Documentation Supporting the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, Quantitative Treatment Limitations Compliance Benefit Design and Parity Testing

To ensure financial parity between Mental Health and Substance Use Disorder (MH/SUD) and medical and surgical benefits, Anthem evaluates all fully insured plan designs using prescribed methodology in compliance with federal regulations 45 C.F.R. 146.136(c)(2)-(3). Plans are evaluated under a “substantially all” and “predominant” three-step process to determine the availability and level of cost sharing (types of cost sharing include copays, coinsurance, or deductibles) that can be applied to MH/ SUD services.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended, and its corresponding regulations requires group health plans, health insurance issuers, and individual health insurance plans to have parity between mental health/substance use disorder (MH/SUD) benefits and medical/surgical benefits with respect to financial requirements and treatment limitations. This law and its implementing regulations, the (“Final Rules”,) are very detailed and contain many complex concepts that may be difficult to implement. However, despite the law’s complexities, covered health plans are required to comply with the law and its implementing regulations.

- **Step 1**: General Parity Requirements and classification of benefits
    - If a plan provides mental health/substance use disorder benefits in any classification of benefits described in the MHPAEA regulations, MH/SUD covered services must be provided in every classification in which medical/surgical covered services are provided.
    - Financial requirements and treatment limitations imposed on benefits vary based on whether a treatment is provided on an inpatient, outpatient, or emergency basis; whether a provider is a member of the plan’s network; or whether the benefit is for a prescription drug. Therefore, to apply MHPAEA’s parity standards with respect to financial requirements and treatment limitations (whether quantitative or non-quantitative), the MHPAEA regulations Final Rules establish six benefits classifications, as follows:
        1. Inpatient, In-Network
        2. Inpatient, Out-of-Network
        3. Outpatient, In-Network
        4. Outpatient, Out-of-Network
        5. Emergency Care
        6. Pharmacy
    - According to the MHPAEA regulations Final Rules, the parity standards for financial requirements and treatment limitations apply on a classification-by-classification basis and, with the exception of certain permissible sub-classifications, are the only classifications permitted for purposes of satisfying MHPAEA regulations.

  - Using a reasonable method for allocating allowed claims (i.e., claim cost before member cost sharing is applied) and based on additional guidance from the Department of Labor, the covered services payment experience for Anthem health plans, incurred and paid the previous year, were extracted from Anthem claim systems based on medical/surgical covered services. These claims were used in order to perform the" substantially all" and "predominant" financial requirements and quantitative treatment limitation analysis.

- **Step 2:** A Substantially All or 2/3s test is applied to determine if that Financial Requirements (FR) or Quantitative Treatment Limitations (QTL) type can be applied to Mental Health/Substance Use Disorder (MH/SUD) benefits within a classification.
  - ***A cost share type can apply to MH/SUD services*** if it applies to at least two-thirds of all medical and surgical services within that benefit classification.
  - ***A cost share type cannot apply to MH/SUD services*** if it does not apply to at least two-thirds of all medical benefits.
  - ***Note***: The evaluation criteria for the tiering of prescription drug benefits differs and is based on reasonableness factors including cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. Anthem's current pharmacy structures are compliant with these regulations.
  - The expected claims cost are summed for each applicable FR type (i.e. Deductible, Out-of-Pocket Maximum, Copayments, Coinsurance) and QTL (i.e. annual or lifetime day or visit limits) in order to determine if that FR type or QTL applies to substantially all or at least 2/3's of the medical and surgical benefits in that classification. Medical and surgical benefits subject to a zero level of a type of FR was designated as not subject to that FR type. In addition, medical and surgical benefits subject to an unlimited QTL was considered not subject to that QTL type.
  - See illustrative numerical example below for step 2

- **Step 3:** If a FR or QTL type is determined to apply to at least two thirds (2/3) of the medical and surgical benefits in that classification, then a predominant or 50% rule test is performed in order to determine the level of FR or QTL that can be applied to MH/SUD benefits.
  - First, we determine if a single level of the substantially all type of FR or QTL applies to greater than 50% of the medical/surgical services in that classification. If so, that cost share level or a less restrictive cost share of the same type can apply to the MH/SUD benefits in that classification.
  - If no single level of FR or QTL applies to greater than 50% of the medical/surgical benefits, then a combination of FR or QTL levels are combined from most to least restrictive until the sum of expected claims cost is greater than 50% of the total expected claims in that classification for the type of FR or QTL. The least restrictive level of FR or QTL are the expected claims summed to greater than 50% and are determined to be the predominant FR or QTL type. This FR or QTL level and type can apply to MH/SUD benefits within the classification.
  - See illustrative numerical example below for step 3.

Illustration of Step 2 and Step 3 as found in the FMHP Results Table

Outpatient Other In-Network	Substantially All (2/3s) Test	Predominance (50%) Test	Facility	Professional
Medical/Surgical	% of Claims	Max Cost Share	MH/SA Cost Share	MH/SA Cost Share
Deductible	93.2%	$5,500	$5,500	$5,500
OOP Max	93.2%	$6,650	$6,650	$6,650
Copays	90.3%	$350	$350	$75
Coins	20.7%	No Coins	No Coins	No Coins

Step 2: This illustrates that copays apply to 90.3% of claims dollars for outpatient participating provider facility based medical and surgical covered services

Step 3: This illustrates that the predominant copay level is $350 representing the maximum copay that could be applied to outpatient mental health/substance use services at a hospital

- **Summary:** The above steps were performed for all defined benefit classifications on both In-Network and Out-of-Network benefits where applicable.

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