

Review Requirements Checklist
MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS PARITY

NOTICE: A health insurance product form filing submission must include: (i) a product-specific checklist, (ii) a mental health and substance use disorder benefits parity checklist, (iii) the essential health benefits (EHB) checklist for the individual and small group markets; and (iv) the supplemental pediatric dental EHB checklist (for embedded pediatric dental products complying with EHB in the individual and small group markets). Each required checklist must be completed in its entirety. The failure to submit a completed checklist will result in a delay of the review of the submission, and may result in the rejection of the filing.

This document is intended to assist carriers in preparing form filings for approval by the Bureau of Insurance. It provides guidance based on current Virginia laws and regulations. It should be noted, however, that this checklist should not be used exclusive of other important resources, including, but not limited to, any and all other applicable state insurance laws and associated rules and regulations. It is the responsibility of the carriers to verify that their products and plans comply with all relevant statutory and regulatory requirements.

The Life and Health Division, Forms Section will review submissions based on the requirements noted in this checklist. Please contact this Section at (804) 371-9110 if you have questions or need additional information about these requirements.

Identify and explain in the checklist on page 4 the location in the filing of the form provisions that address Virginia requirements relating to the coverage of mental health and substance use disorder benefits, as required in accordance with Virginia Code §§ 38.2-3412.1 and 38.2-3451 that incorporate federal requirements, including the Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA); Federal Register / Vol. 78 , No. 219. Refer to the explanations below for information relating to each of the specific review requirements.

Review Criteria

Determining Parity:

Mental Health/Substance Use Disorder (MH/SUD) benefits must be provided in parity with Medical/Surgical (Med/Surg) benefits.

- Definition of Mental Health Conditions – must be consistent with generally recognized independent standards of current medical practice.
- Any condition defined as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice.
- Definition of Substance Use Disorders – must be consistent with generally recognized independent standards of current medical practice.
- Any condition defined as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice.

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Financial and Quantitative Requirements:

Classifications

- Inpatient, In-network
- Inpatient, Out-of-network
- Outpatient, In-network
- Outpatient, Out-of-network
- Emergency Services
- Prescription Drugs

Requirements

- MH/SUD benefits must be provided in every classification in which Med/Surg benefits are provided.
- Copays, coinsurance, deductible and out-of-pocket maximums for MH/SUD benefits must be no more restrictive than the predominant* copay, coinsurance, deductible, or out-of-pocket maximum for substantially all** Med/Surg benefits in the same classification.
- Must not have separate deductible or out-of-pocket maximum for MH/SUD benefits and Med/Surg benefits.
- No annual or lifetime dollar limits if EHB. For non-EHB, aggregate lifetime dollar limits and annual dollar limits no more restrictive for MH/SUD benefits than the predominant* annual or lifetime dollar limit for substantially all** non-EHB Med/Surg benefits.
- Visit/day/supply limits for MH/SUD benefits no more restrictive than the predominant* visit/day/supply limits for substantially all** Med/Surg benefits in the same classification.
- If different levels of copay, coinsurance, deductible, out-of-pocket maximum or day/visit limits are applied to individual vs. family coverage, the predominant level that applies to substantially all** Med/Surg benefits in the classification must be determined separately for individual vs. family coverage.
- The applicable Out-of-network classification is to be used for plans with no network or for a plan that provides out-of-network benefits.
- If the plan provides Med/Surg benefits using multiple in-network tiers, such as a tier of preferred providers, the plan may establish sub-classifications under MHPAEA reflecting the network tiers based on reasonable factors such as quality, performance, and market standards. Once sub-classifications are established, copays, coinsurance, deductible and out-of-pocket maximums for MH/SUD benefits must be no more restrictive than the predominant* copay, coinsurance, deductible, or out-of-pocket maximum for substantially all** Med/Surg benefits in the sub-classification.
- The plan may divide the Outpatient, In-network or Outpatient, Out-of-network classifications into sub-classifications of (i) office visit (physician charges) and (ii) all other outpatient services (outpatient surgery charges, facility charges for day treatments, lab charges, medical items). Other divisions such as generalists/specialists are not permitted.
- For tiered prescription drug plans, level of copay, coinsurance, deductible, out-of-pocket maximum, or supply must be determined based on reasonable factors, and without regard to whether the RX is generally prescribed for Med/Surg or MH/SUD benefits. Reasonable factors include cost, efficacy, generic vs. brand name, and mail order vs. retail.
- Benefits for intermediate levels of services (skilled nursing, home health, residential treatment for substance use disorders) must be consistent between MH/SUD benefits and Med/Surg benefits and placed in the same classification.

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*** Predominant = The level of copay, coinsurance, deductible, out-of-pocket maximum, or day/visit limit that applies to more than one-half (1/2) of the Med/Surg benefits in the classification for which “substantially all” of the Med/Surg benefits in the classification use that type of copay, coinsurance, deductible, out-of-pocket maximum, or day/visit limit.**

**** Substantially All = At least two-thirds (2/3) of all Med/Surg benefits in a classification use this type of copay, coinsurance, deductible, out-of-pocket maximum, or day/visit limit.**

Nonquantitative Treatment Limitations

It is not required that the same nonquantitative treatment limitations (NQTLs) are used for MH/SUD benefits as for Med/Surg benefits. However, processes, strategies, evidentiary standards and other factors, used to determine when a MH/SUD benefit is subject to an NQTL must be comparable to and not more stringent than those used for Med/Surg benefits in each classification. Also, an NQTL must not be designed to restrict access to MH/SUD benefits.

Examples of NQTLs:

- Medical Necessity/Appropriateness, including pre-certification and pre-authorization;
- In- and out-of-network geographic limits;
- Experimental treatment limits;
- Step therapy protocols;
- Methods for determining UCR;
- Network adequacy;
- Standards for accepting participating providers into the network, including reimbursement rates;
- Network tier design; and
- Restrictions based on geographic location, facility type, provider specialty and other criteria limiting the extent of plan benefits.

MH/SUD NQTLs must not exist when there is no comparable requirement applicable to Med/Surg benefits, such as:

- A requirement for an exhaustion of benefits under an Employee Assistance Program;
- Limits on inpatient services when the enrollee is a threat to self or others;
- Exclusions for court-ordered and involuntary holds; and
- Pre-certification or pre-authorization for all MH/SUD benefits when pre-authorization is only required for inpatient Med/Surg benefits.

Plan Information

The criteria for MH/SUD benefit determinations must be made available upon request to any current or prospective enrollee or contracting provider. Must disclose within 30 days of request medical necessity criteria for Med/Surg and MH/SUD benefits, and information used to apply any nonquantitative treatment limitation under the plan.

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