UTAH MENTAL HEALTH PARITY AND SUBSTANCE ABUSE ATTESTATION

INSURER NAME: _____ NAIC #:_____

FORM NUMBER(S):_____

The submitted forms are subject to the Mental Health Parity and Addiction Equity Act: ☐ Yes ☐ No
If yes, please complete this form and include all applicable attachments necessary for completion of this form.

Failure to complete this form and include all required attachments will result in the filing being rejected. A rejected filing is not considered filed with the Department and must be submitted as a new filing.

REQUIREMENT	REFERENCE	DESCRIPTION OF STANDARDS OR REQUIREMENTS	DOCUMENTATION
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES (MH/SUD)		*The Mental Health Parity and Addiction Equity Act (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.	1. 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. 2. 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 (e.g. occupational therapy). List all services and items that are considered mental health benefits, substance use disorder benefits, and medical/surgical benefits. 3. Provide a list, if any, of all MH/SUD conditions excluded from coverage.

Lifetime and annual dollar limits	42 U.S.C. 300gg-26 45 CFR 146.136(b) 45 CFR 146.136(b)(2) 45 CFR 146.136(b)(3) 45 CFR 146.136(b)(5)	The policy or contract shall not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health/ substance abuse disorder (MH/SUD) benefits.	A thorough review of the policy and related documents has been completed and it has been determined that it does not impose aggregate lifetime or annual dollar limit on MH/SUD benefits, or the aggregate lifetime or annual dollar limit on MH/SUD benefits is no less than an average limit calculated for medical/surgical benefits. Initial: _____
Classifying benefits	42 U.S.C. 300gg-26 42 U.S.C. 18031(j) 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)	The issuer shall assign MH/SUD benefits to each of the six classifications and permitted sub-classifications. The issuer must apply the same standards to medical/surgical benefits and to MH/SUD benefits in determining the classification or sub-classification in which a particular benefit belongs.	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. Provide a list that specifies which benefits were assigned to each of the six classifications and permitted sub-classifications. The six classifications are: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs.
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 MH/SUD benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification).	1. 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. 2. Demonstrate that any type of financial requirement or quantitative treatment limitation applied to MH/SUD benefits in a classification (or applicable sub-classification) that applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or applicable sub-classification). 3. Demonstrate that the level of financial requirement or quantitative treatment limitation imposed upon MH/SUD benefits in a classification (or applicable subclassification) 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. Include the 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.
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 MH/SUD benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.	A thorough review of all policies and contracts has been performed and it has been determined that there are no separate cumulative financial requirements or quantitative treatment limitations for MH/SUD benefits. Initial: _____

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 MH/SUD 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 include 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, such as 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, such as restrictions on facility type, geographic location.	For each NQTL imposed on MH/SUD benefits, in each classification where a 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 MH/SUD 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 MH/SUD 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). Initial: _____
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 MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.	1. The issuer has a description of 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 MH/SUD medical necessity determinations. Initial: _____ 2. The issuer provides the reason for any denial of reimbursement for MH/SUD benefits and that it has documentation to support this attestation. Initial: _____ 3. Provide a detailed description of methods 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 description shall include the issuer's protocol for ensuring that it discloses medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a NQTL with respect to medical/surgical benefits and MH/SUD benefits under the policy or contract, when those specific items are requested. 4. All claims processing and disclosure regarding adverse benefit determinations comply with the federal claims and appeals regulations and the issuer has documentation to support this attestation. Initial: _____
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 MH/SUD benefits it shall ensure that it coordinates with the MBHO to secure compliance with MHPAEA.	The issuer coordinates with its MBHO (if applicable) to ensure that MH/SUD benefits are designed and applied no more restrictively than how medical/surgical benefits are designed and applied. Initial: _____

Acceptance by the Department does not absolve the submitting entity from future findings of non-compliance. The descriptions the issuer attests to maintaining shall be made available upon request of the Commissioner.

I HEREBY ATTEST that the responses in this attestation and the relevant documents are accurate and complete. A false attestation may be subject to administrative action under Section 31A-2-308.

Name Title

Signature Date