starting in January 2022, if you think your health plan's decision to not pay part or all of a claim violates the new surprise billing protections, you can appeal that decision. You can use the external review process described in your plan documents and denial notices to request the external review of your plan's decision.

If you have a question about these new rules or believe the rules are not being followed, contact the "No Surprises" Help Desk at 1-800-985-3059 or submit a complaint online at https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

Attachment 5

IDOI ACA Checklist and Attestations for Plan Year 2023

This document is a checklist of steps carriers need to take to avoid common mistakes. Please click on each checkbox to indicate that the appropriate verification has been done. Then, please type your name, title, and date. This list is not exhaustive.

Notation: Throughout this document PY will represent the Plan Year, which is the year the plans being filed will be used by policy holders. Also, PY-1 will represent the year preceding PY.

IDOI Rate and Crosswalk Template (IDOI RCT)

Template Changes: The name of the crosswalk tab has been changed to "Crosswalk".

Attestations:

- ☐ All plans that were approved in PY-1 are listed and crosswalked to plans being offered in PY.

  If applicable, we will no longer be offering plans in the following counties:

  _____
  _____
  _____
  _____

- ☐ All fields for the PY columns are completed.
- ☐ The Service Area IDs and Network IDs associated with each plan are consistent with the Plans tab of the IDOI EHB Verification Template.
- ☐ The counties associated with the Service Area IDs in the IDOI RCT are consistent with the counties associated with the Service Area IDs in the Service Area template.
- ☐ The HIOS Plan IDs listed in the IDOI RCT for PY match the Standard Component IDs listed on the Plans tab of the Binder.
- ☐ No previously terminated HIOS Plan IDs are being reused for PY.

IDOI EHB Verification Template (IDOI EHB VT)

Template Changes: The instructions on the Product Comparison tab were updated to make it clearer that different products are expected to display what differentiates them from all the carrier's other products on the Product Comparison tab.

The MHPAEA Instructions tab was updated to state that cost-sharing for Outpatient Office Visits must trivially pass parity review by requiring the cost-sharing type (copay/coinsurance) used for medical/surgical and mental health/substance use disorder outpatient office visits to be the same.

Attestations:

- *Benchmark Benefits Package*
  - ☐ The Benchmark Benefits Package tab has been thoroughly reviewed. Any corrections, clarifications, exclusions, benefit explanations, or additions that apply to most of our products have been entered in red on this tab.
- *Product Comparison*
  - ☐ All plans under at least one product cover morbid obesity. The forms for products that cover morbid obesity show the coverage without any bracketing. (Small group carriers that only have a single product are expected to cover morbid obesity on all their plans.)
  - ☐ Each product is clearly differentiated from all other products by the benefits or plan type.
  - ☐ Each product has its own Summary of Benefits in the filing.
- *Plans*
  - ☐ All fields (except possibly the Issuer Actuarial Value field) are completed.
- *MHPAEA*
  - ☐ All plans that do not have a financial requirement type that applies to substantially all medical/surgical benefits under a classification (sub-classification for office visits) do not charge any cost sharing for mental health/substance use disorder benefits in that (sub-)classification.
  - ☐ We understand that Indiana requires carriers to sub-classify Outpatient Office Visits and requires that the cost-sharing requirement type (i.e., Copay/Coinsurance) is the same for medical/surgical outpatient office visits as for mental health/substance use disorder outpatient office visits. (This is required to make the demonstration of the parity of coverage for outpatient office visits straight-forward. Only plan designs that are clearly compliant with parity for outpatient office visits will be approved. [Example: A plan requires a $10 copay and 20% coinsurance for medical/surgical office visits. Then the maximum copay and coinsurance for mental health/substance use disorder office visits would be $10 and 20% respectively.])

Plans and Benefits Template (PBT)

Attestations:

- ☐ We will only include the following language on Benefits Package tabs if it is indicative of our plan design.
  - "No Copayment/Coinsurance will apply to orally administered cancer chemotherapy when obtained from a Network Pharmacy, Mail Service Program, or Specialty Pharmacy Network."

Federal Review Tools

Attestations:

- ☐ We have run the review tools available at https://www.qhpcertification.cms.gov/s/Review%20Tools.

IDOI Clinical Appropriateness Tool

Attestations:

☐ Our formularies pass the IDOI Clinical Appropriateness Tool review. (This tool is available at https://www.in.gov/idoi/compliance-rates-and-forms/accident-and-health-rate-filing-and-plan-management-binder-information-and-instructions/).

ECP/Network Adequacy Template (NAT)

Attestations:

☐ The Counties listed on the "Facilities&Pharmacies" and "IndividualProviders" tabs have been checked and are accurate. (Keep in mind that many zip codes overlap several counties and so assigning a county based on the zip code rather than the address will lead to inaccurate results.)

SERFF Filing and Binder Contact Info

Attestations:

☐ The contact information provided in the Filing and Binder sections of SERFF is up to date.

Attestation

I certify that the statements indicated above are correct and accurate.

Name:_____

Title: _____

Date:_____