UnitedHealthcare
ASO

Mental Health Parity Checklist

This checklist reflects UnitedHealth Group's current understanding of the Mental Health Parity (MHP) Final Rules published in November 2013 and located in 26 CFR Part 54, 29 CFR Part 2590 and 45 CFR Part 146 (FR). The FR has examples of how the rule is applied.

Visit the United for Reform Resource Center at **uhc.com/reform**, and select the "Mental Health Parity provision page" for more information.

For a summary of the Final Rules, select the **Mental Health Parity and Addiction Act of 2008: A Summary of the Final Rules: What You Need to Know**.

Under the final regulations, plans are now allowed to subdivide the outpatient classification into two subcategories:

- Outpatient "office visits"
- Outpatient "all other"

Based on the guidance, the following MH/SUD services have been realigned.

- Partial hospital (PH)/day treatment from the inpatient classification to the outpatient "all other classification"
- intensive outpatient (IOP) treatment from the outpatient classification to the outpatient "all other classification"

Based on the final rules, testing classifications were updated in the 2016 plan portfolios beginning January 1, 2016 (WA) and July 1, 2016 (all other states) to allow for greater cost-sharing flexibility in these categories.

Self-funded clients are responsible for ensuring plans are in compliance with the final MHP rules. If a client would like to retest, OptumInsight is available to retest for a fee.

This document is for informational purposes only and not intended to provide legal or actuarial advice to you or your Plan. Please seek advice of counsel in assessing the legal requirements and the impact on your health plan.

NOTE: Determining compliance with MHP requirements is the legal responsibility of an ASO customer. As such, UnitedHealth Group does not offer MHP testing for ASO customers. Testing options for ASO customers include, but may not be limited to:

1. Test MHP compliance on their own.
2. Utilize OptumInsight to test.

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Mental Health Parity Checklist (ASO) (continued)

Question	Response/Impact on Plan	
Q1. Does plan include mental health (MH) and/or substance use disorder (SUD) benefits?	☐ **Yes.**	Need to comply with MH Parity Rule. Go to **Q2.**
	☐ **No.**	Don't need to comply with MH Parity Rule or continue with this checklist. Note: Health Care Reform may consider MH/SUD essential health benefits so these benefits may need to be included. Please check with your benefits counsel about the impact of Health Care Reform to your plan(s).
Q2. Does plan have deductibles or out-of-pocket (OOP) maximums for MH/SUD that are separate from those deductibles and OOP maximums applied to medical/surgical benefits? *Deductibles and OOP maximums are examples of cumulative financial requirements.*	☐ **Yes.**	Separate deductibles and out-of-pocket (OOP) maximums for MH/SUD are no longer permitted. Plan must combine deductibles for medical/surgical and MH/SUD or have no deductible apply to MH/SUD. If plan has separate OOP maximums, plan must combine these into one OOP maximum shared between medical/surgical and MH/SUD, or either eliminate the OOP maximums on both MH/SUD and medical/surgical or apply 100% co-insurance to MH/SUD, in which case there is no OOP maximum for MH/SUD. See also Q6 for additional testing of deductibles and OOP maximums. Go to **Q3.**
	☐ **No.**	No action needed. Go to **Q3.**
Q3. Does plan apply other financial or quantitative treatment limits to MH/SUD that accumulate separately for MH/SUD from similar limits that are applied to medical/surgical? *Example for Q3: Day or visit limits (whether annual or lifetime) are examples of these types of requirements. For other types of limits, see Q5 below for applicability to other limits, specifically annual dollar and aggregate lifetime dollar limits.*	☐ **Yes.**	Separate cumulative financial or treatment limits are no longer permitted (FR c (3) (v)). Need to remove these limits, (e.g., day and visit limits) to comply. Go to **Q4.**
	☐ **No.**	No action needed. Go to **Q4.**
Q4. Does plan have a multi-tiered prescription drug benefit? If so, answer these questions: **A.** Does plan vary benefit levels based on anything other than reasonable factors determined under the nonquantitative treatment limitations of the FR? **B.** Does it vary benefit levels based on whether a drug is prescribed for MH/SUD diagnoses versus medical/surgical?	**A.** ☐ **Yes.**	Only "reasonable factors" determined under FR c (4) (i) are permitted. Check to see if the prescription drug benefit applies any unreasonable factors (i.e., discriminates against MH/SUD versus medical/surgical) and, if so, remove those distinctions. (See "Nonquantitative treatment limitations" in 45 C.F.R. 146.13 (c)(4). Go to **Q4B.**
	B. ☐ **Yes.**	Varying benefits based on whether a drug is prescribed for MH/SUD versus medical/surgical is not allowed. Remove this differentiation in the plan design. Go to **Q5.**
	A. ☐ **No.**	No action needed. Go to **Q5.**

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Mental Health Parity Checklist (ASO) (continued)

Question	Response/Impact on Plan	
Q5. Does plan have aggregate or annual dollar limits that apply to MH/SUD?		
A. Does plan have limit(s) on less than one-third of all medical/surgical benefits? *Example: Plan applies $2,500 annual limits to prosthetics and durable medical equipment and has no other annual limits. Since from the chart in Q6 this category accounts for less than one-third of total medical plan costs for outpatient in-network, the $2,500 limits cannot be applied to MH/SUD.*	**A. ☐ Yes.**	Plan determines the limit applies to less than one-third of all medical/surgical benefits. The limit therefore fails the test for aggregate or annual dollar limits. It cannot apply that limit to MH/SUD. *Note: Health Care Reform may consider MH/SUD essential health benefits. If so, then all annual and lifetime dollar maximums must be removed from these benefits.* *Note: Plan is allowed to determine the % of plan payments in this test that will constitute one-third or two-thirds using any reasonable method. The FR does not specify what is "reasonable." It only states that for this test, all plan payments "expected to be paid under the plan for the plan year" should be considered. Consult your actuarial advisor for guidance, if needed.* Go to **Q6.**
B. Does plan have the limit(s) on more than two-thirds of all medical/surgical benefits? *Example: Plan applies $5,000,000 aggregate limit to both medical/surgical and MH/SUD, so it passes test.*	**B. ☐ Yes.**	Plan must either apply limit(s) to both MH/SUD and medical/surgical benefits in a manner that does not distinguish between them or not include a limit on MH/SUD less than limit on medical/surgical. Go to **Q6.**
C. Does plan have limit between one-third and two-thirds of all medical/surgical benefits?	**C. ☐ Yes.**	Plan must either apply no aggregate or annual dollar limit on MH/SUD or impose limit for MH/SUD no less than average limit for medical/surgical calculated per section b(6) of FR. Go to **Q6.**
	C. ☐ No.	No action needed.

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Mental Health Parity Checklist (ASO) (continued)

Question	Response/Impact on Plan
Q6. Does plan pass the "Substantially All" (two-thirds) test for co-pays, deductibles and co-insurance for each category below? • Inpatient (IP) in-network • IP out-of-network (OON) • Outpatient (OP) in-network (see example) • OP OON • Emergency • Pharmacy	☐ **Yes.** Go to **Q7** to determine the level of the requirement to use. ☐ **No.** **If plan fails two-thirds test for a category and particular financial requirement, it cannot apply that financial requirement to MH/SUD benefits to that category. May modify plan design if necessary/desired to apply requirement**. Guidelines: Substantially All test, OP network
Q7. Does plan pass the "Predominant" test for a financial requirement (e.g., co-pays)? **A.** Do any of total claims for each level constitute more than 50% of the total claims subject to that requirement? *Example: Plan has 3 co-pay levels with no single co-pay level at 50% of total expected claims for co-pays:*	**(Only for classifications that pass two-thirds test!)** ☐ **Yes.** That level is the predominant level. ☐ **No.** Add claims for each level, starting with highest dollar level, until you reach level where total claims greater than 50% of the classification. The least restrictive level within the combined dollar levels can be applied to MH/SUD. ◀ For this requirement (i.e., co-pay), predominant level is $40. Co-pays do not vary (are same for single employees and families), so no need to do Predominant test separately by coverage unit.
Q8. Does the plan need to provide the result of the MHP testing for Partial Hospital/Intensive Outpatient Treatment (PH/IOP)? **A.** ASO customers are responsible for providing UnitedHealthcare with any change in cost sharing for mental health and substance use disorder benefits that is required as a result of the customer's MHP testing results. Failure to provide such information may cause the customer's ASO plan design to be non-compliant with the federal MHP laws.	If PH/IOP cost-share is not provided at time of confirmation of sold plans; UnitedHealthcare will apply the medical Outpatient Surgery cost-share to the Outpatient Partial Hospital/Intensive Outpatient Treatment categories (typically deductible/co-insurance). This may result in MHP non-compliance.

Co-pay levels	Services	% total claims for co-pays	Cumulative claim %
$100	Outpat Surg	23 % (=17%/74%)	23%
$40	Spec OV, UC, surgery (prof fees), major diag, therap	42% (=31%/74%)	65%
$20	All other services with co-pays	35% (=26%/74%)	100%