COMMONWEALTH OF VIRGINIA

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BOI OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
scc.virginia.gov

MHPAEA QTL/Financial Requirement Guidance
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As compliance with the QTL/Financial Requirement component of the Mental Health Parity and Addiction Equity Act (MHPAEA) continues to be a topic of discussion between the industry and the Bureau of Insurance (BOI), the BOI is providing the below guidance[1]. It is the expectation of the BOI that all carriers follow this guidance to comply with § 38.2-3412.1 B of the Code and MHPAEA.

Defining MH/SUD benefits and M/S benefits

It has come to the BOI's attention that some carriers are not correctly defining mental health/substance use disorder (MH/SUD) benefits. MHPAEA is driven by diagnosis/condition, and carriers must define MH/SUD benefits and medical/surgical (M/S) benefits based on the condition being treated on a given claim. For example, a primary care physician (PCP) office visit for a flu shot would be an M/S benefit, but a PCP office visit for an anxiety medication management visit would be an MH/SUD benefit.

Defining a service as M/S or MH/SUD based on which one it is most commonly used to treat (more than 50% of the time) does not comply with MHPAEA. This position has also been confirmed with the Federal Departments and is clarified in the Final Rules published in 2024.

Diagnosis Codes on Claims

Carriers have expressed concerns with being able to determine whether a service should be considered an MH/SUD benefit or M/S benefit based on the condition being treated. The BOI would like to clarify that it is the responsibility of the provider to make this determination based on diagnostic criteria and to submit a claim with a diagnosis code indicating the condition being treated. Carriers are simply required to recognize benefits as M/S versus MH/SUD based on the condition identified by this diagnosis code. The BOI has no expectation that carriers will perform further analysis of individual claims to determine if they disagree with the diagnosis code submitted by the provider. If a provider submits a claim with an M/S diagnosis code, the BOI expects that carriers would consider that claim to be an M/S benefit, and if a provider submits a claim with an MH/SUD diagnosis code, the BOI expects that carriers would consider that claim to be an MH/SUD benefit.

While identifying MH/SUD benefits and M/S benefits can generally be accomplished by using the primary diagnosis code, carriers are also expected to make reasonable efforts to

[1] Please note that this guidance was originally provided on January 13, 2022 in the context of preparing for 2023 form filings. Carriers should now be complying with this guidance, and references to 2023 form filings have been removed.

account for scenarios where an MH/SUD diagnosis may not be primary but the item or service still meets the definition of an MH/SUD benefit that is protected by MHPAEA. For example, a patient may have an underlying etiology of a traumatic brain injury with a manifestation of a neurocognitive disorder that is treated with psychotherapy. The claim may be submitted with a primary M/S diagnosis of S06.2XAS ("diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela") and a secondary MH/SUD diagnosis of F02.B2 ("major neurocognitive disorder due to traumatic brain injury, moderate, with psychotic disturbance"), but the psychotherapy is still a service used to treat the neurocognitive disorder and is therefore an MH/SUD benefit.

The Federal Departments have also clearly conveyed that autism spectrum disorder (ASD) may be treated with speech and occupational therapy and that eating disorders may be treated with medical nutrition therapy. If such services are submitted with a primary M/S diagnosis and an MH/SUD diagnosis (i.e., ASD or an eating disorder) listed in another position, the services are provided in connection with an MH/SUD condition and are therefore still MH/SUD benefits protected by MHPAEA.

Carriers must contemplate scenarios where generally recognized independent standards of current medical practice identify mental health conditions or substance use disorders that may be the drivers of treatment even when such conditions or disorders are not billed as primary diagnoses.

Expected Claim Dollar Amounts

When performing a QTL/Financial Requirement analysis, expected claim dollar amounts need to account for diagnosis codes/the conditions being treated. Expected claim dollar amounts should only be those associated with M/S benefits and should not include the dollar amounts associated with an MH/SUD diagnosis code. While MHPAEA allows the use of "any reasonable method" to determine expected claim dollar amounts, this language does not grant any flexibility in the requirement to define M/S benefits and MH/SUD benefits based on the condition being treated. The following FAQs include clarification that a carrier should use plan-level data for the analysis, but if sufficient plan-level data is not available it may be reasonable to use data from other plans in the book of business (i.e., reference to "any reasonable method" is speaking to the types of data used and methodology for actuarial projections rather than granting flexibility in defining benefits):

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 31, MENTAL HEALTH PARITY IMPLEMENTATION, AND WOMEN'S HEALTH AND CANCER RIGHTS ACT IMPLEMENTATION (See Question 8)

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 34 AND MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION (See Question 3)

The BOI acknowledges that some services may be difficult to break out for expected claim dollar amounts. The BOI is understanding of these situations, but carriers are expected to make a concerted effort to account for diagnosis codes. For example, a mental health wellness check performed by a PCP as part of a routine physical may not be identifiable based on the way the claim was submitted (if the provider submitted with only an M/S diagnosis code or did not even break this claim line out at all), and the BOI would allow flexibility if a carrier is unable to carve out those expected claim dollar amounts. However, if a patient goes to their PCP solely for treatment of an MH/SUD condition and the claim is submitted with an MH/SUD diagnosis code, the company

should be able to capture that and ensure these dollar amounts are not included in the M/S figures.

It is generally not the intention of the BOI to question expected claim dollar amounts as long as the carrier can confirm it has made a concerted effort to account for diagnosis codes and reduce the expected claim dollar amounts for the applicable service by the dollar amounts associated with the treatment of MH/SUD conditions. However, an explanation from a carrier that certain services, such as PCP office visits, occupational therapy, nutritional counseling, and others are never used to treat MH/SUD conditions and have no associated MH/SUD diagnosis codes would not be acceptable.

Carrier Policy Design of "Mental Health & Substance Use Disorder" Benefits

Carriers commonly have a specific section under the policy's schedule of benefits labelled as "Mental Health & Substance Use Disorder Benefits," and this section includes services that are unique to the treatment of MH/SUD conditions. The BOI acknowledges that, in regard to this component of the schedule of benefits, carriers are generally making an effort to be in compliance with MHPAEA in applying the predominant level of cost sharing, not applying visit limits, and correctly not including payments for these treatments in the M/S expected claim dollar amounts. While the BOI does not have specific concerns with the methodology behind this section of the schedule of benefits at this time, we offer the following reminders/suggestions:

1. If a carrier sub-classifies Outpatient benefits into "Office" and "All Other," it should be able to list the services placed in each sub-classification and provide justification for why those services were placed in "Office" or "All Other." Carriers are reminded that if different predominant levels apply to "Office" and "All Other," the services placed in each sub-classification should be assigned the correct cost sharing. For example, if a $25 copay is the predominant level of cost sharing in the "Outpatient, In-Network, Office" sub-classification and a $45 copay is the predominant level of cost sharing in the "Outpatient, In-Network, All Other" subclassification, a psychiatrist office visit that is placed in the "Outpatient, In-Network, Office" subclassification should be assessed the $25 copay and not the $45 copay. In addition, if the BOI requests that a carrier complete and submit for review Virginia's QTL Data Collection Tool, the way services are presented on that spreadsheet should clearly align with the schedule of benefits and the carrier should clearly identify the page and section each service would be processed under in the schedule of benefits.

2. Carriers need to ensure that intermediate services are consistently classified. For example, partial hospitalization for MH/SUD benefits and home health for M/S benefits need to be placed in the same classification (generally Outpatient), and residential treatment facility for MH/SUD benefits and skilled nursing facility for M/S benefits need to be placed in the same classification (generally Inpatient).

Dual Benefits

To comply with MHPAEA, in addition to services that are unique to MH/SUD benefits, carriers need to account for all of the "dual benefits" (services that can treat both M/S and MH/SUD conditions) in the schedule of benefits. While some services are clearly only MH/SUD benefits (intensive outpatient programs) or only M/S benefits (cardiac rehabilitation), there are others that can be both MH/SUD benefits and M/S benefits depending on the diagnosis code submitted on the claim (occupational therapy). The BOI requires the following regarding dual benefits:

1. Expected claim dollar amounts for dual benefits should only include the payments associated with claims for M/S conditions. When completing the BOI's QTL Data Collection Tool, dual benefits should be broken down on multiple lines. For example, occupational therapy should be listed on one line as an MH/SUD benefit with no expected claim dollar amount and listed on another line as an M/S benefit with an expected claim dollar amount, and the expected claim dollar amount on the M/S line should be reduced by whatever dollar amount is associated with the MH/SUD line (although the MH/SUD dollar amount is not listed in the spreadsheet).

2. Visit limits should not be applied to claims where dual benefits are used to treat MH/SUD conditions. The most common area to watch for is physical, occupational, and speech therapy (habilitative and rehabilitative services). While visit limits are prohibited by § 38.2-3418.17 of the Code of Virginia in the treatment of ASD, visit limits are unlikely to pass the required thresholds under MHPAEA in the Outpatient classification and should not be applied when physical, occupational, and speech therapy are used to treat other MH/SUD conditions (these claims would generally be submitted with an MH/SUD diagnosis code).

3. For Financial Requirements (cost sharing), areas to watch for include but are not limited to physical therapy, occupational therapy, speech therapy, labs, urgent care, nutritional counseling, ambulance, PCP office visits, and others, as each of these would be a dual benefit. If a claim for one of these services is submitted with an MH/SUD diagnosis code, the predominant level of cost sharing must be applied under MHPAEA.

4. Carriers must be cognizant of cost-sharing requirements and correct classification methodology regarding services in the "Emergency Care" classification. To comply with the requirements of 45 CFR 146.136 (c)(2)(ii)(A), carriers must apply the same standards to MH/SUD benefits and M/S benefits in determining the classification in which a particular benefit belongs. This means that carriers must place emergency room visits and mobile crisis response services, as well as support and stabilization services provided in a residential crisis stabilization unit or crisis receiving center, in the "Emergency Care" classification[2]. While 45 CFR 146.136 does not specifically dictate the classification for emergency ambulance services, carriers are cautioned that the placement of emergency ambulance services in any classification besides "Emergency Care" (e.g., "Outpatient, All Other") is unlikely to comply with MHPAEA. Carriers are also cautioned that they should be able to provide justification for whether they decide to place urgent care in the "Outpatient-All Other" sub-classification or in the "Emergency Care" classification, and that the classification of urgent care should be consistent with policy design, placement in the schedule of benefits, the nature of the product (for example, some products only cover out-of-network benefits if they are emergency services), and the methodology applied for determining placement of other benefits in the same classification.

Alternative Approaches/Possible Flexibility

If several of the services under a plan's schedule of benefits are subject to deductible/coinsurance, it is possible that a copay will not pass the substantially all threshold in

[2] Please note that § 38.2-3412.1 B of the Code requires coverage for mobile crisis response services and support and stabilization services provided in a residential crisis stabilization unit or crisis receiving center to the extent that such services are covered in other settings or modalities, regardless of any difference in billing codes.

the Outpatient classifications and cannot be applied to any claim submitted with an MH/SUD diagnosis code. This may also result in situations where a low copay (for example, $20), such as that applied to the PCP office visit or to habilitative/rehabilitative services would technically not be permitted under MHPAEA if these services are used in the treatment of an MH/SUD condition (submitted with an MH/SUD diagnosis code). Rather than strictly requiring carriers to apply the deductible/coinsurance in these situations, the BOI offers the following alternatives:

1. The carrier can continue to apply the copay, but it should be able to provide an actuarial justification upon request to document that the copay is more favorable to the patient than the deductible/coinsurance. This justification should also contemplate situations where the patient has met the deductible and coinsurance would be applied.

2. The carrier can continue to apply the copay, but it should be able to provide an explanation upon request to confirm it contemplated this issue during the MHPAEA QTL/Financial Requirement analysis upon plan design and determined the copay was more favorable to the patient despite the specific result of the substantially all/predominant analysis. This explanation should include reference to why the carrier deems the copay to be more favorable than deductible and coinsurance and any internal claims analysis, including reference to applicable allowed amounts, performed to support this position.

   The BOI adds these caveats regarding the alternative approaches:

   - If no cost sharing passes the required MHPAEA thresholds in a classification, the carrier would not be able to charge any cost sharing for claims submitted with an MH/SUD diagnosis code in that classification, and the alternatives specified above would not be applicable.

   - The alternatives specified above may not be applicable for services that commonly carry higher copays, such as an $80 urgent care copay, as it may be difficult to justify that this copay is more favorable to the patient than the deductible/coinsurance.

   - The expected claim dollar amounts for all services still need to account for diagnosis codes (as referenced in the “Expected Claim Dollar Amounts” section of this document), even if the carrier elects one of the alternatives above for certain copays.

   - MH/SUD benefits need to be identified based on the diagnosis code/condition being treated in all instances for NQTL analysis.

   - The BOI cannot guarantee that other states will allow any alternative approaches for QTLs/Financial Requirements.

Policy Design/Claims Administration

The BOI offers the following suggestions for policy design and claim processing going forward for QTL/Financial Requirements under MHPAEA:

1. The schedule of benefits can be designed so that all dual benefits have a subsection with one cost sharing for an M/S diagnosis and another for an MH/SUD diagnosis. For

example, under “PCP Office Visit” there could be a further breakdown referencing a $20 copay for an M/S benefit and a $15 copay for an MH/SUD benefit.

2. The schedule of benefits can be designed so the cost sharing that meets the predominant level in a given classification is applied to all dual benefits, regardless of whether they are MH/SUD or M/S.

3. The dual benefits can default to being processed under the “Mental Health & Substance Use Disorder Benefits” section of the schedule of benefits if they are submitted with an MH/SUD diagnosis code.

4. If the carrier chooses one of the alternatives offered by the BOI for low copays (as referenced in the “Alternative Approaches/Possible Flexibility” section of this document), it is possible that the plan design may not require many changes. The carrier could need to make changes to services that often require higher copays, such as urgent care, labs, and others. However, as these services likely have a low percentage of claims submitted with an MH/SUD diagnosis code, the carrier could potentially implement a manual process to account for these situations and ensure compliant cost sharing is applied, or some of these services may already be assigned the predominant level of cost sharing.

Steps For Compliance

As MHPAEA is driven by diagnosis/condition, MH/SUD benefits and M/S benefits must be defined based on the condition being treated on a given claim. Health carriers are advised that the following steps must be taken for compliance with MHPAEA and § 38.2-3412.1 B of the Code:

1. Recognize that there are services that are most commonly performed to treat an M/S condition but that may be used to treat an MH/SUD condition. When used to treat an MH/SUD condition, these services become MH/SUD benefits subject to the protections of MHPAEA;

2. When determining the expected claims dollar amounts for the M/S services during the QTL/Financial Requirement analysis, identify the claims where that service is used to treat an MH/SUD condition and reduce the expected claim dollar amounts for that service by the dollar amounts associated with the treatment of MH/SUD conditions;

3. Ensure that cost-sharing compliant with the substantially all/predominant requirements is applied to MH/SUD benefits and that all covered services are correctly classified; and

4. Establish processing guidelines to ensure that, even if a service most commonly used to treat M/S conditions is submitted with an MH/SUD diagnosis code on a given claim, MHPAEA-compliant Financial Requirements and QTLs are applied. This rationale also specifically requires that if a physical, occupational, or speech therapy claim is treating an MH/SUD condition (submitted with an MH/SUD diagnosis code), it must be considered an MH/SUD benefit under MHPAEA. While visit limits for any treatments for ASD are prohibited in Virginia, visit limits should not be applied in the treatment of any other MH/SUD condition unless they satisfy the substantially all/predominant requirements. Please note that separately accumulating visit limits for MH/SUD benefits are impermissible.

If you have any questions regarding this request, please feel free to contact me at 804-371-9490 or via email at brant.lyons@scc.virginia.gov.

Sincerely,

Brant Lyons, MCM
Principal Insurance Market Examiner
Health Market Conduct Section
Life and Health Division
Telephone No. (804) 371-9490