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August 13, 2014

Sent Via E-Mail and Via Certified Mail

(Insert Address)

RE: (Insert Company)
Mental Health Parity Survey – Maryland Business Only

Dear (Insert Name) :

Pursuant to §§ 2-108 and 2-205 of the Insurance Article, Annotated Code of Maryland, the Maryland Insurance Administration is gathering information to verify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Please provide a detailed response to the following questions as they relate to fully-insured group and individual health benefit plans. Do not include any self-funded groups or federal programs. When referencing small and large groups, the employer/group contract must be sitused in the state of Maryland with one or more Maryland employees.

1. List all markets in which you currently write business subject to MHPAEA (individual/small group/large group).

    a. Do you have the same or different requirements for MHPAEA compliance within each market?
    b. If the requirements are different between markets, describe the differences.

2. The MHPAEA final rule[1] differentiates between six different classifications of benefits: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4)

[1] *See* "Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program; Final Rule." 78 F.R. 219 at 68240 (Wednesday, November 13, 2013).

outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.[2] MHPAEA requires that services within a particular classification be treated the same for mental illness and substance use disorders as they would be treated for medical and surgical conditions.

a. How do you determine into which classification a particular benefit belongs?
b. Please provide a detailed description of the process you utilize in categorizing benefits into the six different classifications.

3. To comply with MHPAEA's general parity requirement,[3] a plan may not apply any "financial requirement"[4] or "treatment limitation"[5] to mental health or substance use disorder benefits in any classification that is more restrictive than the "predominant" [6] financial requirement or treatment limitation of that type applied to "substantially all"[7] medical/surgical benefits in the same classification.

a. Please describe the process that you use to determine whether the "substantially all" test is met.
b. Please describe the process that you use when developing a plan design to determine the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits in each classification. Include an explanation of how you ensure that financial limitations and treatment limitations are not more restrictive for mental health/substance use disorder benefits than limitations for medical/surgical benefits in the same classification.
c. Provide a detailed example of your process using your plan with the most enrollees in Maryland (please specify market).

4. Under MHPAEA, a plan may not impose a nonquantitative treatment limitation (NQTL) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes,

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[2] *See* 45 C.F.R. 146.136(c)(2)(ii).
[3] *See* 45 C.F.R. 146.136(c)(2)(i).
[4] *Financial requirements* include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. *See* 45 C.F.R. 146.136(a).
[5] *Treatment limitations* include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage (see question 4 below for an illustrative list of NQTLs). A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. *See* 45 C.F.R. 146.136(a).
[6] A financial requirement or treatment limitation is "predominant" if it applies to more than one-half of substantially all of the medical/surgical benefits in the same classification. *See* 45 C.F.R. 146.136(c)(3)(i)(B).
[7] A financial requirement or treatment limitation applies to "substantially all" medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in the classification. *See* 45 C.F.R. 146.136(c)(3)(i)(A).

strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.[8] Under MHPAEA, NQTLs include:

> (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
> (B) Formulary design for prescription drugs;
> (C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
> (D) Standards for provider admission to participate in a network, including reimbursement rates;
> (E) Plan methods for determining usual, customary, and reasonable charges;
> (F) 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);
> (G) Exclusions based on failure to complete a course of treatment; and
> (H) 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. [9]

a. Provide a description of how you develop NQTLs applicable to mental health and substance use disorders. Include in this description a demonstration of how the processes, strategies, evidentiary standards and other factors used in applying an NQTL to mental health/substance use disorder benefits are comparable to and applied no more stringently than medical/surgical benefits in each classification.
b. How do you provide the policyholder with information pertaining to NQTLs?

5. Medical Necessity Criteria

a. Do you use a Private Review Agent (PRA) to determine the medical necessity or appropriateness of mental health/substance use disorder benefits? If so, what company do you use?
b. Is that company different than the PRA you use for medical/surgical benefits? If so, what steps does your company take to ensure that the medical necessity or appropriateness criteria used by your PRA for mental health/substance use disorder benefits is consistent with the necessity or appropriateness criteria used by your PRA for medical/surgical benefits?

6. Formulary Design for Prescription Drugs

[8] *See* 45 C.F.R. 146.136(c)(4)(i).
[9] *See* 45 C.F.R. 146.136(c)(4)(ii).

a. Describe your process for placing mental health/substance use disorder and medical/surgical medications into tiers.
b. Explain how you determine when to apply each NQTL to mental health/substance use disorder and medical/surgical medications.

7. Provider Networks

a. Provide a description of your network admission, credentialing, and network closure standards for mental health/substance use disorder providers and medical/surgical providers.
b. Provide a description of your process for determining the fee schedule and reimbursement rates for mental health/substance use disorder providers and medical/surgical providers.

Pursuant to COMAR 31.04.20.05 E, the Company is required to confirm the accuracy of all information provided and submit a "Certificate of Compliance" signed by an officer of the Company acknowledging in a written certification that the information provided is, "to the best of the individual's knowledge, information, and belief, a full, complete, and truthful response to the Commissioner's response," and that the "individual making the certification was undertaken an adequate inquiry to make the required certification."

The response to this survey along with the Certificate of Compliance must be provided to Salama Karim-Camara, Market Data Analyst, no later than close of business on September 30, 2014. If you have any questions or concerns, please contact Nour Benchaaboun, Chief, Market Analysis at (410) 468-2222 or by e-mail at nour.benchaaboun@maryland.gov.

Thank you for your time and consideration in this matter.

Sincerely,

Nour E. Benchaaboun, AIRC, MCM
Chief, Market Analysis