Mental Health and Substance Use Disorder (MHSUD)

Financial Requirement Parity Certification

*Required to be submitted with Plan Year (PY) 2025*

*ACA Individual and Small Group Market Rate Filings*

## Purpose

Issuers are required to comply with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations and guidance, such as Chapter 284-43 WAC Subchapter K, Mental Health and Substance Use Disorder. Financial requirements and treatment limitations applicable to mental health/substance use disorder (MHSUD) benefits cannot be more restrictive than those applicable to medical/surgical benefits.

This document is intended to provide a framework for compliance with the financial parity requirements under MHPAEA and WAC 284-43-7040. For quantitative treatment limitations (QTL) and non-quantitative treatment limitations (NQTL), see the checklist under the form filing instructions; for QTL and NQTL definitions, see MHPAEA and WAC 284-43-7010.

Financial requirements are defined in MHPAEA and under WAC 284-43-7010 as cost sharing measures, such as deductibles, copayments, coinsurance, and out-of-pocket maximums; the definition does not address aggregate lifetime or annual dollar limits.

## Requirement Highlights

1. Benefit Classifications [see particularly WAC 284-43-7020]

Parity requirements must be applied within each of the six benefit classifications or permitted subclassifications (as applicable). In determining the classification or subclassification in which a particular benefit belongs, each plan must apply the same standards to medical/surgical benefits as are applied to MHSUD benefits. This includes applying the same logic to intermediate MHSUD benefits (e.g., residential treatment, partial hospitalization, and intensive outpatient treatment) as to comparable intermediate medical/surgical benefits.

Note that for parity testing, all medical/surgical benefits and MHSUD benefits must be considered part of one of the defined benefit classifications. Review the definitions for mental health benefits, substance use disorder benefits, and medical/surgical benefits in WAC 284-43-7010. Review acceptable benefit classifications in WAC 284-43-7020.

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network

(3a) Outpatient, In-Network – Office Visits

(3b) Outpatient, In-Network – All Other Outpatient

1. Outpatient, Out-of-Network

(4a) Outpatient, Out-of-Network – Office Visits

(4b) Outpatient, Out-of-Network – All Other Outpatient

1. Emergency Care
2. Prescription Drugs

Note: Per WAC 284-43-7020(6)(a), plans and issuers may sub-classify outpatient into “office visits” and “all other outpatient items and services.” A particular plan should address (3) **or** (3a)+(3b), not all three; similarly, a particular plan should address (4) **or** (4a)+(4b), not all three.

**Provide attestation in section III below.**

1. Financial requirements [see particularly WAC 284-43-7020(4) and WAC 284-43-7040]
2. Overview of financial requirement parity:

Within each benefit classification defined under WAC 284-43-7020, a plan or issuer may not apply any financial requirement to an MHSUD benefit that is more restrictive than the corresponding predominant level applied to medical/surgical benefits. Parity analysis must be done on a classification-by-classification basis

WAC 284-43-7010 indicates that a type of financial requirement is considered to apply to “**substantially all**” medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification as determined by WAC 284-43-7040(2)(a).

Additionally, WAC 284-43-7010 indicates if a type of financial requirement applies to substantially all medical/surgical benefits in a classification, the “**predominant level**” is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement.

Financial requirement parity analysis considers both type and level. Types of financial requirements include deductibles, copayments, coinsurance and out-of-pocket maximums. Levels of financial requirements are amounts of the financial requirement, such as coinsurance of 20% or coinsurance of 25%. Note also that if a medical/surgical copayment or coinsurance applies before or after meeting the deductible, MHSUD copayment and coinsurance financial requirements should similarly apply before or after meeting the deductible.

Substantially all and predominant level determinations are made separately for each type of financial requirement within each classification or subclassification. Assessments are based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the health plan for the 2025 plan year; dollar amounts should be stated as allowed amounts before enrollee cost sharing because payments based on the allowed amounts cover the full scope of the benefits being provided. A reasonable actuarial method must be used to project the dollar amounts. Note that WAC 284-43-7040(1)(d) clarifies how to handle certain dollar threshold complications.

Also note WAC 284-43-7040(2) clarifies that calculations must be done separately for different coverage units if different levels of financial requirements apply to different coverage units. WAC 284-43-7010 defines a coverage unit as the way in which a plan or issuer groups individuals for purposes of determining benefits, or premiums or contributions. For example, different coverage units could be self-only, family, and employee-plus-spouse.

1. Rate filing documentation of financial requirement parity

Separately address the following for each plan and benefit classification/subclassification. If different levels of financial requirements apply to different coverage units as discussed in WAC 284-43-7040(2), also separate responses by coverage unit.

* Show the different medical/surgical benefit financial requirements. Then, demonstrate what meets the substantially all requirements and what qualifies as the predominant level.
* Show how MHSUD benefit financial requirements compare to substantially all and predominant level results.
* As noted under #1 above, WAC 284-43-7020(6)(a) allows for, but does not require, subclassifications within outpatient – (a) office visits versus (b) all other outpatient items and services. For each plan, please indicate how the outpatient parity testing was conducted and provide information and results accordingly.

In the Unified Rate Review (URR) Part III Actuarial Memorandum, please describe how the 2025 annual projected plan and benefit classification/subclassification amounts were determined. Address the following:

* Describe the underlying claims data source and characteristics as well as any adjustments made. Explain any differences versus the data used to project PY2025 claims and premium rates.
* Ensure amounts reflect what the plan allows before reductions for enrollee cost sharing.
* Keep in mind guidance related to expectations for data and projections, such as the following:

The underlying data set will *not* usually be your issuer’s entire projected book of business; additionally, the projections will reflect plan-level assumptions as opposed to product-level assumptions (see the (\*) CMS FAQs listed below, for example).

* Certify that a reasonable actuarial method was used to project amounts for each plan in accordance with WAC 284-43-7040(1)(c)(ii) and in compliance with applicable Actuarial Standards of Practice.

(\*) CMS/CCIIO ACA FAQ 31; April 20, 2016; Q8. CMS/CCIIO ACA FAQ 34; October 27, 2016; Q3.

* Provide additional requested data details on the ‘Data Information’ tab in your complementary Excel workbook of MHSUD financial requirement parity calculations.

**Provide attestation in section III below.**

1. Cumulative financial requirements [see particularly WAC 284-43-7040(3)]

A plan or issuer may not apply cumulative financial requirements (e.g., deductibles and out-of-pocket maximums) for MHSUD benefits in a classification that accumulate separately from any cumulative requirement established for medical/surgical benefits in the same classification. Cumulative requirements must also satisfy the quantitative parity analysis.

**Provide attestation in section III below.**

1. Prohibited exclusions [see particularly WAC 284-43-7080]

A plan cannot exclude mental health and substance use disorder treatment or services for any of the reasons documented in WAC 284-43-7080. Observe that the WAC 284-43-7080 citation for prohibited exclusions was updated with changes effective 1/1/2022. Please see the updated WAC for the latest requirements.

**Provide attestation in section III below.**

## Attestation

| **General Information** | |
| --- | --- |
| Issuer Name: | <<Enter Issuer Name Here>> |
| Applicable Market: | <<Enter Market Here; Individual or Small Group>> |
| Plan Year: | 2025 |

Please complete and submit one set of MHSUD financial requirement parity certification documents for each rate filing. (1) Submitting a PDF version of this certification document. (2) Submit an Excel file (and its corresponding PDF file) that highlights each plan’s financial requirements and demonstrates parity testing results.

For the calculations, use the OIC-developed Excel template found on our website ([Certification - Rates - 2025 MHSUD Parity Calculations](https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts)). Start by reviewing the instructions on the first worksheet tab in the Excel file. Then, populate information in each worksheet, as appropriate, including uploading details for every plan in this rate filing. After completely populating the Excel file, create a copy of the file as a PDF. Submit both the Excel and PDF file formats. Remember to have the Excel and PDF file contents and file names exactly match with the only exception being that the Excel file name will end in “DUPLICATE.”

List below the names of the supporting files:

|  |
| --- |
| <<enter Excel file name(s) here>>  <<enter PDF file name(s) here>> |

Complete the actuarial certification below. Check attestation boxes, where appropriate, to signify your agreement. Then complete the signature block.

**Actuarial Certification of MHSUD Financial Requirement Parity for Plan Year 2025 ACA Rate Filing:**

I, <<insert *name of actuary including the actuary’s credentials*>>,

Am an employee of <<insert company name>> or

Am a consultant associated with the firm of <<insert name of consulting firm>>;

Am a qualified actuary as outlined in Chapter 284-05 WAC. I am a member of the American Academy of Actuaries, and I am acting within the scope of my training, experience, and qualifications.

For the 2025 plan year, I certify the accuracy of the cost shares for both medical/surgical and MHSUD benefits that are used to evaluate parity of MHSUD financial requirements as loaded into this calculation workbook: *<<insert the name of your MHSUD Financial Requirement Parity Workbook>>* and as otherwise discussed in this rate filing.

I attest that the issuer (1) has criteria documented as to how medical/surgical benefits were assigned to each permitted classification and (2) the criteria use the same standards for MHSUD benefits as for medical/surgical benefits. Upon request, the documentation can be made available to the Washington OIC within 10 business days.

I attest to parity (as outlined in Chapter 284-43 WAC Subchapter K Mental Health and Substance Use Disorder) between MHSUD benefits and medical/surgical benefits in

Financial requirements outlined in Chapter 284-43 WAC Subchapter K Mental Health and Substance Use Disorder

Financial accumulators, such as deductibles and out-of-pocket maximums, by plan and classification [see particularly WAC 284-43-7040(3)]

I certify that each plan submitted in this rate filing meets the “substantially all” and “predominant” / ”predominant level” financial requirement parity testing requirements under MHPAEA and WAC 284-43-7040.

Type: I attest that for each plan, the type of financial requirement imposed upon MHSUD benefits in each classification (or applicable subclassification) applies to at least two-thirds of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification).

Level: I attest that for each plan, the level of financial requirement imposed upon MHSUD benefits in each classification (or applicable subclassification) is no more restrictive than the level of financial requirement imposed upon more than one-half of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification).

I attest that if a single financial requirement did not meet the one-half threshold for a particular plan and classification (or applicable subclassification), then the level of financial requirement imposed upon MHSUD benefits was determined after combining levels until the combination of levels covered more than one-half of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification) as described in WAC 284-43-7040(2)(b)(ii) and (iii).

I attest that the above statements are supported by details in the complementary MHSUD financial requirement calculation workbook (cited above) and submitted as part of this rate filing.

WAC 284-43-7020(5)(a): A plan or issuer must treat the least restrictive level of the financial requirement that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to MHSUD benefits in the same classification.

I certify that this does not apply to any plans in this rate filing. The plans do not use provider tiers, or the financial requirements do not vary by provider tier.

This situation applies to plans in this rate filing, and I certify that the requirements were addressed. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

WAC 284-43-7020(5)(b): If a plan or issuer classifies providers into tiers and varies cost-sharing based on the different tiers, the criteria for classification must be applied to generalists and specialists providing MHSUD services no more restrictively than such criteria are applied to medical/surgical benefit providers.

I certify that this does not apply to any plans in this rate filing. The plans do not use provider tiers, or the cost-sharing does not vary by provider tier.

This situation applies to plans in this rate filing, and I certify that the requirements were addressed. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

WAC 284-43-7020(6)(b): A plan or issuer may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers if the tiering is based on reasonable factors and without regard to whether a provider is an MHSUD provider or a medical/surgical provider.

I certify that this does not apply to plans in this rate filing. The plans do not use network tiers.

This situation applies to plans in this rate filing, and I certify that the requirements were addressed. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

WAC 284-43-7020(6)(c): After network tiers are established, the plan or issuer may not impose any financial requirement on MHSUD benefits in any tier that is more restrictive than the predominant financial requirement that applies to substantially all medical/surgical benefits in that tier.

I certify that this does not apply to any plans in this rate filing. The plans do not use network tiers.

This situation applies to plans in this rate filing, and I certify that the requirements were addressed. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

WAC 284-43-7020(6)(d): If a 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 with respect to medical/surgical benefits or with respect to MHSUD benefits, the plan satisfies the parity requirements with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

I certify that none of the plans in this rate filing use prohibited prescription drug tiers. Prescription drug tiers are based only on the reasonable factors listed above and without regard to whether a drug is prescribed for medical/surgical or MHSUD benefits.

WAC 284-43-7080 (*including rule updates effective January 1, 2022 for gender affirming treatment*): A plan cannot exclude mental health and substance use disorder treatment or services for any of the reasons documented in WAC 284-43-7080.

I certify that none of the plans in this rate filing apply exclusions prohibited by WAC 284-43-7080.

I attest that, to the best of my knowledge, each of the plans otherwise satisfy the requirements under MHPAEA and Chapter 284-43 WAC Subchapter K.

Actuary’s Name & Designations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Attestation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_