

DEPARTMENT OF INSURANCE

OFFICE OF THE COMMISSIONER

Statutory Authority: 18 Delaware Code, Sections 311, 3343 and 3571U, and 81 Del. Laws, c. 406, Section 4) (18 **Del.C.** §§311, 3343 and 3571U & 81 Del. Laws, c. 406, §4)

PROPOSED

PUBLIC NOTICE

1410 Reporting Medical Management Protocols for Insurance Coverage for Serious Mental Illness and Drug And Alcohol Dependency

A. Type of Regulatory Action Required

Proposed New Regulation

B. Synopsis of the Subject Matter of the Regulation

1. Mental health and substance abuse coverage in Delaware

Sections 3343 and 3578 of the Delaware Insurance Code, 18 **Del.C.** §§3343 and 3578, govern insurance coverage for serious mental illness, including drug and alcohol dependency disorders under individual and group and blanket health insurance plans, respectively. These sections provide, in relevant part, that:

- All health benefit plans offered in Delaware must include coverage for serious mental illnesses and drug and alcohol dependencies (see 18 **Del.C.** §§3343(b)(1)a and 3578(b)).
- Coverage for serious mental illnesses and drug and alcohol dependencies must include:
 - (1) Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies; and
 - (2) Unlimited medically necessary treatment for drug and alcohol dependencies as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) (MHPAEA), and determined by the use of the full set of American Society of Addiction Medicine (ASAM) criteria, in treatment provided in residential setting, intensive outpatient programs, and inpatient withdrawal management (see 18 **Del.C.** §§3343(b)(1)a1-2 and 3578(b)(1)a1-2);
- Subject to other provisions of the law, a carrier is prohibited from issuing any health benefit plan containing terms that “place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan” (see 18 **Del.C.** §§3343(b)(1)b and 3578(b)(1)b); and
- A health benefit plan that provides coverage for prescription drugs must, in pertinent part, provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that includes immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law (see 18 **Del.C.** §§3343(b)(2)a and 3578(b)(2)a).

2. New Delaware statutory reporting requirements

Senate Bill No. 230 as amended by Senate Amendment No. 1 (SB 230/SA1) became effective on September 1, 2018. See Del. S.B. 230/Del. S.A. 1, 149th Gen. Assem. § 1 (2018). Carriers are now required to submit a report to the Delaware Health Information Network, Inc., in conjunction with the Delaware Department of Insurance (the Department) on or before July 1, 2019, and “every year thereafter in which the carrier makes significant changes to how it designs and applies its medical management protocols.” *Id.*

In the report, the carrier must:

- Describe how the carrier designs and applies its medical management protocols (see 18 **Del.C.** §§3343(g)(1) and 3571U(1));
- Within each classification of benefits, describe all non-quantitative treatment limitations (NQTLs) (for example, preauthorization requirements, first-fail requirements) that are applied to mental health treatment and treatment for substance abuse disorders (MH/SUD) benefits, and to all medical and surgical (M/S) benefits (this subsection also specifically prohibits the use of an NQTL that applies to a MH/SUD benefit that does not also apply to a M/S benefit) (see 18 **Del.C.** §§3343(g)(2) and 3571U(2));

- Describe how the medical management protocols and the NQTLs that are applied to each MH/SUD benefit are applied on parity with the corresponding M/S benefit within the corresponding classification of benefits (the Parity Analysis) (see 18 **Del.C.** §§ 3343(g)(3) and 3571U(3)). The five parts of the Parity Analysis include:
 1. Identifying the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;
 2. Identifying and defining the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL;
 3. Providing the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, for mental illness and drug and alcohol dependencies benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits;
 4. Providing the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental illness and drug and alcohol dependencies benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and
 5. Disclosing the specific findings and conclusions reached by the carrier that the results of the analyses made in the four steps above indicate that the carrier is in compliance with Sections 3343 and 3571U and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations, which includes 45 CFR 146.136, 45 CFR 147.160, and any other related federal regulations found in the Code of Federal Regulations.

Section 3 of SB 230/SA1 amended Section 25 of Title 31 to now require identical reporting requirements for coverage for serious mental illness and drug and alcohol dependency for recipients of aid under the Federal Medicaid assistance program, which is administered through Delaware's Department of Health and Social Services.

At Section 4 of SB 230/SA1, the General Assembly charged the Department with adopting regulations regarding the format and submission timing of the reports required under Sections 1 through 3 of SB 230/SA1.

3. Federal Parity Reporting Requirements

As mentioned above, the Parity Analysis required under new Title 18 Delaware Code Sections 3343(g) and 3571U includes a five factor test, the fifth of which involves the parity analysis required under the federal MHPAEA, 42 U.S.C. 300gg-26, and its implementing regulations, 45 CFR 146.136 and 45 CFR 147.160.

Like 18 **Del.C.** §§3343 and 3571U, the MHPAEA and its implementing regulations require that any financial requirement such as copayments, deductibles, coinsurance, or out-of-pocket maximums, or quantitative treatment limitations such as day or visit limits, imposed on MH/SUD benefits be no more restrictive than the predominant financial requirement or treatment limitation of that type that applies to substantially all M/S benefits, on a classification-by-classification basis.

Both the Delaware Code at 18 **Del.C.** §§3343 and 3571U and the MHPAEA regulations prohibit imposing an NQTL with respect to MH/SUD benefits in any classification. However, the prohibition against imposing an NQTL does not apply if, pursuant to the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation to M/S benefits in the same classification.

Neither Delaware law nor MHPAEA applies to excepted benefit plans or to short-term limited duration insurance.

4. Enforcement of mental health parity requirements

Federal law relies on state insurance regulators as the first-line enforcers of health reform provisions in the individual, small group, and large group insurance markets. State Departments of Insurance investigate the conduct of insurers in the marketplace by conducting Market Conduct Examinations.

On December 19, 2018, the Market Conduct Examination Standards (D) Working Group of the National Association of Insurance Commissioners (NAIC) adopted revisions to its model *Market Regulation Handbook* that include a general guidance document addressing mental health parity review. The revisions include a series of questions to be posed to health insurance carriers by insurance department examiners, and a regulator data collection tool for mental health parity analysis.

Drafts of the two documents, which "were developed with the assistance of regulator subject matter experts in mental health parity review," were circulated to the Working Group for review on July 9, 2018 and were discussed during the Group's monthly conference calls thereafter. See Market Conduct Examination Standards (D) Working Group Conference Call minutes (November 29, 2018), available for download at https://www.naic.org/documents/cmte_d_market_conduct_exam_standards_181219_materials.pdf?79.

The NAIC anticipates that the development of state market conduct compliance tools for MHPAEA "will result in enhanced state collaboration, to provide more consistent interpretation and review of parity standards." See of NAIC

5. Proposed new Regulation 1410

To the extent that the NAIC has adopted a model enforcement mechanism concerning mental health parity reporting which is designed to standardized data requests on this issue, insurers are on notice of the data that they will likely be required to provide during a market conduct examination that includes a review of the carrier's administration of its mental health and substance abuse coverage benefits.

The Department believes that it is important to synchronize the data reporting that is required under SB230/SA1, the data reporting under MHPAEA's implementing regulations and the data reporting that will likely be required under a Market Conduct Examination. Accordingly, the Department is proposing to satisfy the SB230/SA1 requirement for regulations by codifying the NAIC model state market conduct compliance tools for MHPAEA as new 18 **DE Admin. Code** 1410, entitled "Reporting Medical Management Protocols for Insurance Coverage for Serious Mental Illness and Drug and Alcohol Dependency."

The proposed new regulation appears below and may also be viewed at the Department's website at <http://insurance.delaware.gov/information/proposedregs/>. The Department does not intend to hold a public meeting regarding these proposed new regulations.

Any person may file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed new regulation by email to leslie.ledogar@delaware.gov or by mailing to:

Delaware Department of Insurance
Attn.: Leslie W. Ledogar, Esq., Regulatory Specialist
Docket No. 4042-2019
841 Silver Lake Boulevard
Dover, DE 19904

Any written or emailed submission in response to this notice and relevant to the proposed new regulation must be received by the Department no later than 4:30 p.m. on the 1st day, May, 2019.

1410 Reporting Medical Management Protocols for Insurance Coverage for Serious Mental Illness and Drug And Alcohol Dependency

1.0 Purpose

The purpose of this regulation is to set forth the format and submission requirements for the mental health parity report that is required to be submitted to the Delaware Health Information Network and the Department in accordance with 18 Del.C. §§3343 and 3571U.

2.0 Applicability

This regulation applies to every carrier as defined in Section 4.0 of this regulation who issues a health benefit plan as defined in Section 4.0 of this regulation.

3.0 Authority

The authority for this regulation is 18 Del.C. §§311, 3343 and 3571U and Del. S.B. 230/Del. S.A. 1, 149th Gen. Assem. §4 (2018), and promulgated in accordance with the Delaware Administrative Procedures Act, 29 Del.C. Chapter 101.

4.0 Definitions

The following words and terms, when used in this regulation, have the following meaning unless the context clearly indicates otherwise:

"Carrier" means any entity that provides health insurance in this State. For the purposes of this section, "carrier" includes an insurance company, health service corporation, health maintenance organization, managed care organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with a health benefit plan. "Carrier" also includes any carrier who administers a health benefit plan under 31 Del.C. §505(3).

"Commissioner" means the Insurance Commissioner of the State of Delaware.

"Department" means the Delaware Department of Insurance.

"FR" means financial requirements, and includes but is not limited to deductibles, copayments, coinsurance, and out-of-pocket maximums.

"Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract, as defined and qualified under 18 Del.C. §§3343 and 3578, and any assistance provided to an individual under 31 Del.C. §505(3).

"Mental health parity report" means the report that is to be submitted to the Department and to the Delaware Health Information Network pursuant to Section 5.0 of this regulation.

"MHPAEA" means the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) as amended and supplemented.

"MH/SUD benefits" means mental health and substance use disorder benefits.

"M/S benefits" means medical and surgical benefits.

"NQLT" means non-quantitative treatment limitation, and includes but is not limited to preauthorization requirements and first-fail requirements.

"QTL" means quantitative treatment limitation, and includes but is not limited to lifetime limits, episode limits, and day and visit limits.

5.0 Reporting Content and Format

5.1 Each carrier shall complete a mental health parity report, using forms provided by the Department, in which the carrier shall report on the following:

5.1.1 Whether the health insurance coverage is or is not exempt from MHPAEA. If the carrier reports that the health insurance coverage is exempt from MHPAEA, the carrier shall indicate the reason for the exemption, which may include, by way of example only, retiree-only plan, excepted benefits (45 CFR § 146.145(b)), short term limited duration insurance, small employer exemption (45 CFR § 146.136(f)), or increased cost exemption (45 CFR § 146.136(g));

5.1.2 If the health insurance coverage is not exempt from MHPAEA pursuant to subsection 5.1.1 of this regulation:

5.1.2.1 How the health insurance coverage provides MH and/or SUD benefits in addition to providing M/S benefits; and

5.1.2.2 Using the data collection tool incorporated as Appendix A of this regulation, how the insurance coverage provides MH/SUD benefits in each of the following six coverage classifications in which M/S benefits are provided:

5.1.2.2.1 Inpatient, in-network;

5.1.2.2.2 Inpatient, out-of-network;

5.1.2.2.3 Outpatient, in-network;

5.1.2.2.4 Outpatient, out-of-network;

5.1.2.2.5 Emergency care; and

5.1.2.2.6 Prescription drugs.

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

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

5.1.5 Whether the plan complies with the parity requirements for aggregate lifetime and annual dollar limits, including the prohibition on lifetime dollar limits or annual dollar limits for MH/SUD benefits that are lower than the lifetime or annual dollar limits imposed on M/S benefits. To comply with this reporting requirement, a carrier shall list the services subject to lifetime or annual limits, separated into MH/SUD and M/S benefits.

5.1.6 Whether the plan imposes any FR or QTLs on MH/SUD benefits in any classification that is more restrictive than the predominant FR or QTL of that type that applies to substantially all M/S benefits in the same classification. To comply with this reporting requirement a carrier shall demonstrate compliance with

this standard by completing the data collection tool incorporated as Appendix A of this regulation by reference;

5.1.7 Whether the plan applies any cumulative financial requirements or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for M/S benefits in the same classification. To demonstrate compliance with this standard, the carrier shall complete the data collection tool incorporated as Appendix A to this regulation;

5.1.8 Whether the plan imposes NQTLs on MH/SUD benefits in any classification. If so, the carrier shall demonstrate compliance with parity requirements by completing the data collection tool incorporated as Appendix A of this regulation. For purposes of this subsection 5.1.8, examples of NQTLs include but are not limited to:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization and ongoing authorization requirements;
- Concurrent review standards;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or insurer's methods for determining usual, customary and reasonable charges;
- 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);
- Restrictions on applicable provider billing codes;
- Standards for providing access to out-of-network providers;
- Exclusions based on failure to complete a course of treatment;
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan; and
- Any other non-numerical limitation on MH/SUD benefits; and

5.1.9 Whether the carrier complies with MHPAEA disclosure requirements including:

5.1.9.1 Criteria for medical necessity determinations for MH/SUD benefits; and

5.1.9.2 The reasons for any denial of benefits of any kind.

5.2 Nothing in this Section shall supersede any federal or State law governing the privacy of health information.

6.0 Report submission deadlines and deadline extension request requirements

6.1 Each carrier who is required to submit a mental health parity report pursuant to this regulation shall submit its initial report on or before July 1, 2019.

6.2 Each carrier who is required to submit a mental health parity report pursuant to this regulation shall submit an amended report 30 calendar days after the close of any year during which the carrier made significant changes to how it designs and applies its medical management protocols.

6.3 One copy of each report required to be prepared in accordance with this Regulation shall be submitted to each of the following addresses:

Delaware Health Information Network
Attn.: Mental Health Parity Report
107 Wolf Creek Blvd. #2
Dover, DE 19901

Delaware Department of Insurance
Attn.: Mental Health Parity Report
841 Silver Lake Blvd.
Dover, DE 19904

6.4 A carrier may request from the Commissioner an extension of the deadline for submission of the initial report to be submitted pursuant to subsection 6.1 of this regulation, and any subsequent reports to be submitted pursuant to subsection 6.2 of this regulation for due cause. To request an extension pursuant to this subparagraph, the carrier shall, no later than 30 days prior to the reporting deadline, petition the Commissioner for a reporting deadline extension, with a copy of the request to the Delaware Health Information Network, stating the reasons for the extension request.

6.4.1 No reporting deadline shall be extended for a period longer than 60 days.

6.4.2 If the Commissioner fails to affirmatively approve or disapprove an extension request within 30 days of receipt of the request, the request shall be deemed approved.

6.4.3 The Commissioner may extend the 30-day review period for not more than 30 additional days by providing the carrier with written notice of the extension before the expiration of the initial 30-day review period.

7.0 Enforcement Authority.

- 7.1 To ensure compliance with the provisions of this regulation and to protect Delaware health care consumers, the Commissioner may, in his or her discretion, examine the business and financial affairs of a carrier doing business in this state by utilizing the powers granted by 18 **Del.C.** §§320, 3343(g)(5), 3571U(a)(5), and other provisions of Title 18 as may be applicable.
- 7.2 Any person or entity who violates any provision of this regulation shall be subject to the penalties provided in 18 **Del.C.** Chapter 3, and such other provisions of Title 18 as may be applicable.

8.0 Severability

If any provision of this regulation, or the application thereof to any person or circumstance, is held invalid, such invalidity shall not affect other provisions or applications of this regulation which can be given effect without the invalid provision or application, and to that end the provisions of this regulation are severable.

9.0 Effective Date

This regulation shall be effective on {insert date that is 10 days after the date of the publication of the order adopting this regulation as a final regulation}.

APPENDIX A

DATA COLLECTION TOOL FOR MENTAL HEALTH PARITY ANALYSIS

Most parity analysis examines benefits by comparing MH/SUD to M/S within a classification. 45 CFR 146.136(c)(2)(i). The exception is aggregate lifetime or annual dollar limits (to the extent the plan is not prohibited from imposing such limits under Federal or State law), which are examined for the plan as a whole. See 45 CFR 146.136(b). The following is intended to simplify data collection for parity analysis at the classification level.

A-1 GUIDANCE FOR PLACING BENEFITS INTO CLASSIFICATIONS:

MH/SUD and M/S benefits must be mapped to one of six classifications of benefits: (1) inpatient in-network, (2) inpatient out-of-network, (3) outpatient in-network, (4) outpatient out-of-network, (5) prescription drugs, and (6) emergency care (see subsection 5.1.3 of this regulation and 45 CFR 146.136(c)(2)(ii)):

- The “inpatient” classification typically refers to services or items provided to a beneficiary when a physician has written an order for admission to a facility, while the “outpatient” classification refers to services or items provided in a setting that does not require a physician’s order for admission and does not meet the definition of emergency care.
- “Office visits” are a permissible sub-classification separate from other outpatient services.
- The term “emergency care” typically refers to services or items delivered in an emergency department setting or to stabilize an emergency or crisis, other than in an inpatient setting. See 18 **Del.C.** Chapters 33 and 35 concerning emergency care standards.
- Some benefits, for example lab and radiology, may fit into multiple classifications depending on whether they are provided during an inpatient stay, on an outpatient basis, or in the emergency department.
- Insurers should use the same decision-making standards to classify all benefits, so that the same standard applies to M/S and MH/SUD benefits. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for M/S benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits.

A-2 FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS:

Types of FRs include deductibles, copayments, coinsurance, and out-of-pocket maximums. See 45 CFR 146.136(c)(1)(ii). Types of QTLs include annual, episode, and lifetime day and visit limits, for example number of treatments, visits, or days of coverage. See 45 CFR 146.136(c)(1)(ii). A two-part analysis applies to FRs and QTLs. In general, MHPAEA regulations require that any FR or QTL imposed on MH/SUD benefits not be more restrictive than the predominant level of financial requirement or treatment limitation of that type that applies to substantially all medical/surgical benefits in a classification.

If the plan applies a cumulative FR or QTL (a FR or QTL that determines whether or to what extent benefits are provided

based on accumulated amounts), the FR or QTL must not accumulate separately from any established for M/S benefits in a classification.

FINANCIAL REQUIREMENTS						
<u>Benefit Plan Design(s) Identifier(s):</u> <u>Submit a separate form for each benefit plan design.</u> <u>Plan Name: Date:</u> <u>Contact Name: Telephone Number: Email:</u> <u>Line of Business (HMO, EPO, POS, PPO):</u> <u>Contract Type (large group, small group, individual):</u> <u>Benefit Plan Effective Date:</u>						
	<u>Inpatient In-Network</u> <u>(if network tiers, may separate into tiers in accordance with 45 CFR 146.136 (c)(3)(iii)(B)).</u>	<u>Inpatient Out-of- Network</u>	<u>Outpatient In-Network</u> <u>(Issuer may choose to have sub-classifications for Outpatient Office Visits, and Other Outpatient Services)</u> <u>(if network tiers, may separate into tiers in accordance with 45 CFR 146.136 (c)(3)(iii)(B))</u>	<u>Outpatient Out-of-Network</u> <u>(Issuer may choose to have sub-classifications for Outpatient Office Visits, and Other Outpatient Services)</u>	<u>Emergency Care</u>	<u>Prescription Drugs</u>
<u>Does the plan provide MH/ SUD benefits?</u>						
<u>Does the plan provide M/S benefits?</u>						
<u>Total dollar amount of ALL plan payments for M/S benefits expected to be paid for the relevant plan year</u>						
<u>List each financial requirement that applies to the classification for MH/SUD benefits.</u>						

For each type of financial requirement that applies to MH/ SUD benefits, list the expected percentage of plan payments for M/S benefits in each classification that are subject to that same type of financial requirement.						
For each level of each type of financial requirement that applies to at least 2/3rds of all M/S/ benefits in the classification, list the expected percentage of plan payments for M/S benefits subject to that financial requirement, that are subject to that level.						
Does the plan impose a separate cumulative financial requirement or QTL for MH/ SUD benefits that accumulates separately from any cumulative financial requirement or QTL for M/S benefits?						

QUANTITATIVE TREATMENT LIMITATIONS

Benefit Plan Design(s) Identifier(s):
 Submit a separate form for each benefit plan design.
 Plan Name: Date:
 Contact Name: Telephone Number: Email:
 Line of Business (HMO, EPO, POS, PPO):
 Contract Type (large group, small group, individual):
 Benefit Plan Effective Date:

	<u>Inpatient In-Network (if network tiers, may separate into tiers in accordance with 45 CFR 146.136 (c)(3)(iii)(B)).</u>	<u>Inpatient Out-of-Network</u>	<u>Outpatient In-Network (Issuer may choose to have sub-classifications for Outpatient Office Visits, and Other Outpatient Services) (if network tiers, may separate into tiers in accordance with 45 CFR 146.136 (c)(3)(iii)(B))</u>	<u>Outpatient Out-of-Network (Issuer may choose to have sub-classifications for Outpatient Office Visits, and Other Outpatient Services)</u>	<u>Emergency Care</u>	<u>Prescription Drugs</u>
<u>List each QTL that applies to the classification for MH/SUD benefits.</u>						
<u>For each type of QTL that applies to MH/SUD benefits, list the expected percentage of plan payments for M/S benefits in each classification that are subject to that same type of QTL.</u>						
<u>For each level of each type of QTL that applies to at least 2/3rds of all M/S benefits in the classification, list the expected percentage of plan payments for M/S benefits subject to that QTL, that are subject to that level.</u>						

A-3 NON-QUANTITATIVE TREATMENT LIMITATIONS:

NQTLs include but are not limited to medical management techniques such as step therapy and pre-authorization requirements. Coverage cannot impose a NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no

more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification. Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

All plan standards that are not FRs or QTLs and that limit the scope or duration of benefits for services are subject to the NQTL parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy.

The following data collection chart is modeled after a tool used in federal MHPAEA examinations. Insurers who have completed "Table 5" for NQTLs may substitute those documents for completion of this chart.

<u>NON-QUANTITATIVE TREATMENT LIMITATIONS</u>			
Benefit Plan Design(s) Identifier(s): <u>Submit a separate form for each benefit plan design.</u> Plan Name: Date: Contact Name: Telephone Number: Email: Line of Business (HMO, EPO, POS, PPO): Contract Type (large group, small group, individual): Benefit Plan Effective Date:			
<u>Area</u>	<u>Medical/Surgical Benefits</u> <u>Summarize the plan's applicable NQTLs, including any variations, by benefit.</u>	<u>Mental Health/Substance Use Disorder Benefits</u> <u>Summarize the plan's applicable NQTLs, including any variations, by benefit.</u>	<u>Explanation</u> <u>Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below.</u>
<u>A. Definition of Medical Necessity</u> <u>What is the definition of medical necessity?</u>			
<u>B. Prior-authorization Review Process</u> <u>Include all services for which prior authorization is required. Describe any step therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans.</u> <u>Inpatient, In-Network:</u>			

Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			
Outpatient, Out-of-Network: Other Items and Services:			
C. Concurrent Review Process, including frequency and penalties for all services. <i>Describe any step therapy or "fail first" requirements and requirements for submission of treatment required forms or treatment plans.</i>			
Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			
Outpatient, Out-of-Network: Other Items and Services:			
D. Retrospective Review Process, including timeline and penalties.			
Inpatient, In-Network:			
Outpatient, In-Network: Office Visits:			
Outpatient, In-Network: Other Outpatient Items and Services:			
Inpatient, Out-of-Network:			
Outpatient, Out-of-Network: Office Visits:			
Outpatient, Out-of-Network: Other Items and Services:			
E. Emergency Services			
F. Pharmacy Services <i>Include all services for which prior authorization is required, any step therapy or "fail first" requirements, any other NQTLs.</i>			
Tier 1:			
Tier 2:			
Tier 3:			
Tier 4:			

<u>G. Prescription Drug Formulary Design</u> <u>Describe how formulary are decisions made for the diagnosis and medically necessary treatment of medical, mental health and substance use disorder conditions.</u>			
<u>Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.</u>			
<u>What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in development of the formulary for medications to treat medical, mental health and substance use disorder conditions?</u>			
<u>H. Case Management</u> <u>What case management services are available?</u>			
<u>What case management services are required?</u>			
<u>What are the eligibility criteria for case management services?</u>			
<u>I. Process for Assessment of New Technologies</u> <u>Definition of experimental/ investigational:</u>			
<u>Qualifications of individuals evaluating new technologies:</u>			
<u>Evidence consulted in evaluating new technologies:</u>			
<u>J. Standards for Provider Credentialing and Contracting</u> <u>Is the provider network open or closed?</u>			
<u>What are the credentialing standards for physicians?</u>			
<u>What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers?</u>			

What are the credentialing/ contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?			
<u>K. Exclusions for Failure to Complete a Course of Treatment</u> Does the plan exclude benefits for failure to complete treatment?			
<u>L. Restrictions that Limit Duration or Scope of Benefits for Services</u> Does the plan restrict the geographic location in which services can be received; e.g., service area, within the state, within the United States?			
Does the plan restrict the type(s) of facilities in which enrollees can receive services?			
<u>M. Restrictions for Provider Specialty</u> Does the plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?			
<u>List of Documents Referenced Above</u> List each document referenced above, including reference to exhibit number, file name, or other identifying information for examiners.			