MHPAEA QUESTIONNAIRE

The purpose of this questionnaire is to gather information to determine compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) found at 42 U.S.C. 300gg-26 and its implementing regulations found at 45 CFR §146.136 and 45 CFR §147.160, and is to be used for plans that offer mental health and/or substance use disorder benefits.

Generally, MHPAEA regulations require that any financial requirement (FR) (e.g.. copayments, deductibles, coinsurance, or out-of-pocket maximums) or quantitative treatment limitation (QTL) (e.g., day or visit limits) imposed on mental health and substance use disorder (MH/SUD) benefits not be more restrictive than the predominant financial requirement or treatment limitation of that type that applies to substantially all medical and surgical benefits, on a classification-by-classification basis, as discussed below. With regard to any nonquantitative treatment limitation (NQTL) (e.g., preauthorization requirements, fail-first requirements), MHPAEA regulations prohibit imposing an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical (M/S) benefits in the same classification.

MHPAEA applies to major medical group and individual health insurance. Mental health and substance use disorder treatment are essential health benefits under the Patient Protection and Affordable Care Act, so examination of individual and small group ACA-compliant plans will include parity analysis. In the large group market, an insurer's plan is not required to cover mental health and/or substance use disorder services under federal law. However, all group and individual health insurance coverage subject to § 38.2-3412.1 of the Code of Virginia, except grandfathered small group coverage, is required to provide mental health and substance use disorder benefits in parity with medical and surgical benefits in accordance with MHPAEA. MHPAEA does not apply to excepted benefit plans, nor to short-term limited duration insurance.

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group, and large group insurance markets.

FOR EACH OF THE SELECTED PLANS, PLEASE COMPLETE A SEPARATE QUESTIONNAIRE, QTL DATA COLLECTION TOOL, AND NQTL DATA COLLECTION TOOL. IF THE SAME NQTLS ARE APPLIED IN THE SAME MANNER TO EACH OF THE SELECTED PLANS, THE COMPANY MAY COMPLETE ONE NQTL DATA COLLECTION TOOL AND LIST ALL OF THE APPLICABLE PLANS IN THE FIRST WORKSHEET/TAB.

WHILE THE BUREAU OF INSURANCE IS ONLY REQUESTING THIS DOCUMENTATION FOR THE SELECTED PLANS AT THIS TIME, PLEASE BE ADVISED THAT THE COMPANY SHOULD BE PERFORMING THE ANALYSIS SET FORTH IN THESE DOCUMENTS FOR ALL PLANS IN EFFECT IN THE INDIVIDUAL, SMALL GROUP, AND LARGE GROUP MARKETS TO ENSURE COMPLIANCE WITH MHPAEA.

LIST OF QUESTIONS

Question 1.

Is this insurance coverage exempt from MHPAEA (45 CFR §146.136(f))? If so, please indicate the reason (e.g., retiree-only plan, excepted benefits (45 CFR §146.145(b)), short term, limited duration insurance,* small employer exemption (45 CFR §146.136(f)), increased cost exemption (45 CFR §146.136(g)).

IF THE COVERAGE IS EXEMPT, DO NOT COMPLETE ANY ADDITIONAL QUESTIONS IN THIS QUESTIONNAIRE.

**Under the Public Health Services Act (as added by HIPAA), short term limited duration insurance is excluded from the definition of individual health insurance coverage (45 CFR. §144.103).*

Question 2.

Are all conditions that are defined as being or as not being a mental health condition, a substance use disorder or a medical condition defined in a manner that is consistent with generally recognized independent standards of current medical practice?

Explain whether the company defines autism spectrum disorders as medical conditions or as mental health conditions and provide the basis for this determination. Are all benefits provided for autism spectrum disorders provided as mental health benefits, medical/surgical benefits, or a combination? If combination, please describe.

Are benefits for Applied Behavior Analysis (ABA) covered? If so, please describe any limitations imposed.

See 45 CFR §146.136(a). This section provides definition of "mental health benefits" and "substance use disorder benefits".

Question 3.

Does the insurance coverage provide MH/SUD benefits in every classification in which M/S benefits are provided?

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 45 CFR §146.136(c)(2)(ii).
Because parity analysis for this standard is at the classification level, data must be collected for each classification.

Question 4.

If the plan includes multiple tiers in its prescription drug formulary, are the tier classifications based on reasonable factors (such as cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up) determined in accordance with the rules for NQTLs at 45 CFR §146.136(c)(4)(i), and without regard to whether the drug is generally prescribed for MH/SUD or M/S benefits? Explain how the plan's tiering methodology for MH/SUD prescription drugs is comparable to and are applied no more stringently than the tiering methodology for M/S prescription drugs.

In addition, identify any financial requirements/QTLs applied to pharmacy benefits and explain/document how the application to MH/SUD benefits complies with MHPAEA.

See 45 CFR §146.136(c)(3)(iii)(A).

Question 5.

If the plan includes multiple network tiers of in-network providers, is the tiering based on reasonable factors (such as quality, performance, and market standards) determined in accordance with the rules for NQTLs at 45 CFR §146.136(c)(4)(i), and without regard to whether a provider provides services with respect to MH/SUD benefits or M/S benefits? Explain how the plan's tiering methodology for MH/SUD network tiers are comparable to and are applied no more stringently than the tiering methodology for M/S network tiers.

See 45 CFR §146.136(c)(3)(iii)(B).

Question 6.

Does the plan comply with the parity requirements for aggregate lifetime and annual dollar limits, including the prohibition on lifetime dollar limits or annual dollar limits for MH/SUD benefits that are lower than the lifetime or annual dollar limits imposed on M/S benefits? List the services subject to lifetime or annual limits, separated into MH/SUD and M/S benefits.

In addition, explain/document how the application of aggregate lifetime and annual dollar limits complies with MHPAEA to include any applicable calculations and expected claim dollar amounts.

See 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 M/S benefits, or it includes one that applies to less than one-third of all M/S benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. 45 CFR §146.136(b)(2). Also note that the parity requirements regarding lifetime and annual dollar limits only apply to the provision of MH/SUD benefits that are not EHBs because lifetime limits and annual dollar limits are prohibited for EHBs, including MH/SUD services.

Question 7.

Does the plan impose any financial requirements (e.g., deductibles, copayments, coinsurance, and out-of-pocket maximums) or quantitative treatment limitations (e.g., annual, episode, and lifetime day and visit limits) on MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type that applies to substantially all M/S benefits in the same classification? Demonstrate compliance with this standard by completing the attached data collection tool.

See 45 CFR §146.136(c)(2). Because parity analysis is at the classification level and analysis is based on the dollar amount for expected benefits paid, data must be collected per classification. A data collection tool is provided, which collects information needed to answer this question.

Financial Requirements (FRs) include deductibles, copayments, coinsurance, and out-of-pocket maximums. 45 CFR §146.136(c)(1)(ii). Quantitative Treatment Limitations (QTLs) include annual, episode, and lifetime day and visit limits, such as number of treatments, visits, or days of coverage. 45 CFR §146.136(c)(1)(ii).

Question 8.

Please provide a chart listing the type and level of all financial requirements/QTLs applied to MH/SUD benefits in each classification.

Question 9.

Does the plan 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 M/S benefits in the same classification? Demonstrate compliance with this standard by completing the attached data collection tool.

See 45 CFR §146.136(c)(3)(v). For example, a plan may not impose an annual $250 deductible on M/S 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 those two terms are excluded from the meaning of financial requirements). 45 CFR §146.136(a).

Cumulative financial requirements and treatment limitations are also subject to the predominant and substantially all tests in Question 7.

Question 10.

Does the plan impose Non-Quantitative Treatment Limitations (NQTLs) on MH/SUD benefits in any classification? If so, demonstrate compliance with parity requirements by completing the attached data collection tool.

Please include any applicable plan documents.

Examples of NQTLs (not exclusive):

a) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

b) Prior authorization and ongoing authorization requirements;

c) Concurrent review standards;

d) Formulary design for prescription drugs;

e) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

f) Standards for provider admission to participate in a network, including reimbursement rates;

g) Plan or insurer's methods for determining usual, customary and reasonable charges;

h) 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);

i) Restrictions on applicable provider billing codes;

j) Standards for providing access to out-of-network providers;

k) Exclusions based on failure to complete a course of treatment;

l) 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; and

m) Any other non-numerical limitation on MH/SUD benefits.

Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

See 45 CFR §146.136(c)(4) and pages 14-20 of the Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/out-activities/resource-center/publications/compliance-guide-appendix-a-mhpaea.pdf.

Question 11.

Does the insurer comply with MHPAEA disclosure requirements including (1) criteria for medical necessity determinations for MH/SUD benefits, and (2) the reasons for any denial?

Explain/document how the insurer complies.

See 45 CFR §146.136(d)(1) and (2).
Note that the state's grievance procedure and external review statutes may contain additional disclosure requirements.