Appendix 1

NORTH CAROLINA DEPARTMENT OF INSURANCE

MHPAEA Compliance Checklist to be Completed by Regulated Entity for pre-market filing (Insurers, HMOs, Municipal Cooperative Health Benefit Plans and Student Health Plans)

REQUIREMENT	REFERENCE	DESCRIPTION OF STANDARDS OR REQUIREMENTS	DOCUMENTATION
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES (MH/SUD)		*The MHPAEA requirements below apply to any group health plan that had more than 50 total employees, for plan years beginning on or after October 3, 2009.* *The MHPAEA requirements below apply to health insurance coverage issued in the individual and small group markets on and after January 1, 2014.*	
Defining MH/SUD benefits	42 U.S.C. 300gg-26 42 U.S.C. 18031(j) 45 CFR 146.136(a) 45 CFR 156.115(a)(3)	The policy or contract shall define mental health benefits or substance use disorder benefits to mean items or services for the treatment of a mental health condition or substance use disorder, as defined by the policy or contract or applicable state law. Any condition or disorder defined as not a mental health condition or substance use disorder must be consistent with generally recognized independent standards of current medical practice and applicable state law. Please list, if any, all MH/SUD conditions excluded from coverage.	☐ Describe which independent standards were used to define mental health conditions, substance use disorders, and medical/surgical conditions and how these standards and definitions are consistent with applicable state law. ☐ Describe how the issuer determines that services and items are mental health benefits, substance use disorder benefits, or medical/surgical benefits, particularly for services and items that could be for multiple types of benefits (eg occupational therapy). List all services and items that are considered mental health benefits, substance use disorder benefits, and medical/surgical benefits.
Classifying benefits	42 U.S.C. 300gg-26 42 U.S.C. 18031(j)	The issuer shall assign MH/SUD benefits to each of the six classifications and permitted sub-classifications. The issuer must	☐ The issuer shall provide a list that specifies which

	45 CFR 146.136(c)(2)(ii)(A) 45 CFR 146.136(c)(3)(iii)(A) 45 CFR 146.136(c)(3)(iii)(B) 45 CFR 146.136(c)(3)(iii)(C) 45 CFR 156.115(a)(3)	apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits in determining the classification or sub-classification in which a particular benefit belongs. The issuer shall demonstrate that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are covered.	benefits were assigned to each of the six classifications and permitted sub-classifications. Describe the standards used in assigning benefits to classifications or sub-classifications for MH/SUD benefits and demonstrate that the same standards were used in assigning medical/surgical benefits to classifications and sub-classifications.
Financial requirements and quantitative treatment limitations	42 U.S.C. 300gg-26(a)(3)(A) 42 U.S.C. 18031(j) 45 CFR 146.136(c)(2)(i) 45 CFR 146.136(c)(3)(i)(A) 45 CFR 146.136(c)(3)(i)(B)(1) 45 CFR 146.136(c)(3)(i)(B)(2) ACA FAQ 34 Q3 45 CFR 156.115(a)(3)	The policy or contract shall not apply any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification).	☐ Provide a list of all financial requirements and quantitative treatment limitations imposed upon MH/SUD benefits in each classification of benefits and applicable sub-classification. The issuer shall demonstrate that any type of financial requirement quantitative treatment limitation applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification).

			☐ The issuer shall demonstrate that the level of financial requirement or quantitative treatment limitation imposed upon mental health or substance use disorder benefits in a classification (or applicable sub-classification) is no more restrictive than the level of financial requirement imposed upon more than one-half of expected plan payments that are subject to the financial requirement within that classification for medical/surgical benefits. The issuer shall demonstrate how it combined levels of the financial requirement to satisfy the predominant test if there is no single level that applies to more than one-half of medical/surgical benefits in the classification. ☐ The issuer shall provide a certification from an actuary that an actuarial cost model was built to test each financial requirement and quantitative treatment limitation. An issuer shall

			use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice.
Cumulative financial requirements and cumulative quantitative treatment limitations	42 U.S.C. 300gg-26(3) 45 CFR 146.136(c)(3)(v)	The issuer shall not apply any cumulative financial requirement or quantitative treatment limitation to mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.	☐ The issuer shall attest that it has performed a thorough review of all policies and contracts and has determined that there are no separate cumulative financial requirements or quantitative treatment limitations form mental health or substance use disorder benefits.
Nonquantitative treatment limitations (NQTLs)	42 U.S.C. 300gg-26(a)(3)(A) 42 U.S.C. 18031(j) 45 CFR 146.136(c)(i) 45 CFR 156.115(a)(3)	The issuer shall justify the application of any NQTL to mental health or substance use disorder benefits within a classification of benefits (or applicable sub-classification) such that any processes, strategies, evidentiary standards, or other factors used to apply a limitation, as written and in operation, are comparable to, and are applied no more stringently, than the processes, strategies, evidentiary standards, or other factors used to apply the limitation to medical/surgical benefits within the classification (or applicable sub-classification). NQTLs shall be categorized as such: 1) medical management- which includes issuer prior authorization, concurrent review and retrospective review protocols and the medical necessity criteria utilized in conjunction with them; 2) exclusions of coverage; e.g., experimental or investigational; 3) plan provider network matters- credentialing criteria, network tiering; 4) network adequacy; i.e. plan MH/SUD network performance; 5) provider reimbursement rates; 6) prescription drugs; 7) other NQTLs as identified by the issuer- restrictions on facility type, geographic location.	☐ The issuer shall provide a list of all NQTLs imposed upon mental health or substance use disorder benefits within each classification of benefits (or applicable sub-classification), including the methodology used to identify those NQTLs. ☐ The issuer shall provide an attestation that for each NQTL imposed on MH/SUD benefits, in each classification the limitation is imposed, the issuer has performed an analysis that contains the following:

			1) Identifies factors that trigger the imposition of the NQTL for MH/SUD benefits and for medical/surgical benefits 2) Describes the evidentiary standards that define the factors and any other evidence relied upon to design and apply the NQTL 3) Comparative analyses to determine that the processes and strategies, as written, for mental health and substance use disorder benefits are comparable to, and are applied no more stringently, than the processes and strategies, as written, for medical/surgical benefits 4) Comparative analyses to determine that the processes and strategies used to apply the NQTL, in operation, to mental health and substance use disorder benefits are comparable to, and are applied no more stringently, than the processes and strategies used to apply the NQTL, in operation, to medical/surgical benefits. 5) Detailed summary explaining how the

			information and analyses required above demonstrate compliance with 45 CFR 146.136(c)(4) The analyses must be available upon request within X business days.
Disclosure	42 U.S.C. 300gg-26(a)(4) 45 CFR 146.136(d)(1) 45 CFR 146.136(d)(2) 45 CFR 146.136(d)(3) 45 CFR 147.136(b)(2) 45 CFR 147.136(b)(3)	The issuer shall ensure that it complies with all availability of policy or contract information and related disclosure obligations regarding: 1) criteria for medical necessity determinations; 2) reasons for denial of services; 3) information relevant to medical/surgical, mental health, and substance use disorder benefits 4) rules regarding claims and appeals, including the right of claimants to free reasonable access and copies of documents, records and other information including information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.	☐ The issuer shall demonstrate the method by which it makes available to any current or potential participant, beneficiary, or contracting provider upon request the medical necessity criteria used to make mental health or substance use disorder medical necessity determinations. ☐ The issuer shall demonstrate that it provides the reason for any denial of reimbursement for mental health or substance use disorder benefits. ☐ The issuer shall demonstrate its method for responding to requests for all documents, records, and other information relevant to the claimant's claim for benefits after an

			adverse benefit determination. This shall include the issuer's protocol for ensuring that it discloses medical necessity criteria for both medical/ surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a NQTL with respect to medical/ surgical benefits and mental health or substance use disorder benefits under the policy or contract, when those specific items are requested. ☐ The issuer must demonstrate that all claims processing and disclosure regarding adverse benefit determinations complies with the federal claims and appeals regulations
Issuer coordination with vendors	78 FR 68250	If the issuer contracts with a managed behavioral health organization (MBHO) to provide any or all of the issuer's mental health or substance use disorder benefits it shall ensure that it coordinates with the MBHO to secure compliance with MHPAEA.	☐ The issuer must attest that it coordinates with its MBHO (if applicable) to ensure that mental health or substance use disorder benefits are designed and applied no more restrictively than how medical/surgical benefits are designed and applied.

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