School District of Osceola County

Mental Health Parity Report

2022 Plan Year

Claims Data – Incurred & Paid (1/1/2022-12/31/2022)

Prepared by

Windsor Strategy Partners

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September 19, 2023

UPDATED October 31, 2023

Contents

Introduction

The purpose of this analysis is to demonstrate whether the School District of Osceola County is in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and additional related requirements under the Employee Retirement Income Security Act (ERISA). MHPAEA, as a federal law, set minimum standards for groups with respect to parity requirements; it generally requires that group health plans and health insurance issuers offering group or individual 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 the parity part of the Act.

The Department of Labor's Self-Compliance Tool for MHPAEA establishes eight questions that, if answered in the affirmative, would demonstrate that Osceola School District is in compliance with the law. Absent any additional guidance, this analysis will answer the eight questions and then make a determination as to whether compliance has been met.

Scope: Windsor Strategy Partners (WSP) was engaged to determine whether the School District of Osceola County complies with the Mental Health Parity and Addiction Equity Act.

Windsor Strategy Partners is a leading healthcare actuarial consulting firm headquartered in Princeton, New Jersey. The company, founded by David Wilson, began operations April 1, 2004. The company remains privately held.

WSP's staff consists of healthcare actuaries, healthcare data analysts, underwriters, management consultants and support staff. We have employees in California, Nevada, Pennsylvania, New Jersey, New Hampshire, Delaware, and Florida.

Our clients are risk takers involved in all aspects of healthcare financing. Our clients include reinsurers, insurers, HMOs, government agencies, managing general underwriters, multiple employer welfare associations, self-funded health plans, healthcare provider organizations and captive insurance companies. Additionally, our services are available for employers looking for complete and impartial analysis on all aspects of health plans.

Our staffing model is somewhat unique in that most of our consulting staff have had senior leadership roles in healthcare risk takers. As an organization we understand risk. Risk is our business. More about our firm can be found at wspactuaries.com.

Summary of Results

In our opinion the School District of Osceola County is **not in compliance** with the MHPAEA because it does not pass Question 7 of the Department of Labor's Self-Compliance Tool.

A detailed answer to each question can be found below. The questions are broken into seven sections: applicability, coverage in all classifications, lifetime and annual limits, financial requirements and quantitative treatment limitations, cumulative financial requirements, and treatment limitations, nonquantitative treatment limitations, and disclosure requirements.

UPDATE: The plan has made changes to the plan design to account for the NQTL deficiencies found in Question 7. Based on these changes, in my opinion, the plan would be compliant with Question 7 of the Self-Compliance tool. We are still waiting for plan year data to test Questions 5 and 8, after which we can complete the analysis.

Data Provided

1. A request was made for the School District of Osceola County's incurred and paid claims data between January 1, 2022 and December 31, 2022. This included a detailed report with Claim Policy Number, Place of Service, Place of Service Description, Procedure Type, Procedure Code, Procedure Description, In/Out of Network Indicator, Billed Amount, Allowed Amount, Coinsurance Amount, Copay Amount, Deductible Amount, Plan Payment Amount, etc. The data was unworkable in the format it was presented in. After numerous attempts at salvaging the data, we determined that it was unusable, unreliable and would lead to problematic or potentially inaccurate conclusions.
    a. The same data request has been made to a different data vendor. Once the data has been received and reviewed for reasonableness, we will complete the data portion of the self-compliance tool. We decided that it was more important to publish results rather than wait for perfect data. We do not believe that the results will change based on data, however, it will be necessary for future evaluations for the group to be in compliance.
2. Plan Documents for the medical plan

Notes and assumptions:

1. To answer questions 5-8, the data would be broken into Mental Health versus Non-Mental Health claims. Mental Health claims will be determined by the following revenue codes:

Inpatient MH/BH/SA Codes	
hcfa_plc_srv_cd	revenue_cd
55	0100
56	0100
21	0114
21	0124
22	0124
55	0124
56	0124
99	0124
21	0126
55	0126
56	0126
56	0128

52	0129
55	0129
56	0129
61	0134
21	0204
61	0206
51	1001
51	1000
51	1002
21	1001
21	1000
21	1002
61	1001
61	1000
61	1002
51	0124
55	0116
55	0156
56	0116
22	0126
52	0126
99	0126
57	0128
21	0134
56	0138
21	0154
21	DG883
21	DG896
21	DG897
22	DG897

Outpatient MH/BH/SA Codes	
hcfa_plc_srv_cd	revenue_cd
11	0900
11	0905
11	0906
11	0912
11	0914
11	0915

11	0916
21	0900
22	0900
22	0901
22	0905
22	0906
22	0911
22	0912
22	0913
22	0914
22	0915
22	0916
22	0918
22	0919
22	0944
22	0945
22	0961
23	0900
23	0911
23	0914
52	0905
52	0912
52	0913
52	0916
62	0911
62	0918
65	0900
65	0914
99	0900
99	0914
61	0900
19	0905
19	0906
19	1002
55	0961
55	1002

2. The Place of Service (POS) definitions are:

hcfa_plc_srv_cd	POS Description
01	Pharmacy **
02	Telehealth
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home *
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Off Campus-Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	On Campus-Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance – Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility-Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities

55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
58	Non-residential Opioid Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

Reliance on Data:

WSP is relying on plan designs and claims data supplied by the Osceola School district. The plan design information looks to be in good order (visual inspection – not audited). The claims data had some difficulties as mentioned above in the Data Provided section.

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).

Answer: Because the School District provides MH/SUD benefits to more than 50 employees, it is not exempt from MHPAEA.

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?

Answer: Yes, the health insurance coverage provides MH/SUD benefits.

From the plan document (Page 99), Mental Health and Substance Abuse Benefits are defined as:

> Benefits are available for Inpatient or Outpatient care for mental health and Substance Abuse conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider. Rehabilitation facilities will include all defined accreditations as shown in the Definitions section of this Plan as well as any facilities approved by the Plan. Benefits are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

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?

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.

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

1) inpatient, in-network

Plan	**Inpatient; In-Network**	**Compliant?**
Healthy Essentials	Deductible then 30% coinsurance	Yes – MH/SUD benefits same as Med/Surg
Healthy Advantage Plus	Deductible then 25% coinsurance	Yes – MH/SUD benefits same as Med/Surg

2) inpatient, out-of-network

Plan	**Inpatient; Out-of-Network**	**Compliant?**
Healthy Essentials	Deductible then 30% coinsurance	Yes – MH/SUD benefits same as Med/Surg
Healthy Advantage Plus	Deductible then 25% coinsurance	Yes – MH/SUD benefits same as Med/Surg

3) outpatient, in-network

Plan	**Outpatient; In-Network**	**Compliant?**
Healthy Essentials	Deductible then 30% coinsurance	Yes – MH/SUD benefits same or richer as Med/Surg
Healthy Advantage Plus	Deductible then 25% coinsurance	Yes – MH/SUD benefits same as Med/Surg

4) outpatient, out-of-network:

Plan	**Outpatient; Out-of-Network**	**Compliant?**
Healthy Essentials	Deductible then 30% coinsurance	Yes – MH/SUD benefits same as Med/Surg
Healthy Advantage Plus	Deductible then 25% coinsurance	Yes – MH/SUD benefits same as Med/Surg

5) emergency care

Plan	**Inpatient; In-Network**	**Compliant?**
Healthy Essentials	Deductible then 30% coinsurance	Yes – MH/SUD benefits same as Med/Surg
Healthy Advantage Plus	Deductible then 25% coinsurance	Yes – MH/SUD benefits same as Med/Surg

6) prescription drugs

Plan covers prescription drugs with no indication of limiting availability of mental health and/or substance use disorder drugs relative to non-MH/SD drugs.

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?

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.

Answer: There is no mention of annual or lifetime maximums; these are assumed to be unlimited.

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?

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.

Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums.

Types of QTLs include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage.

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

  The prevailing financial requirement is deductible and coinsurance based on the Copay, Deductible, and Coinsurance amounts paid.

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.

- 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.
- 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.
- 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.

Answer: Because there is only one reimbursement structure, deductible and coinsurance, mental health and substance abuse services and medical/surgical are subject to the same quantitative treatment limitations. The School District of Osceola County is compliant with Question 5 of the Mental Health Parity Self-Assessment Tool. When we receive appropriate data, we will demonstrate this in a series of tables.

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?

- 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.
- 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).
- 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.

Answer: The plan document does not place any treatment limitations or financial limitations on mental health and/or substance use disorder benefits. Therefore, the plan is in compliance with Question 6 of the MHPAEA.

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?

• 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.

• 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.

Answer: There are pre-certification requirements for Applied Behavioral Analysis (ABA), Intensive Outpatient Treatment (Mental Health/Substance Abuse), and Partial Hospitalizations (Mental Health/Substance Abuse). Because the plan requires pre-certification for these MH/SUD benefits, it is my opinion that it is not in compliance with Question 7 of the Mental Health Parity. Removing the pre-certification requirement for these benefits may lead to the plan being in compliance with the Nonquantitative Treatment Limitation section of the self-compliance tool.

UPDATE: The School District of Osceola County removed the pre-certification requirements for ABA Therapy, Intensive Outpatient Treatment (Mental Health/Substance Abuse), and Partial Hospitalizations (Mental Health/Substance Abuse) from the Summary Plan Document for the Health Services Plan. A copy of the formal response from the school district can be found in Appendix B of this report. In my opinion, the school district addressed the issue that caused the plan to fail Question 7 of the Self-Compliance tool; the plan should be compliant with Question 7 moving forward.

SECTION G. DISCLOSURE REQUIREMENTS

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

Answer: WSP plans to determine what percent of claims were ineligible or denied in the MH/SUD category vs Medical/Surgical claims. The pending results will illustrate whether the standards for claims being denied are not unfairly weighted towards MH/SUD type claims. If there is a disproportionate amount of ineligible or denied MH/SUD claims, it would suggest that the plan either does not have equitable access to mental health providers and medical/surgical providers or the plan limits access to mental health services by denying claims. This would cause the plan to not be compliant with MHPAEA. Results to follow.

Actuarial Opinion:

1. The School District of Osceola's health plans are not compliant with the Mental Health Parity and Addiction Equity Act of 2008. This opinion is based on the DOL Self-Compliance Tool for Mental Health Parity and Addiction Equity Act.
2. Each section of the Self-Compliance Tool has been addressed in the report above. It is our opinion that the plan is not in compliance due to NQTLs. Specifically, there are pre-certification requirements for ABA, Intensive Outpatient Treatment, and Partial Hospitalizations.
    a. **UPDATE:** Having removed the pre-certification requirements from the plan document, I believe the School District of Osceola County is in compliance with the NQTL section of the Self-Compliance Tool.
3. A full report will be available once the data becomes available.
4. WSP is available to answer any regulatory questions with the permission of the School District of Osceola County.

Future Considerations:

This report determines compliance based on specific plan designs and plan documents. To ensure compliance for future plans, consider the following plan provisions related to provider reimbursements. These 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.

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.

Step Two: Identify the factors considered in the design of the NQTL.

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

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?

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.

Next Steps:

1. While DOL guidelines are vague regarding the frequency at which this report is required, we recommend that it is updated annually.
2. If a group health plan is audited by DOL investigators for MHPAEA compliance, DOL may ask for at least the following, among other items:

   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.

Certification: I, David Miller, am an Actuary at WSP, an actuarial consulting firm. I am a Fellow of the Society of Actuaries (FSA) and a member of the American Academy of Actuaries (MAAA). This study represents an independent opinion as to whether the TPSPBT complies with the Mental Health Parity.

Actuarial methods, considerations and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board. These standards form the basis of this study. The results in this study are projections and not guarantees. The questions have been answered to the best of my knowledge. I have not been influenced in any way to render an opinion other than my own.

This report is an opinion by Windsor Strategy Partners and not a guarantee of compliance. With the permission of TPSPBT, WSP is available to discuss this report and explain our rationale to the DOL or any state insurance agency that has questions on the results.

David Miller FSA, MAAA
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September 19th, 2023
UPDATED: October 31, 2023

Peer Reviewed:
Paul Fallisi FSA, MAAA
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Appendix A: Biographies

DAVID MILLER, FSA, MAAA
Senior Actuary
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David joined Windsor Strategy Partners in 2018 as an Associate Actuary. Prior to joining the firm, he spent over three years at Blue Cross and Blue Shield of Texas working in various roles including Performance Management, Cost and Utilization, Disease Management, and Government Programs. David works closely with Paul Fallisi, President of Windsor Strategy Partners, and other members of the Windsor team on a diverse range of projects. He has experience with MEWAs, Monte Carlo simulations, reserves, and stop-loss pricing.

David graduated with an MS in Actuarial Science from Temple University in 2014. He is also a member of the Lafayette College Class of 2009 with degrees in Mathematics and Economics and Business. He is a Fellow of the Society of Actuaries, and a member of the American Academy of Actuaries.

David currently resides in Wayne, PA with his wife and two sons.

PAUL FALLISI, FSA, MAAA
President
pfallisi@wspactuaries.com

Paul Fallisi is the President and CEO of Windsor Strategy Partners (WSP), an industry leading actuarial consulting firm specializing in health care. Paul and the founder of the company, David Wilson, have worked together in various capacities for over 30 years.

Before WSP, Paul served as President and CEO of Munich Re Stop Loss (MRSL). During his tenure, MRSL achieved exceptional growth and bottom-line profits.

Prior to MRSL, Paul was one of the Founding Fathers of Cairnstone. Before stepping into the President's role, Paul had been the company's Chief Actuary, Chief Underwriter, and Chief Marketing Officer. Cairnstone was later purchased by Munich Re.

Paul was employed by John Alden Life Insurance Company where he was the first in house actuary for the Alden Risk Management (ARMS) division. Paul is also very proud of his roots having been a student actuary at The Hartford Insurance Group during the 1980's.

Paul has attained an FSA designation from the Society of Actuaries. He is also a Member of the American Academy of Actuaries (MAAA). Paul earned his BBA in Actuarial Science from Temple University in Philadelphia, Pennsylvania. Paul resides in Salem, New Hampshire with his wife Veronica and two daughters, Toni and Nicolette.

For fun, Paul enjoys running, Italian wine and watching horse races at Saratoga.

Appendix B: Copy of School District of Osceola County's Formal Response

THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA
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Superintendent of Schools
Dr. Mark Shanoff

David Miller FSA MAAA
Senior Actuary
Windsor Strategy Partners
777 Alexander Rd. #201
Princeton, NJ 08540

September 26, 2023

Dear Mr. Miller:

Thank you for conducting the Mental Health Parity and Addiction Equity Act (MHPAEA) analysis for the 2022 School District of Osceola County Health Services Plan. Per the September 19, 2023 report, SDOC's self-insured plan does not comply with the MHPAEA as it does not pass Question 7 of the Department of Labor's Self-Compliance Tool.

The SDOC has taken the following corrective action to remedy the findings:

> Removed the pre-certification requirement for Applied Behavioral Analysis (ABA), Intensive Outpatient Treatment (Mental Health/Substance Abuse), and Partial Hospitalizations (Mental Health/Substance Abuse) language in the Summary Plan Document for SDOC's Health Services Plan.

I recommend that the full text of this response be appended to the report to show SDOC's corrective action should a member, entity or such other interested party request a copy of the analysis.

Your engagement in the project is greatly appreciated. Please reach out with any questions.

Sincerely,

Lauren M. Haddox
Director
Risk & Benefits Management

Appendix C: Mental Health Parity Provisions Checklist

II. Determining Compliance with the Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act (MHPAEA) Provisions in Part 7 of ERISA (together, the mental health parity provisions)			
If you answer "No" to any of the questions below, the group health plan is in violation of the mental health parity provisions in Part 7 of ERISA.			
	YES	**NO**	**N/A**
Introduction If the plan provides either mental health or substance use disorder benefits, in addition to medical/surgical benefits, the plan may be subject to the mental health parity provisions in Part 7 of ERISA. Retiree-only plans, and those offering excepted benefits, are generally not subject to the mental health parity provisions under part 7 of ERISA. *See 29 CFR 2590.732* for further discussion. (Note: if under an arrangement(s) to provide medical care by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and mental health or substance use disorder benefits, the mental health parity requirements apply separately with respect to each combination of medical/surgical benefits and mental health/substance use disorder benefits and all such combinations are considered to be a single group health plan. *See 29 CFR 2590.712(e).*) If this is the case, answer **Questions 21-28**. If the plan does not provide mental health or substance use disorder benefits, check "N/A" here and skip to Part III of this checklist. Also, the plan may be exempt from the mental health parity provisions under the small employer (50 employees or fewer) exception or the increased cost exception. (To be eligible for the increased cost exception, the plan must have filed a notice with EBSA and notified participants and beneficiaries.) Unless a plan is exempt as previously described, the requirements of MHPAEA generally apply to both grandfathered and non-grandfathered group health plans[1], as defined under the Affordable Care Act. Note that the Department of Health and Human Services' final rule regarding essential health benefits (EHB) requires health insurance issuers offering non-grandfathered health insurance			

[1] Mental health and substance use disorder benefits are defined under the terms of the plan, in accordance with applicable Federal and State law. Any condition or disorder defined by the plan as being or as not being a mental health condition or substance use disorder must be defined in a manner consistent with generally recognized independent standards of current medical practice (e.g., the most current version of the DSM or ICD or State guidelines).

coverage in the small group market through an Affordable Health Insurance Exchange (Marketplace) or outside of a Marketplace to comply with MHPAEA in order to satisfy the requirement to provide EHB. In addition, under MHPAEA, 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. Under the Affordable Care Act, PHSA section 2713, non-grandfathered group health plans are required to provide certain preventive services with no cost-sharing, which includes, among other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening. However, the Departments clarified that nothing in MHPAEA requires a group health plan that provides mental health or substance use disorder benefits only to the extent required under PHSA section 2713, to provide additional mental health or substance use disorder benefits in any classification[2]			

SECTION A. Lifetime and Annual Limits **<u>Question 21 – Does the plan comply with the mental health parity requirements regarding lifetime dollar limits on mental health/substance use disorder benefits?</u> .....** • A plan generally may not impose a lifetime dollar limit on mental health/ substance use disorder benefits that is lower than the lifetime dollar limit imposed on medical/ surgical benefits. *See 29 CFR 2590.712(b).* (Only limits on what the plan would pay are taken into account, as contrasted with limits on what an individual may be charged.) **Note:** These provisions are affected by section 2711 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime and annual dollar limits on essential health benefits (EHB), which includes mental health and substance use disorder services. Accordingly, for mental health and substance use disorder benefits that are EHB, plans cannot impose lifetime limits. For mental health and substance use disorder benefits that are not EHB, parity requirements regarding aggregate lifetime dollar limits apply. (For information regarding the Affordable Care Act, please visit our Website at <u>dol.gov/ebsa/healthreform</u>).	☒	☐	

Question 22 – Does the plan comply with the mental health parity requirements regarding annual dollar limits on mental health/substance use disorder benefits? ..... • A plan generally may not impose an annual dollar limit on mental health/ substance use disorder benefits that is lower than the annual dollar limit imposed on medical/surgical benefits. *See 29 CFR 2590.712(b).* (Again, only limits on what the plan would pay are taken into account, as contrasted with limits on what an individual may be charged.) **Tip:** There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at **Question 26.** A plan may impose annual out-of-pocket dollar limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.			
	YES	**NO**	**N/A**
Note: These provisions are affected by section 2711 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits annual dollar limits on essential health benefits, which includes mental health and substance use disorder services. Accordingly, the parity requirements regarding annual dollar limits only apply to the provision of mental health and substance use disorder benefits that are not Essential Health Benefits. Note also that for plan years beginning in 2015, the annual limitation on an individual's maximum out-of-pocket (MOOP) costs in effect under ACA is $6,600 for self-only coverage and $13,200 for coverage other than self-only coverage. *See ACA Implementation FAQ Part XXI at dol.gov/ebsa/faqs/faq-aca21.html.* (For information regarding the Affordable Care Act, please visit our Website at dol.gov/ebsa/healthreform).			

SECTION B. Financial Requirements and Quantitative Treatment Limitations **<u>Question 23 – Does the plan comply with the mental health parity requirements for parity in financial requirements and quantitative treatment limitations?</u> .....** • A plan may not impose a financial requirement or quantitative treatment limitation applicable to mental health/substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type that is applied to substantially all medical/surgical benefits in the same classification. *See 29 CFR 2590.712(c)(2).* o Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 29 CFR 2590.712(c)(1)(ii).* o Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 29 CFR 2590.712(c)(1)(ii).* • 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 29 CFR 2590.712(c)(2)(ii).* • Under the plan, any financial requirement or quantitative treatment limitation that applies to mental health/substance use disorder benefits within a particular classification **cannot be more restrictive** than the predominant requirement or limitation that applies to substantially all medical/surgical benefits within the same classification. *See 29 CFR 2590.712(c)(2).*	☐	☐	

*See page 81 for special rules related to classifications.

	YES	NO	N/A

Detailed steps for applying these rules are set forth below:

- To determine compliance, each type of financial requirement or quantitative treatment limitation within a coverage unit[2] must be analyzed separately within each classification. *See 29 CFR 2590.712(c)(2)(i).* If a plan applies different levels of a financial requirement or quantitative treatment limitation 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 29 CFR 2590.712(c)(3)(ii).*
- **Step One:** First determine if a particular type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in the relevant classification of benefits.
  - o Generally, a financial requirement or quantitative treatment limitation 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 29 CFR 2590.712(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. *See 29 CFR 2590.712(c)(3)(i)(C).* (Any reasonable method can be used for this calculation. *See 29 CFR 2590.712(c)(3)(i)(E)*.)
- **Step Two:** If the type of financial requirement or quantitative treatment limitation 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 quantitative treatment limitation that applies to medical/ surgical benefits subject to that type of financial requirement or quantitative treatment limitation in that classification of benefits. (**Note:** If the type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to mental health/substance use disorder benefits in that classification.) v Generally, the predominant level will apply to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation. *See 29 CFR 2590.712(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, 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 quantitative treatment limitation in the classification. The least

[2] 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, and employee plus spouse. *See 29 CFR 2590.712(c)(1)(iv).*

restrictive level within the combination is considered the predominant level.[3] *See 29 CFR 2590.712(c)(3)(i)(B)(2).*			

[3] 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.

	YES	NO	N/A
***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. • After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health/substance use disorder 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 final rules. • Other than as explicitly permitted under the final rules, subclassifications 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. (*See* **Question 24** for more information regarding specialists and generalists.) **2. Special rule for prescription drug benefits:** • There is a special rule for multi-tiered prescription drug benefits. A plan complies with the mental health parity provisions if the plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed for medical/surgical or mental health/substance use disorder benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. *See 29 CFR 2590.712(c)(3) (iii).* **3. Special rule for multiple network tiers:** • There is a special rule for multiple network tiers. If a plan provides benefits through multiple tiers of in-network providers (such as innetwork preferred and in-network participating providers), the plan may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers, if the tiering is based on reasonable factors (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect			

to medical/surgical benefits or mental health or substance use disorder benefits. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/ surgical benefits in the sub-classification. **Tips:** Ensure that the plan does not impose cost-sharing requirements or quantitative treatment limitations that are applicable **only** to mental health/ substance use disorder benefits. Ensure that with respect to conducting the predominant/substantially all test, the analysis must be done with respect to the dollar amount of <u>all</u> plan payments expected to be paid for the relevant plan year. Basing the analysis on an insurer's entire overall book of business for the year or book of business in a specific region or State is not a permissible analysis for demonstrating compliance with MHPAEA.			

	YES	NO	N/A
<u>Question 24 – If the plan imposes a higher, specialist financial requirement, such as a copay, on mental health/substance use disorder benefits, can the plan demonstrate that the specialist level of the financial requirement is the predominant level that applies to substantially all medical/surgical benefits within the classification?</u> ..... • The six classifications outlined in **Question 23** are the only classifications that may be used when determining the predominant financial requirements or quantitative treatment limitations that apply to substantially all medical/ surgical benefits. *See 29 CFR 2590.712(c)(2)(ii).* A plan may not use a separate sub-classification under these classifications for generalists and specialists. *See preamble language at 75 FR 5413.* **Tip:** A plan may still be able to impose the specialist level of a financial requirement or quantitative treatment limitation if it is the predominant level that applies to substantially all medical/surgical benefits within a 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 outpatient, in-network classification, the plan may apply the specialist level copay to mental health/ substance use disorder benefits in the outpatient, in-network classification. *See 29 CFR 2590.712(c)(3).*	☒	☐	

SECTION C. Coverage in all Classifications

Question 25 – Does the plan comply with the mental health parity requirements for coverage in all classifications? .....

- If a plan provides mental health/substance use disorder benefits in any classification of benefits (the classifications are listed in **Question 23**), mental health/substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 29 CFR 2590.712(c)(2)(ii)(A).*
  - o In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits and to mental health/substance use disorder benefits. *See 29 CFR 2590.712(c) (2)(ii)(A).* This rule also applies to intermediate services provided under the plan or coverage. Plans must assign covered intermediate mental health and substance use disorder benefits (such as residential treatment, partial hospitalization and intensive outpatient treatment) to the existing six classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan classifies skilled nursing and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify residential treatment facilities for mental health and substance use disorder benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient mental health/substance use disorder services and partial hospitalization must be considered outpatient benefits as well. A plan must also comply with MHPAEA's NQTL rules, discussed in the following section, in assigning any benefits to a particular classification. *See 29 CFR 2590.712(c)(4).*

Tips:

- If the plan does not contract with a network of providers, all benefits are out- of-network. If a plan that has no network imposes a financial requirement or treatment limitation on inpatient or outpatient benefits, the plan 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 29 CFR 2590.712(c)(2)(ii)(C), Example 1.*
- If a plan 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 mental health and substance use disorder benefits.

The plan must ensure that all combinations of benefits comport with parity.

Note: As explained in the Introduction to this section, nothing in MHPAEA requires a non-grandfathered group health plan that provides mental health or substance use

disorder benefits only to the extent required under PHSA section 2713, to provide additional mental health or substance use disorder benefits in any classification.			

SECTION D. Cumulative Financial Requirements and Treatment Limitations **Question 26 – Does the plan comply with the mental health parity provisions on cumulative financial requirements or cumulative quantitative treatment limitations? .....** • A plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health/substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. *See 29 CFR 2590.712(c)(3)(v).* o 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 29 CFR 2590.712(a)* For example, a plan may not impose an annual $250 deductible on all medical/surgical benefits and a separate $250 deductible on all mental health/ substance use disorder benefits.	☒	☐	

SECTION E. Nonquantitative Treatment Limitations **Question 27 – Does the plan comply with the mental health parity provisions for parity within nonquantitative treatment limitations?.....** • Nonquantitative treatment limitations (NQTLs) include: o Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; o Formulary design for prescription drugs; o For plans with multiple network tiers (such as preferred providers and participating providers), network tier design; o Standards for provider admission to participate in a network, including reimbursement rates; o Plan methods for determining usual, customary, and reasonable charges;	☒	☐	

o 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); o Exclusions based on failure to complete a course of treatment; and o 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. This is an **illustrative**, **nonexhaustive** list. *See 29 CFR 2590.712(c)(4)(ii).* **General rules:** • A plan may not impose an NQTL with respect to mental health/substance use disorder benefits in any classification (such as inpatient, out-of- network) 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 mental health/substance use disorder benefits in the classification are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the NQTL with respect to medical/surgical benefits in the classification. *See 29 CFR 2590.712(c)(4)(i).* A group health plan may consider a wide array of factors in designing medical management techniques for both mental health/substance use disorder 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) mental health/substance use disorder benefits, as well as for some medical/ surgical benefits, but not for others. *See 29 CFR 2590.712(c)(4), Example 8.* **Examples:** The Departments have published several examples that help illustrate how the MHPAEA regulations apply to some common plan NQTLs, including: ***1)*** The penalty for failure to obtain preauthorization is more punitive with respect to mental health/substance use disorder benefits than with respect to medical/surgical benefits. *See 2590.712(c)(4)(iii), Example 3.* ***2)*** The plan uses an employee assistance program as a gatekeeper to obtaining mental health or substance use disorder benefits. *See 2590.712(c)(4)(iii), Example 6.*			

3) Utilization management practices that differ among different plan benefits. *See 29 CFR 2590.712(c)(4)(iii), Example 8.* **Tips: Do not focus on results.** Look at the **underlying processes and strategies** used in applying NQTLs (such as utilization review (UR) and standards for network admission). Are there arbitrary or discriminatory differences in how the plan is applying those processes and strategies to medical/ surgical benefits versus mental health/substance use disorder benefits? A plan or issuer that limits eligibility for mental health and substance use disorder benefits until after benefits under an EAP are exhausted has established an NQTL subject to the parity requirements. If no comparable requirement applies to medical/surgical benefits such a requirement could not be applied to mental health or substance use disorder benefits. **Questions You Might Ask:** 1) What classification of benefits is being analyzed? Does the plan clearly define which benefits are treated as medical/surgical and which benefits are treated as mental health/substance use disorder under the plan. Are benefits (such as non-hospital inpatient and partial hospitalization) assigned to classifications using a comparable methodology across medical/surgical benefits and mental health/substance use disorder benefits? 2) What is the type and description of any NQTL being applied and is it applied in parity? 3) Overall explanation of how each NQTL is applied with respect to medical/surgical benefits and mental health and substance use disorder benefits. (Note: this includes requirements that both the participant and provider may be subject to pursuant to the NQTL). If only certain benefits are subject to an NQTL, such as meeting a fail first protocol or requiring preauthorization, how were the specific medical/surgical and mental health or substance use disorder benefits subject to the NQTL determined? To the extent medical guidelines are relied upon, is there a process for determining variation/application of the guidelines that is comparable with respect to both medical/surgical and mental health or substance use disorder benefits? 4) Even if benefits are subject to the same NQTL, does the plan impose stricter penalties for noncompliance with respect to mental health and substance use disorder benefits (for example, reducing benefits to 50% of eligible expenses for failure to obtain prior authorization for mental health and substance use disorder benefits, vs. 20% for medical/surgical benefits)?			

5) If utilization review is conducted by different entities/individuals for medical/surgical and mental health or substance use disorder benefits provided under the plan, what processes are in place to ensure comparability in the standards used for UR and comparability in the independence and qualifications of the individuals performing UR?
6) Has the plan documented its analysis that its NQTL processes and strategies (such as UR) are comparable across medical/surgical and mental health/substance use disorder benefits?

Tip: Plans should keep records documenting NQTL processes and how they are being applied to both medical/surgical as well as mental health and substance use disorder benefits to ensure they can demonstrate compliance with the law. Such records may also be helpful to plans in responding to inquiries from participants and beneficiaries regarding benefits under the plan. See a more detailed discussion of disclosure requirements in the following section.

Illustrations. Set forth below are additional illustrations of how a plan may have differences in nonquantitative treatment limitations but may still comply with the Departments' regulations, based on the facts and circumstances involved:

- Plan X covers neuropsychological testing but only 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 they will cover this service and the rationale for excluding certain diagnoses? The result may be that the plan covers neuropsychological testing for some medical/surgical or mental health conditions, but not for all. This outcome may be permissible to the extent the plan has based the exclusion on clinical efficacy and/or other factors if done in a comparable manner and applies the NQTL in a comparable manner.
- Plan Y 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 mental health or substance use disorder 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 mental health/substance use disorder benefits and are well documented.

These evidentiary standards and other factors are available to participants and beneficiaries free of charge upon request. 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 is comparable and applied no more stringently with respect to mental health and substance use disorder benefits than those applied with respect to medical/surgical benefits. • Plan Z classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits and likewise treats any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit. In addition, the plan treats home health care as an outpatient benefit and, likewise treats intensive outpatient and partial hospitalization for mental health or substance use disorder services as outpatient benefits. In this example, the plan assigns covered intermediate mental health and substance use disorder benefits to the six classifications in the same way that it assigns comparable intermediate medical/surgical benefits. • Master's degree training and state licensing requirements often vary among provider types. Plan Z consistently applies its standard that any provider must meet whatever is the most stringent licensing requirement standard related to supervised clinical experience requirements in order to participate in the network. Therefore, Plan Z requires master's-level therapists to have post- degree, supervised clinical experience in order to join their provider network. There is no parallel requirement for master's-level general medical providers because their licensing does require 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. 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.			

	YES	**NO**	**N/A**

SECTION F. Disclosure Requirements

Question 28 – Does the plan comply with the mental health parity disclosure requirements? .....

- The plan administrator (or the health insurance issuer) must make available the criteria for medical necessity determinations made under a group health plan with respect to mental health/substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) to any current or potential participant, beneficiary, or contracting provider upon request. *See 29 CFR 2590.712(d)(1).*

- The plan administrator (or health insurance issuer) must make available the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health/substance use disorder benefits to any participant or beneficiary 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, claims related to medical judgment (including mental health/substance use disorder) are eligible for external review. The internal claims and appeals rules include the right of claimants (or their authorized representative) 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 mental health/substance use disorder benefits under the plan. *See 29 CFR 2590.712(d)(3).*

- If coverage is denied based on medical necessity, medical necessity criteria for the mental health/substance use disorder 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, or provider or other individual if acting as an authorized representative of the beneficiary or participant. *See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).*

Make Showing Compliance Simple!

Documents or Plan Instruments Participants and Beneficiaries or DOL may request:

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 request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or nonquantitative treatment limitation is in compliance with MHPAEA. For example, participants and beneficiaries may ask for:

- An analysis showing that the plan meets the predominant/substantially all test. The plan may need to provide information regarding the amount of medical/surgical claims subject to a certain type of QTL, such as a co-payment, in the prior year in a classification or its basis for calculating claims expected to be subject to a certain type of QTL in the current plan year in a classification, for purposes of determining the plan's compliance with the predominant/substantially all test.
- A description of an applicable requirement or limitation, such as preauthorization or concurrent review, that the plan has authorized for mental health/substance use disorder services and medical/surgical benefits within the relevant classification (in- or out-of-network, in- or outpatient). These might include references to specific plan documents, for example provisions as stated on specified pages of the 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 mental health or substance use disorder 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 have been used in any given mental health/substance use disorder service adverse benefit determination (ABD) within the relevant classification;
- Medical necessity guidelines relied upon for in and out-of-network medical/ surgical and mental health and substance use disorder benefits.

Tips:
Participants, beneficiaries 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 adverse benefit determination.

Plans may need to work with insurance carriers 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 plan uses mental health and substance use disorder vendors and carve-out service providers, the plan must ensure that all combinations of benefits comport with parity, therefore vendors and carve out providers should provide documentation of the necessary information to the Plan to ensure that all combination of benefits comport with parity. **Note:** Compliance with the disclosure requirements of MHPAEA is not determinative of compliance with any other provision or other applicable Federal or State law. Be sure that the Plan, in addition to these disclosure requirements, is disclosing information relevant to medical/surgical, mental health, and substance use disorder benefits as required pursuant to other applicable provisions of law.			