Mental Health and Substance Use Disorder (MH/SUD)

Financial Requirement Parity Certification

*Required to be submitted with the Plan Year 2022*

*Individual or Small Group Market Rate Filing*

## 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. Under MHPAEA and Chapter 284-43 WAC Subchapter K, financial requirements and treatment limitations applicable to mental health/substance use disorder (MH/SUD) benefits cannot be more restrictive than those applicable to medical/surgical benefits.

This checklist 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 measurers such as deductibles, copayments, coinsurance, and out-of-pocket maximums; note that in this case, the financial requirements definition does not include aggregate lifetime or annual dollar limits.

## Response Section

| **General Information** |
| --- |
| Issuer Name: | <<Enter Issuer Name Here>> |
| Applicable Market: | <<Enter Market Here; Individual or Small Group>> |
| Plan Year: | 2022 |

Please complete and submit one set of MH/SUD Financial Requirement Parity Certifications for each rate filing. In addition to this certification document, submit an Excel file and corresponding PDF file summarizing the financial requirements and demonstrating the parity testing results.

Although not required, it is recommended that you use the OIC-developed Excel template found on our website ([Certification - Rates - 2022 MHSUD Parity Calculations](https://www.insurance.wa.gov/insurers-regulated-entities)). Instructions for populating the template can be found on the first tab of the Excel workbook. After populating the information in Excel, also submit the information in PDF format; remember to have the Excel and PDF file contents exactly match including the file names except that the Excel file name will end in DUPLICATE.

List below the names of the submitted supporting files:

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

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

Description of Requirements:

Parity requirements must be applied within each of the six benefit classifications or permitted sub-classifications (as applicable). In determining the classification or sub-classification in which a particular benefit belongs, each plan must apply the same standards to medical/surgical benefits as are applied to MH/SUD benefits. This includes assigning intermediate MH/SUD benefits such as residential treatment, partial hospitalization, and intensive outpatient treatment to the classifications in the same way that comparable intermediate medical/surgical benefits are assigned.

Note that for parity testing, all medical/surgical benefits and MH/SUD benefits must be categorized as being offered in one of the six defined benefit classifications. The medical/surgical benefits must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or state guidelines) [WAC 284-43-7010].

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.” For a particular plan, only (3) **or** (3a) with (3b) is required; similarly, only (4) **or** (4a) with (4b) is required.

Attestation: See the attestation section in #4 below.

1. Financial requirements [see particularly WAC 284-43-7020(4) and WAC 284-43-7040]

Description of Requirements:

Within each benefit classification defined under WAC 284-43-7020, a plan or issuer may not apply any financial requirement to an MH/SUD benefit that is more restrictive than the corresponding predominant level applied to medical/surgical benefits. This 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 include the amounts of the financial requirement such as coinsurance of 20%, copayment of $15, deductible of $500, and out-of-pocket maximum of $8,000. Note also that if a medical/surgical copayment or coinsurance applies before or after meeting the deductible, MH/SUD 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 sub-classification. The determination is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the health plan for the 2022 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 include self-only, family, and employee-plus-spouse.

Required Filing Documentation:

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

For each of the six benefit classifications and the two outpatient sub-classifications, show the different medical/surgical financial requirements. Then demonstrate compliant substantially all and predominance testing results for the various financial requirements.

As noted under #1 above, WAC 284-43-7020(6)(a) allows for, but does not require, sub-classifications 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 explain how you projected the plan and benefit classification/sub-classification dollar amounts. Include information about the underlying claims data source and characteristics as well as any adjustments that were made. Explain any differences versus the data used to project the PY2022 claims and premium rates. Note that the underlying data set will *not* usually be an issuer’s entire projected book of business; additionally, note that the projections are expected to reflect plan-level assumptions as opposed to product-level assumptions (see the (\*) CMS FAQs listed below, for example). Ensure the dollar amounts are based on the amounts that the plan allows, before reductions for enrollee cost sharing. Then, wrap up this piece by certifying that a reasonable actuarial method was used for the dollar projections 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.

Attestation: Add commentary to the URR Part III Actuarial Memorandum as appropriate, and see the attestation section in #4 below.

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

Description of Requirements:

A plan or issuer may not apply cumulative financial requirements (such as deductibles and out-of-pocket maximums) for MH/SUD 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.

Attestation: See the attestation section in #4 below.

1. Attestation

Complete the actuarial certification below. Check the attestation boxes to indicate agreement with each item.

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I, <<insert *name of actuary*>>,

[ ]  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 acting within the scope of my training, experience and qualifications; and

[ ]  Am a member of the American Academy of Actuaries.

I certify that the financial requirements for MH/SUD services and medical/surgical services are consistent with the information outlined in this document and in the attached MH/SUD financial requirement parity workbook, named *<<insert the name of your MH/SUD Financial Requirement Parity Workbook>>*.

[ ]  I attest that the issuer has documentation specifying which benefits were assigned to each of the six classifications and permitted sub-classifications. The documentation describes the standards used to assign benefits and demonstrates that the same standards were used for MH/SUD benefits as for medical/surgical benefits. I also attest that the documentation can be made available upon request within 10 business days.

[ ]  I attest that the plans do not apply cumulative financial requirements (such as deductibles and out-of-pocket maximums) for MH/SUD benefits in any classification or sub-classification that accumulate separately from any cumulative requirements established for medical/surgical benefits in the same classification or sub-classification.

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

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

I attest that the documentation supports this statement.

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

I attest that the documentation supports these statements.

Additional considerations:

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 MH/SUD benefits in the same classification.

[ ]  I certify that this does not apply to any plans in this rate filing.

[ ]  I certify that this applies to plans in this rate filing and was addressed as required. 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 MH/SUD 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.

[ ]  I certify that this applies to plans in this rate filing and was addressed as required. 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 sub-classifications that reflect network tiers, if the tiering is based on reasonable factors and without regard to whether a provider is an MH/SUD provider or a medical/surgical provider.

[ ]  I certify that this does not apply to plans in this rate filing.

[ ]  I certify that this applies to plans in this rate filing and was addressed as required. 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 MH/SUD 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.

[ ]  I certify that this applies to plans in this rate filing and was addressed as required. 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 MH/SUD 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 this does not apply to any plans in this rate filing.

[ ]  I certify that this applies to plans in this rate filing and was addressed as required. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

[ ]  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 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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