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Commissioner

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MARYLAND INSURANCE ADMINISTRATION

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(Date)

Sent Via E-Mail and Via Certified Mail

(Insert Address)

RE: (Insert Company)
2015 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 ("Administration") is gathering information to verify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Administration will be conducting these surveys on a yearly basis for the next three years. 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.

Financial Testing

1) To comply with MHPAEA's general parity requirement,[1] a plan may not apply any "financial requirement"[2] or "treatment limitation"[3] to mental health or substance use disorder benefits in

[1] *See* 45 C.F.R. 146.136(c)(2)(i).
[2] *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).
[3] *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

any classification that is more restrictive than the "predominant"[4] financial requirement or treatment limitation of that type applied to "substantially all"[5] medical/surgical benefits in the same classification.

a) Do you currently write business subject to MHPAEA in the large group market?
b) If so, provide the financial testing explained above for the large group plan with the most enrollees in Maryland.

Nonquantitative Treatment Limitations

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, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.[6]

2) Do you have a fail first requirement for any prescription medications on any formulary the Company employs? If so, provide the following for each formulary:
   a) A description of the terms of the fail first requirement.
   b) A list identifying all mental health/substance use drugs vs. somatic drugs that have this requirement and which drug an individual is required to try first.
   c) A detailed description of how you determine a particular drug should be given a fail first requirement.
   d) Specifically identify if Vivitrol and Suboxone are included in the formulary and if they have a fail first requirement.

3) When creating your provider panel, how do you determine the level of need for a type of provider? Are there parameters or formulas used for mental health/substance use providers and for medical providers? If so, what are they? How do you determine if you have sufficient number of providers in a geographic area to meet the level of need for the type of provider?

4) Provide a detailed description of the processes that are used to determine the length of stay for inpatient/residential treatment for mental health/substance use conditions and for medical/surgical conditions. For example, do you approve only one day at a time for all types of inpatient or residential care, or do different processes for approving inpatient or residential care apply to different conditions?

5) Identify the percentage of total requests for inpatient admissions (including residential treatment services) for which you denied a requested level of care, but authorized a lower level of care for:
   i) mental health diagnoses

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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).

[4] 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).

[5] 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).

[6] *See* 45 C.F.R. 146.136(c)(4)(i) and for a description of what is included in NQTL's *see* 45 C.F.R. 146.136(c)(4)(ii).

ii) substance use disorder diagnoses, and
iii) somatic diagnoses.

Specify the numbers by market segment (individual/small group/large group) for admission authorizations requested between January 1, 2014 and March 31, 2015. Include prior and concurrent authorization requests. Describe the processes, strategies, and evidentiary standards used to determine when lower levels of care are authorized in place of inpatient admissions for MH/SA vs. medical/surgical conditions.

6) a) Please specify if the following levels of care are available in your network for the following conditions and services:
   i) in regard to the treatment of heroin and opioid abuse disorders:
      (1) Inpatient services in a hospital;
      (2) Inpatient services in a facility other than a hospital;
      (3) Intensive Outpatient services;
      (4) Outpatient services.
   ii) In regard to the treatment of diabetes:
      (1) Inpatient services in a hospital;
      (2) Inpatient services in a facility other than a hospital;
      (3) Intensive Outpatient services;
      (4) Outpatient services, e.g. outpatient self-management training and educational services.
   ii) In regard to the treatment of stroke:
      (1) Inpatient services in a hospital;
      (2) Inpatient services in a facility other than a hospital;
      (3) Intensive Outpatient services;
      (4) Outpatient services.
   iii) In regard to treatment of bipolar disorder:
      (1) Inpatient services in a hospital;
      (2) Inpatient services in a facility other than a hospital;
      (3) Intensive Outpatient services;
      (4) Outpatient services.

   b) Provide the number of providers for each level of care for each condition listed in 6(a) and their distribution by geographic area.
   c) Explain how the number of providers at each level of care has been adjusted based on changes in demand for the services over the past three years and the anticipated demand for services in the next three years for each condition listed in 6(a).
   d) If you do not have sufficient providers at a given level of care in a geographic area, how do you determine the amount of reimbursement for an out-of-network provider for each condition? Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the fee schedule on which reimbursement is based.
   e) Explain the processes used to determine the adequacy of the network for each of the four conditions listed in 6(a), including any rules, formulas, and algorithms.
   f) List which drugs are covered at each level of care for each condition listed in 6(a), and how are they tiered. Include limitations on dosage. Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in placing drugs in tiers and determining limitations on dosage.
   g) Provide the requirements for utilization review for each level of treatment for the conditions listed in 6(a) above. Include limitations on length of treatment for each such condition.

Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the requirements for utilization review and the limitations on length of treatment.

h) Provide the medical necessity criteria used for utilization review for each level of treatment for the conditions listed in 6(a) above. Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the medical necessity criteria.

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 has undertaken an adequate inquiry to make the required certification."

The response to this survey along with the Certificate of Compliance must be provided to me no later than close of business on November 30, 2015. If you have any questions or concerns, please call or e-mail me at nour.benchaaboun@maryland.gov.

Thank you for your time and consideration in this matter.

Sincerely,

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