Hello Everyone,

Attached you will find the Bakers Union and FELRA Health and Welfare Fund's completed NQTL Analysis. At the end of the document, you will find our overall findings and conclusions.

As you review the attached report, you will note that in some sections of the analysis we conclude that a determination of parity cannot be made because complete responses to our information requests were not provided by applicable vendors. The absence of this information does not mean that the plan is necessarily out of parity in those categories but does mean that there was insufficient information for MZQ to conclude on behalf of Bakers Union and FELRA Health and Welfare Fund that the Plan is in parity.

In this regard, please note that the entire industry is currently struggling to produce sufficient information to meet the DOL's analysis requirement in this regard. The DOL is currently aware of this issue and is working with key stakeholders to help resolve it. That being said, MZQ believes that the completion of this report at this time demonstrates Bakers Union and FELRA Health and Welfare Fund's good faith effort to meet the NQTL comparative analysis requirements. You will note that our recommendations include continuing to work with the Plan's vendors to ensure more comprehensive responses in the future. For our part, the team at MZQ continues to work diligently with vendors throughout the industry to help guide and enhance their information reporting capabilities in this regard. We are also participating in conversations with the DOL in which we continue to express our concerns and request opportunities to ease this process on behalf of plan sponsors.

It has been a pleasure working with you on this project! If you have any questions after reviewing the report, please let me know.

Additionally, please let me know if you would like to partner with MZQ to obtain an updated analysis using your 2023 plan year data. If so, we will send an updated contract for your review.

Thank you for your continued partnership.

Best,

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MZQ CONSULTING LLC
benefits compliance

MAY 23, 2024

COMPARATIVE ANALYSIS OF THE APPLICATION OF NON-QUANTITATIVE TREATMENT LIMITATIONS AS REQUIRED BY THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

FOR THE BAKERS UNION AND FELRA HEALTH AND WELFARE FUND

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1. Introduction

The Consolidated Appropriations Act of 2021 (CAA) amended the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to provide new protections for health plan participants. The law includes MHPAEA compliance responsibilities for group health sponsors and individual and group health insurers offering both medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) coverage.

The goal of the MHPAEA is to ensure group health plans and health insurance issuers do not provide less favorable MH/SUD coverage than they do M/S coverage. For compliance purposes, the law breaks up M/S and MH/SUD coverage into six benefit classifications: (1) Inpatient In-Network (IN); (2) Inpatient Out-of-Network (OON); (3) Outpatient IN; (4) Outpatient OON; (5) Emergency Care; and (6) Prescription Drugs.

To ensure that covered entities maintain parity concerning non-quantitative treatment limitations (NQTL), the MHPAEA final regulations establish that if a NQTL on MH/SUD benefits applies in any benefit classification, then all processes, strategies, evidentiary standards, or other factors used to establish that NQTL must be applied no more stringently than how the NQTL is applied to M/S benefits in the same classification. The MHPAEA also prohibits NQTLs that only apply to MH/SUD coverage. To aid in the enforcement of these requirements, the CAA requires all covered entities to perform, document, and maintain comparative analyses of the design and application of all NQTLs both as written in Plan documents and in operation.

To comply with the CAA, the Bakers Union and FELRA Health and Welfare Fund (the "Plan") completed this comparative analysis to show how the Plan achieves parity when applying standards for NQTLs. The NQTL analysis was performed by MZQ Consulting, LLC on behalf of the Plan in May 2024. Rebecca Wilen, Compliance Specialist, was the primary analyst responsible for the project, under the supervision of Jennifer Berman, ERISA attorney & CEO of MZQ Consulting, LLC.

The Plan contracts with the following vendors, who apply the various NQTLs. These vendors are referenced throughout this analysis.

- Associated Administrators is responsible for administering claims on behalf of the Plan.
- CareAllies, a Cigna subsidiary, is responsible for applying the Plan's utilization management techniques to assess the appropriateness of care.
- Cigna is responsible for providing the Plan with a robust network of qualified providers and negotiating appropriate reimbursement rates.
- Optum manages the prescription drug offerings of the Plan.

This analysis is based on the following written materials, provided by the Plan:

1. Bakers Union and FELRA Health and Welfare Fund Plans 1, 2, 3, and 4 Summary Plan Description dated July 2016 ("SPD")

2. Cigna Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis dated January 10, 2023 ("Cigna NQTL Analysis")
3. OptumRx Mental Health Parity Comparative Analysis dated March 2021 ("OptumRx NQTL Analysis")

The operational data within this comparative analysis encompasses the period of 2022.

In addition to this introduction, the report includes:

1. An overview of each NQTL, including any specific Plan or coverage terms or other relevant terms regarding the NQTLs applied by the Plan in writing.
2. A list of which MH/SUD and/or M/S benefits to which each NQTL applies in each respective benefit classification.
3. The factors used to determine that each NQTL will apply to MH/SUD benefits and M/S benefits.
4. The written evidentiary standards used for the factors identified, when applicable for each NQTL, including defining each factor and detailing any other source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and M/S benefits, provided that the Plan relies on such evidentiary standards.
5. A comparative analysis of the way the plan designed and applies each NQTL to MH/SUD benefits and M/S benefits in written Plan documents and policies.
6. The results of at least one test and/or spot check question to determine and document how the plan applies each NQTL to MH/SUD benefits and M/S benefits in practice.
7. A comparative analysis of how the plan applies each NQTL during typical Plan operations.
8. An overall analysis and conclusion about how the Plan may meet parity standards in both writing and operationally for each specific NQTL.
9. A final analysis, including both substantive findings and an overall conclusion regarding the Plan's comprehensive compliance with the MHPAEA requirements concerning all the NQTLs applied to MH/SUD benefits and M/S benefits in total.

2. Medical Management Standards

The Plan applies the Medical Management Standards NQTL to all benefits, including both M/S and MH/SUD care. For health services to be covered by the Plan they need to be medically necessary. The Plan's summary plan description (SPD) defines medically necessary as "Services or supplies furnished, prescribed or ordered by a Physician to identify or treat an Illness or Injury, the furnishing of which is consistent with the diagnosis and treatment of the patient's condition in accordance with standards of good medical practice. That service or supply must be required for reasons other than the convenience of the patient or Physician and must be the most appropriate level of service or supply that can be provided safely for the patient. When the term Medically Necessary is used to describe inpatient care in a Hospital, it means that the patient's medical symptoms and condition are such that the service or supply cannot be provided safely to the patient on an outpatient basis. The fact that services or supplies are furnished or prescribed by a Physician does not necessarily mean that the services and supplies are Medically Necessary. The Board in its sole discretion shall determine whether services and supplies are Medically Necessary."

Medical Management Standards as Written

The Plan's Medical Management Standards NQTL as written is described below:

Medical Management Standards as Written		
MHPAEA Classification	*Inpatient IN, Inpatient OON, Outpatient IN, Outpatient OON, Emergency Care, Prescription Drugs*	
Applicable Benefits	M/S	All Covered Benefits
	MH/SUD	All Covered Benefits
Factor One	Necessary Services	
Source	Cigna NQTL Analysis, Pg 1-11	
Definition	Service is required to diagnose or treat an illness, injury, disease or its symptoms.	
Evidentiary Standards	• Internal Cigna clinical coverage policies, which may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. • MCG Guidelines when conducting medical necessity reviews of M/S services, procedures, devices, equipment, imaging, diagnostic interventions.	

	• MCG Care Guidelines when conducting medical necessity reviews of MH/SUD services and technologies. • The ASAM Criteria when conducting medical necessity reviews of SUD services and technologies. • Judgement of Cigna's Coverage Policy Unit, in partnership with Cigna's Medical Technology Assessment Committee, conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. • The work of the Cigna Medical Technology Assessment Committee, which establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational.
Factor Two	Accepted Standards
Source	Cigna NQTL Analysis, Pg 1-11
Definition	In accordance with generally accepted standards of medical practice.
Evidentiary Standards	See Factor One
Factor Three	Clinically Appropriate
Source	Cigna NQTL Analysis, Pg 1-11
Definition	Clinically appropriate in terms of type, frequency, extent, site and duration.
Evidentiary Standards	See Factor One
Factor Four	Convenience

Source	Cigna NQTL Analysis, Pg 1-11
Definition	Not primarily for the convenience of the patient, Physician or other health care provider.
Evidentiary Standards	See Factor One
Factor Five	Cost
Source	Cigna NQTL Analysis, Pg 1-11
Definition	Not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms.
Evidentiary Standards	See Factor One
Factor Six	Care Setting
Source	Cigna NQTL Analysis, Pg 1-11
Definition	Care is rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications.
Evidentiary Standards	• As outlined in Factor One • Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.
Factor Seven	Safe and Effective
Source	Cigna NQTL Analysis, Pg 1-11
Definition	Treatment is safe and effective for the Illness or injury for which it is used.
Evidentiary Standards	See Factor One

Comparative Analysis of Medical Management Standards in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Medical Management Standards NQTL to both M/S and MH/SUD services across all MHPAEA benefit classifications. The Plan also bases this NQTL on clear factors and evidence-based standards which are substantially the same for all affected MH/SUD and M/S benefits. While there is some variation in the evidence used by the Plan to evaluate medical necessity between MH/SUD and M/S services, the variances are appropriate considering the inherent differences between M/S and MH/SUD care and treatment. The Plan uses two different types of MCG standards as part of its M/S and MH determinations, but each is the industry standard for their respective types of care. The ASAM standards used as part of the Plan's SUD care determinations are the industry standard for SUD. Furthermore, these standards are no more stringent for MH/SUD services than they are for M/S services.

Medical Management Standards in Operations

Beyond reviewing how the Plan addresses the Medical Management Standards NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan applies medical management standards no more stringently for MH/SUD care than it does for M/S care, the Plan applied the following operational test. The results are as follows:

Claim Denial Rates

	Number (#) of Claims Denied for Lack of Medical Necessity		Percent (%) of Total Claims Denied for Lack of Medical Necessity	
	M/S	MH/SUD	M/S	MH/SUD
Inpatient IN	0	0	0%	0%
Inpatient OON	n/a	n/a	N/A	N/A
Outpatient IN	0	0	0%	0%
Outpatient OON	n/a	n/a	N/A	N/A

Additionally, to further test whether the Medical Management Standards NQTL is being applied operationally in parity, the Plan posed the following spot test questions and recorded the answers below.

> **Does your Plan ever allow for coverage exceptions, whereby you as the Plan sponsor allow for typically excluded services that have been limited or denied due to medical management reasons to be covered under specified conditions?**
> No

If yes, how does the benefit exceptions process work? Please describe on a practical level.
n/a

Who makes benefit exception determinations?
Board of Trustees always not determinations for the Plan and if appeal process has been followed for an appeal and denied the members can request the appeal be reviewed by an IRO

What process is used to make benefit exception determinations?
Appeal process reviewed by the Board of Trustees. Appeal process noted in the SPD.

What are the qualifications or the people/entities involved in making benefit exceptions?
Board of Trustees only that would review information provided from members supporting there request for an exception (ie: physician statement and medical records). If Trustees denied and member requests a review by an IRO the appeal is forwarded to IRO for consideration.

Do you as the Plan sponsor track the number of benefit exceptions allowed per Plan year?
TPA has an Appeals Department that tracks the number of benefit exceptions approved or denied.

If yes, how many benefit exceptions were allowed during the past Plan year for M/S services?
There were no exceptions permitted in the 2023 Plan year.

How many benefit exceptions were allowed during the past Plan year for MH/SUD services?
No MH/SUD services were appealed this year no exceptions needed.

Do you as a Plan sponsor use a separate outside vendor to administer and/or provide utilization management services for MH/SUD? If yes, please explain and provide details and contact information for that vendor. Also, please confirm that you can provide the Plan's MH/SUD vendor with a separate questionnaire on their utilization management processes so that we can collect accurate Plan data for your analysis.

No

Does the TPA allow Plan sponsors to make benefit exceptions in practice?
The Plan sponsor is the authorized agent to make benefit exceptions in practice at any time. The TPA has no authority over the Plan sponsor or its decisions. Only the Board of Trustees make approve benefit exceptions to the Plan.

If yes, how does the benefit exceptions procedure work in day-to-day operations? Who determines the exceptions and what processes do they use?
The answer to the above is no, however, the TPA can provide the following information. The benefit exceptions are often decided by the Plan sponsor through the appeal process. Once a determination is made by the Plan sponsor and communicated to the TPA, the TPA will adjust the benefit level or coverage. The Plan sponsor holds authority for making benefit-related determinations and decisions. Benefit exemptions are usually made as a result of the Appeal process when a claim is initially denied.

If benefit exceptions are permitted, does the TPA keep track of any benefit exceptions over the course of the Plan year?
Documentation on benefit exceptions made by the Plan sponsor are kept indefinitely on behalf of the Plan sponsor.

If so, how many exceptions were made for M/S claims in the last plan year?
None, according to the TPA's records.

How many for MH/SUD?
None, according to the TPA's records.

Does the Plan use the same medical necessity review process for MH/SUD and M/S? Please explain.
CareAllies did not respond to this question.

Does the Plan have a medical policy review committee? What is its composition?
CareAllies did not respond to this question.

Please explain the scope of the authority of the medical policy review committee.
CareAllies did not respond to this question.

Comparative Analysis of Medical Management Standards in Operation

When tested in practice, the Plan appears to apply the same operational standards to M/S and MH/SUD benefits concerning the Medical Management Standards NQTL, which affects all MHPAEA benefit classifications. The Plan uses the same procedures for both M/S and MH/SUD medical necessity reviews. According to information provided through spot check questions, the Plan also uses the same operational processes when evaluating both M/S and MH/SUD claims. The Plan's overall claims denial rates for M/S and MH/SUD services are similar with no claims denied for lack of medical necessity, indicating no parity concerns. The application of the NQTL is not impacted by whether the services provided are for the treatment of a M/S or MH/SUD condition.

Overall Comparison and Conclusions Regarding Medical Management Standards

The Medical Management Standards NQTL applies to all MHPAEA benefit classifications. A comparison of the Plan's written requirements, as well as a test of the Plan's operational procedures, reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. Whether a condition is MH/SUD or M/S related is not relevant to how the Plan applies the Medical Management Standards NQTL to any classification of benefits.

Based on this evidence, the Plan concludes it meets parity standards regarding the application of the Medical Management Standards NQTL all MHPAEA benefit classifications.

3. Prior Authorization

The Plan requires participants to seek prior authorization for certain Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefits spanning both M/S and MH/SUD care. Prior authorization, also referred to as pre-certification, is based on medical necessity. The SPD states that "You or someone on your behalf must contact CareAllies toll-free at 1-800-768-4695 to pre-certify ALL non-emergency or elective (inpatient and out-patient) Hospital stays and within 48 hours after an emergency admission. If you fail to do this, the Fund will reduce the amount of the benefit it would have paid by 20%, up to a maximum of $1,000. This 20% or $1,000 (whichever is less) is payable by you, in addition to any other Deductibles or Co-Payments you may be responsible for under the regular terms of your Plan."

Prior Authorization as Written

The Plan contracts with CareAllies to apply its prior authorization methodologies. The Plan's Prior Authorization NQTL as written is described below:

Prior Authorization Standards as Written		
MHPAEA Classification	*Inpatient IN, Inpatient OON, Outpatient IN, Outpatient OON*	
Applicable Benefits	M/S	**SPD:** • All elective (non-emergency) admissions • Hospice Care • Home Health Care **CAA NQTL Analysis:** • Acute Inpatient Services • Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc. • Inpatient Professional Services • Advanced imaging services (e.g., CT scans, PET scans, MRIs, diagnostic cardiology) • Certain outpatient surgical procedures • Certain cardiology procedures • Clinical trials • Procedures that may be considered cosmetic in nature • Durable Medical Equipment (DME) • Experimental / Investigational / Unproven (EIU) Procedures • Genetic testing

		• Home Health Care (HHC) / home infusion therapy • Hormone Implant • Hyperbaric Oxygen Therapy • Infertility services • Infused / injectable medications • Medical oncology • Musculoskeletal services (major joint surgery and pain management services) • Negative Pressure Wound Therapy • Outpatient Therapy Services (Outpatient Acute Rehabilitation, Cardiac Rehabilitation, Cognitive Rehabilitation, Speech Therapy, Hearing Therapy, Occupational Therapy, Physical Therapy, Chiropractic, Acupuncture) • Outpatient radiation therapy services • Sleep testing • Speech Therapy • Therapeutic apheresis (aka Extracorporeal photopheresis (ECP) External Counterpulsation • Unlisted procedures or services (note: the phrase "unlisted procedure or service" refers to an instance where a procedure or service is billed as "unlisted," meaning that no existing CPT code exists for the procedure or service)
	MH/SUD	**SPD:** • All MH/SUD care **CAA NQTL Analysis:** • Mental Health Acute Inpatient Services • Mental Health Subacute Residential Treatment • Mental Health Inpatient Professional Services • SUD Acute Inpatient Services • SUD Acute Inpatient Detoxification • SUD Subacute Residential Treatment • SUD Inpatient Professional Services • Partial Hospitalization • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation

Factor One	Medical Necessity
Source	Cigna NQTL Analysis, Pg 11-24
Definition	See Section Two
Evidentiary Standards	See Section Two
Factor Two	Clinical appropriateness
Source	Cigna NQTL Analysis, Pg 11-24
Definition	Appropriate utilization of services by type/level of care and place/setting of service.
Evidentiary Standards	• Internal claims data • UM program operating costs • UM authorization data • Expert Medical Review • Nationally recognized evidence-based guidelines
Factor Three	Cost (Inpatient)
Source	Cigna NQTL Analysis, Pg 11-24
Definition	Value of the service exceeds the administrative costs
Evidentiary Standards	The evidentiary standard relied on to determine whether to apply prior authorization to inpatient benefits is whether application of prior authorization produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business. Cigna has determined the value of subjecting all inpatient In-Network and Out-of-Network services to prior authorization/precertification review must exceed the administrative costs by at least 1:1. The ROI ratio is calculated using the following formula: **M/S:** • The actual or anticipated denial rate of the service multiplied by the average unit cost (or, as applicable, cumulative cost) of the service, with the resulting figure divided by the estimated cost to review the total number of services.

	• For services for which Cigna maintains historic claims data, Cigna calculates the denial rate by reference to the actual denial rate as reflected in the historic book-of-business claims data it maintains. The average unit cost of the service is calculated based on Cigna's historical paid claims for the service across its commercial book of business. The estimated cost to perform a coverage review is $40 per review, which is informed by costs/expenses such as personnel salaries and time. **MH/SUD:** • The actual or anticipated denial rate of the service multiplied by the average unit cost (or, as applicable, cumulative cost) of the service, with the resulting figure divided by the estimated cost to review the total number of services • For services for which Cigna maintains historic claims data, Cigna calculates the denial rate by reference to the actual denial rate as reflected in the historic book-of-business claims data it maintains. The average unit cost of the service is calculated based on Cigna's historical paid claims for the service across its commercial book of business. The estimated cost to perform a coverage review is $100 per review, which is informed by costs/expenses such as personnel salaries and time.
Factor Four	Covered Benefit
Source	Cigna NQTL Analysis, Pg 11-24
Definition	Verification that a service will be rendered for a covered benefit.
Evidentiary Standards	Plan SPD
Factor Five	ROI Threshold (Outpatient)
Source	Cigna NQTL Analysis, Pg 11-24
Definition	To determine whether a service may be subject to prior authorization, one or more of the following variables (i) whether the service is determined to be experimental, investigational or unproven according to clinical evidence (ii) whether the service may present a serious customer safety risk; (iii) whether the treatment type is a driver of high-cost growth; (iv) variability in

	cost, quality and utilization based upon diagnosis, treatment, provider type and/or geographic region; and (v) treatment type subject to a higher potential for fraud, waste and/or abuse must be met first, then a Return on Investment ("ROI") threshold must be established for the service to be subject to prior authorization/concurrent review. i. Whether the service is determined to be experimental, investigational or unproven according to clinical evidence: A service is determined to be experimental, investigational, or unproven (EIU) according to available Clinical Evidence1; ii. Whether the service may present a serious customer safety risk; The service is potentially life-threatening according to available Clinical Evidence. Examples of safety issues considered to be potentially life-threatening include a service such as rapid detoxification under anesthesia, or the use of a service that is the subject of a serious ii. Whether the treatment type is a driver of high-cost growth: For a code to be considered a driver of high-cost growth, to be included on Cigna's Precertification List, the code must include high dollar, low volume or high denial claim costs. While each is considered separately, an average facility spend of $75,000 is considered high dollar. High volume includes averages of 6000 or more claims, and denial of services average of 5% or greater. v. Variability in cost, quality and utilization based upon diagnosis, treatment, provider type and/or geographic region: Variability in cost is identified as a high unit cost per service for consideration in requiring precertification. The volume of services per year is also reviewed, including a review of high denial rates. Cigna does not discriminate by provider type or region of the country. Coverage policies apply to all providers working within the scope of their licensure (for example, Cigna would not consider a coverage request for neurosurgery from a chiropractor). The ideal candidate for precertification is a service that is expensive ($300 or more), not routinely performed and for which data exists from national standards such as "Choosing Wisely" or other professional society recommendations that a denial rate of 15% or more would be expected when the individual request is measured against Cigna's published criteria coverage (Cigna developed Coverage Policy, MCG, or ASAM).

	v. Treatment type subject to a higher potential for fraud, waste and/or abuse: The evidentiary standard for when a treatment type subject to a higher potential for fraud, waste and/or abuse, as identified in publications by organizations that track trends regarding fraud/waste/abuse in utilization of healthcare services consistent with applicable law and regulation. Cigna specifically identifies fraud, waste and abuse as follows: a. "Fraud" means knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit plan/program. (18 U.S.C. § 1347) b. "Waste" means overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system, including health benefit plans/programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources. c. "Abuse" means actions that may, directly or indirectly result in unnecessary costs such as payment for items or services when there is no legal entitlement to that payment and the individual or entity has not knowingly and/or intentionally misrepresented facts to obtain payment. The evidentiary standard used for the ROI factor in the application of Prior Authorization of services in the Outpatient-All Other benefit classification is a ratio of 3.0.
Evidentiary Standards	• COGNOS Internal claims database including measures for volume of services approved, denied, total authorizations, denial rates estimated average cost, cost to review, estimated savings, per member per month savings, return on investment and contracted rates. • Expert Medical Review • Input from national vendors • Medical Economics biannual provider and facility analyses report for codes not included on precertification list • Nationally recognized evidence-based guidelines and CMS and HCPS updates

	• Industry accepted procedures codes developed by:
	  ○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book
	  ○ American Hospital Association (AHA) publication of revenue codes
	  ○ American Formulary Association (AFA) publication of codes
	  ○ Centers for Medicare and Medicaid Services (CMS) publication of codes

Factor Six	Safety (Outpatient)
Source	Cigna NQTL Analysis, Pg 11-24
Definition	Whether the service may present a serious customer safety risk
Evidentiary Standards	See Factor Two

Comparative Analysis of Prior Authorization in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Prior Authorization NQTL to both M/S and MH/SUD services across the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications. The Plan also bases this NQTL on clear factors and evidence-based standards. However, the scope of this NQTL is more stringent for MH/SUD services, presenting parity concerns. While the list of M/S services subject to prior authorization is longer than the list of MH/SUD conditions, the overall scope of the requirement is significantly broader for MH/SUD services than any comparable requirement for M/S benefits. The SPD states that only non-emergent admissions, hospice, and home health care require pre-certification while all MH/SUD services must be pre-certified. It should be noted that the documents provided by CareAllies have a different list of services subject to the NQTL that is both broader and significantly longer than what is in the Plan's SPD. While not a parity concern, the Plan should ensure that the vendor is following what is outlined within the Plan's SPD as it relates to administering the NQTL and that additional services are not being unduly subjected.

Prior Authorization in Operations

Beyond reviewing how the Plan addresses the Prior Authorization NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan, while working in concert with CareAllies, applies prior authorization methodologies no more stringently for MH/SUD care than it does for M/S care, the Plan attempted to compare prior

authorization denial rates and processing speeds. This section remains incomplete because the requested information was not provided.

Prior Authorization Process in Operation

		Number (#) of Prior Authorization Requests		Percent (%)	
Denials		**M/S**	**MH/SUD**	**M/S**	**MH/SUD**
Prior Authorization Requests	*Inpatient IN*			0%	0%
	Inpatient OON			N/A	N/A
	Outpatient IN			0%	0%
	Outpatient OON			N/A	N/A
Prior Authorization Requests Initially Denied	*Inpatient IN*			N/A	N/A
	Inpatient OON			N/A	N/A
	Outpatient IN			N/A	N/A
	Outpatient OON			N/A	N/A
Prior Authorization Requests Appealed	*Inpatient IN*			N/A	N/A
	Inpatient OON			N/A	N/A
	Outpatient IN			N/A	N/A
	Outpatient OON			N/A	N/A
Prior Authorization	*Inpatient IN*			N/A	N/A

Requests Approved Via Appeal	*Inpatient OON*			N/A	N/A
	Outpatient IN			N/A	N/A
	Outpatient OON			N/A	N/A

Processing Time		M/S	MH/SUD
Average Processing Time (in Days) For A Prior Authorization Request	*Inpatient IN*		
	Inpatient OON		
	Outpatient IN		
	Outpatient OON		
Average Processing Time (in Days) For A Prior Authorization Appeal	*Inpatient IN*		
	Inpatient OON		
	Outpatient IN		
	Outpatient OON		

Additionally, to further test whether the Prior Authorization NQTL is being applied operationally in parity, the Plan posed the following spot test questions and recorded the answers below.

If you as the Plan sponsor were given a standard list of Plan services that might be subject to prior authorization, were you able to modify that list of services?
n/a

If yes, what modifications did you make to the standardized list?
n/a

How did you determine these modifications? What factors played into your decision(s)?
n/a

Did you use any outside sources (e.g. research studies, industry standards) to determine what benefits to include/exclude?
n/a

Is an exact list of all benefits subject to prior authorization included in the Plan document (SPD/EOC)? If not, how does the Plan determine what, if any, additional benefits will be subject to prior authorization?
The SPD contains information on the Fund's utilization management/review firm and outlines what services require certification.

Does the Plan sponsor have the option to design or in any way modify the list of benefits that are subject to prior authorization?
CareAllies did not respond to this question.

If the Plan sponsor has some role in developing the list of benefits subject to prior authorization, do you provide them with a standard list of potential benefits that may be subject to prior approval or does the Plan sponsor determine the list without assistance?
CareAllies did not respond to this question.

Please explain what, if any, assistance you provide the Plan sponsor in developing their list of benefits subject to prior authorization and how that process works on a practical level.
CareAllies did not respond to this question.

Alternative Operational Information

CareAllies provided the following Commercial Book-of-Business data for prior authorization:

		Number (#) of Prior Authorization Requests		Percent (%)	
		M/S	MH/SUD	M/S	MH/SUD
Prior Authorization Requests	*Inpatient IN*	50,764	14,157		

	Inpatient OON	3,829	5,532		
	Outpatient IN	3,354,839	11,006		
	Outpatient OON	1,394,567	3,620		
Prior Authorization Requests Initially Denied	*Inpatient IN*	8,785	261	17.31%	1.84%
	Inpatient OON	847	262	22.12%	4.74%
	Outpatient IN	792,056	441	23.61%	4.01%
	Outpatient OON	355,111	320	25.46%	8.84%

Comparative Analysis of Prior Authorization in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Prior Authorization NQTL. However, CareAllies did not provide all of the necessary data needed to conduct a complete analysis despite multiple requests by the Plan to obtain the full scope of information. CareAllies did not respond to the spot check questions and only provided book-of-business data and not Plan-specific claims data. Based on the book-of-business information provided, it appears the Plan is operating in parity. More M/S claims were denied in all benefit classifications than MH/SUD claims. However, without complete stringency test data, it is not possible to fully analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Prior Authorization

The Prior Authorization NQTL applies to the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications. A comparison of the Plan's written requirements reveals the Plan applies the NQTL more stringently to MH/SUD in writing. The SPD states that only non-emergent admissions, hospice, and home health care require pre-certification while all MH/SUD services must be pre-certified. On an operational level, CareAllies offered alternative

and incomplete stringency test data rather than the complete data that was requested by the Plan on multiple occasions.

Based on this evidence, the Plan concludes it does not meet parity standards regarding the application of the Prior Authorization NQTL in the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications.

4. Concurrent Review

The Plan may require concurrent review of care and treatment for certain claims that fall into the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications. These benefits span both M/S and MH/SUD. The Concurrent Review NQTL is intended to assess medical necessity. It should be noted that the Plan's SPD does not mention concurrent review as part of utilization management but does reference it as part of claims filings.

Concurrent Review as Written

The Plan contracts with CareAllies to apply its concurrent review methodologies. The Plan's Concurrent Review NQTL as written is described below:

Concurrent Review as Written		
MHPAEA Classification	*Inpatient IN, Inpatient OON, Outpatient IN, Outpatient OON*	
Applicable Benefits	M/S	All Benefits Subject to Prior Authorization
	MH/SUD	All Benefits Subject to Prior Authorization
Factor One	Clinical appropriateness	
Source	Cigna NQTL Analysis, Pg 24-34	
Definition	Appropriate utilization of services by type/level of care and place/setting of service.	

Evidentiary Standards	• MCG Guidelines
	• ASAM Criteria
	• Industry accepted procedures codes developed by:
	  ○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book
	  ○ American Hospital Association (AHA) publication of revenue codes
	  ○ American Formulary Association (AFA) publication of codes
	  ○ Centers for Medicare and Medicaid Services (CMS) publication of codes
	• Internal claims data
	• UM program operating costs
	• UM authorization data
	• Expert Medical Review of Clinical Criteria
	• Nationally recognized evidence-based guidelines	

Factor Two	Covered Benefit
Source	Cigna NQTL Analysis, Pg 24-34
Definition	Verification that a service will be rendered for a covered benefit
Evidentiary Standards	Plan SPD
Factor Three	Complexity of Condition (Inpatient)
Source	Cigna NQTL Analysis, Pg 24-34
Definition	Complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines
Evidentiary Standards	See Factor One
Factor Four	Expected Timeframe (Inpatient)
Source	Cigna NQTL Analysis, Pg 24-34
Definition	Expected timeframe for clinical response/outcomes based on literature
Evidentiary Standards	See Factor One
Factor Five	Efficacy (Inpatient)
Source	Cigna NQTL Analysis, Pg 24-34
Definition	Efficacy of the treatment modality
Evidentiary Standards	See Factor One
Factor Six	Progress Toward Goals (Inpatient)
Source	Cigna NQTL Analysis, Pg 24-34
Definition	Progress toward goals of therapy
Evidentiary Standards	See Factor One

Factor Seven	Cost (Outpatient)
Source	Cigna NQTL Analysis, Pg 24-34
Definition	• Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Whether the service is associated with a high average cost. Based on an assessment of Cigna's historical paid claims for the service across its commercial book of business, the average unit cost of the service must exceed five hundred dollars ($500), unless either: a. The service is an unlisted or non-specific code where the unit cost may vary from far less than $500 to far more than $500; or b. The service is associated with serial use where the cumulative average use of the services may be represented by a single prior authorization and therefore exceed the dollar threshold.
Evidentiary Standards	See Factor One
Factor Eight	Potential for Fraud/Waste/Abuse (Outpatient)
Source	Cigna NQTL Analysis, Pg 24-34
Definition	Whether there is a high incidence of fraud, waste, and/or abuse as identified in publications by organizations that track trends regarding fraud waste, and abuse in utilization of healthcare services.
Evidentiary Standards	See Factor One
Factor Nine	Return on Investment (Outpatient)
Source	Cigna NQTL Analysis, Pg 24-34
Definition	Projected return on investment and/or savings if treatment type is subjected to concurrent care review
Evidentiary Standards	The ROI ratio is calculated using the following formula:

	a. The actual or anticipated denial rate of the service multiplied by the average unit cost (or, as applicable, cumulative cost) of the service, with the resulting figure divided by the estimated cost to review the total number of services. b. For services for which Cigna maintains historic claims data, Cigna calculates the denial rate by reference to the actual denial rate as reflected in the historic book-of-business claims data it maintains. The average unit cost of the service is calculated based on Cigna's historical paid claims for the service across its commercial book of business. The estimated cost to perform a coverage review is $100 per review, which is informed by costs/expenses such as personnel salaries and time.
Factor Ten	Medical Necessity
Source	Cigna NQTL Analysis, Pg 24-34
Definition	See Section Two
Evidentiary Standards	See Section Two
Factor Eleven	Discharge Planning (Inpatient)
Source	Cigna NQTL Analysis, Pg 24-34
Definition	Discharge / transition planning
Evidentiary Standards	See Factor One

Comparative Analysis of Concurrent Review in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Concurrent Review NQTL to both M/S and MH/SUD services across the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications. The Plan also bases this NQTL on clear factors and evidence-based standards. However, the scope of this NQTL is more stringent for MH/SUD services, presenting parity concerns. The list of subjected benefits is based on the prior authorization list, so while the list of M/S services subjected to the NQTL is longer than the list of MH/SUD conditions, the overall scope of the requirement is significantly broader for MH/SUD services than any comparable requirement for M/S benefits. The SPD

states that only non-emergent admissions, hospice, and home health care require certification while all MH/SUD services must be certified. It should be noted that the documents provided by CareAllies have a different list of services subject to the prior authorization NQTL that is both broader and significantly longer than what is in the Plan's SPD. While not a parity concern, the Plan should ensure that the vendor is following what is outlined within the Plan's SPD as it relates to administering the NQTL and that additional services are not being unduly subjected.

Concurrent Review in Operations

Beyond reviewing how the Plan addresses the Concurrent Review NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan, while working in concert with CareAllies, applies its concurrent review methodologies no more stringently for MH/SUD care than it does for M/S care, the Plan attempted to compare the number of claims subject to concurrent review and the resulting care denial rates. This section remains blank because the requested information was not provided.

Concurrent Review Process in Operation

		Number (#) of Claims		Percent (%) of Total Claims	
Scope		**M/S**	**MH/SUD**	**M/S**	**MH/SUD**
Claims Subject to Concurrent Review	*Inpatient IN*			0%	0%
	Inpatient OON			N/A	N/A
	Outpatient IN			0%	0%
	Outpatient OON			N/A	N/A
Denials		**M/S**	**MH/SUD**	**M/S**	**MH/SUD**
Claims Subject to Concurrent Review Where Review Resulted in Decision to Cover Less than Level of Care Recommended	*Inpatient IN*			N/A	N/A
	Inpatient OON			N/A	N/A
	Outpatient IN			N/A	N/A
	Outpatient OON			N/A	N/A

by Provider or Facility					

Alternative Operational Information

CareAllies provided the following Commercial Book-of-Business data for concurrent review:

		Number (#) of Claims		Percent (%) of Total Claims	
		M/S	**MH/SUD**	**M/S**	**MH/SUD**
Claims Subject to Concurrent Review	*Inpatient IN*	420,339	80,157		
	Inpatient OON	13,834	31,034		
	Outpatient IN	128,333	36039		
	Outpatient OON	7,464	13231		
Denials		**M/S**	**MH/SUD**	**M/S**	**MH/SUD**
Claims Subject to Concurrent Review Where Review Resulted in Decision to Cover Less than Level of Care Recommended by Provider or Facility	*Inpatient IN*	41,276	1785	9.82%	2.23%
	Inpatient OON	1972	1263	14.25%	4.07%
	Outpatient IN	509	1244	0.40%	3.45%
	Outpatient OON	126	711	1.69%	5.37%

Comparative Analysis of Concurrent Review in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Concurrent Review NQTL. However, CareAllies did not provide all the necessary data needed to conduct a complete analysis despite multiple requests by the Plan to obtain the full scope of information. Based on the book-of-business information provided, it appears the Plan may be more stringent to M/S Inpatient claims which is not a parity concern.

However, without complete stringency test data, it is not possible to fully analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Concurrent Review

The Concurrent Review NQTL applies to the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications. A comparison of the Plan's written requirements reveals the Plan applies the NQTL more stringently to MH/SUD in writing. The SPD states that only non-emergent admissions, hospice, and home health care require pre-certification while all MH/SUD services must be pre-certified. On an operational level, CareAllies offered alternative and incomplete stringency test data rather than the complete data that was requested by the Plan on multiple occasions.

Based on this evidence, the Plan concludes it does not meet parity standards regarding the application of the Concurrent Review NQTL in the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications.

5. Retrospective Review

The Plan requires a retrospective review of care and treatment for certain M/S and MH/SUD claims spanning the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications. The Retrospective Review NQTL is intended to assess medical necessity. It should be noted that the Plan's SPD does not mention the retrospective review as part of utilization management but does reference post-service claims as part of claims filings.

Retrospective Review as Written

The Plan contracts with CareAllies to apply its retrospective review methodologies. The Plan's Retrospective Review NQTL as written is described below:

Retrospective Review as Written		
MHPAEA Classification	*Inpatient IN, Inpatient OON, Outpatient IN, Outpatient OON*	
Applicable Benefits	M/S	All services subject to prior authorization
	MH/SUD	All services subject to prior authorization
Factor One	Medical Necessity	
Source	Cigna NQTL Analysis, Pg 34-42	
Definition	See Section Two	
Evidentiary Standards	See Section Two	

Comparative Analysis of Retrospective Review in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Retrospective Review NQTL to both M/S and MH/SUD services across the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications. The Plan also bases this NQTL on clear factors and evidence-based standards. However, the scope of this NQTL is more stringent for MH/SUD services, presenting parity concerns. The list of subjected benefits is based on the prior authorization list, so while the list of M/S services subjected to the NQTL is longer than the list of MH/SUD conditions, the overall scope of the requirement is significantly broader for MH/SUD services than any comparable requirement for M/S benefits. The SPD states that only non-emergent admissions, hospice, and home health care require certification while all MH/SUD services must be certified. It should be noted that the documents provided by CareAllies have a different list of services subject to the prior authorization NQTL that is both broader and significantly longer than what is in the Plan's SPD. While not a parity concern, the Plan should ensure that the vendor is following what is outlined within the Plan's SPD as it relates to administering the NQTL and that additional services are not being unduly subjected.

Retrospective Review in Operations

Beyond reviewing how the Plan addresses the Retrospective Review NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan, while working in concert with CareAllies, applies its retrospective review methodologies no more stringently for MH/SUD care than it does for M/S care, the Plan attempted to compare the number of claims subject to utilization review and the resulting denial rates. This section remains blank because the requested information was not provided.

Retrospective Review Process in Operation

		Number (#) of Claims		Percent (%) of Total Claims	
Scope		**M/S**	**MH/SUD**	**M/S**	**MH/SUD**
Claims Subject to Retrospective Claims Review	*Inpatient IN*			0%	0%
	Inpatient OON			N/A	N/A
	Outpatient IN			0%	0%
	Outpatient OON			N/A	N/A
Denials		**M/S**	**MH/SUD**	**M/S**	**MH/SUD**
Claims Subject to Retrospective Claims Review Resulting in a Denial of Coverage	*Inpatient IN*			N/A	N/A
	Inpatient OON			N/A	N/A
	Outpatient IN			N/A	N/A
	Outpatient OON			N/A	N/A

Alternative Operational Information

CareAllies provided the following Commercial Book-of-Business data for retrospective review:

		Number (#) of Claims		Percent (%) of Total Claims	
Scope		**M/S**	**MH/SUD**	**M/S**	**MH/SUD**
Claims Subject to Retrospective Claims Review	*Inpatient IN*	160,064	823		
	Inpatient OON	5,082	1,134		
	Outpatient IN	92,389	421		
	Outpatient OON	63,352	488		
Denials		**M/S**	**MH/SUD**	**M/S**	**MH/SUD**
Claims Subject to Retrospective Claims Review Resulting in a Denial of Coverage	*Inpatient IN*	18,293	193	11.43%	23.45%
	Inpatient OON	1217	358	23.95%	31.57%
	Outpatient IN	31,500	140	34.09%	33.25%
	Outpatient OON	34,651	164	54.70%	33.61%

Comparative Analysis of Retrospective Review in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Retrospective Review NQTL. However, CareAllies did not provide all of the necessary data needed to conduct a complete analysis despite multiple requests by the Plan to obtain the full scope of information. Based on the information provided, it appears the Plan may have parity concerns in the Inpatient IN and OON benefit classifications. The book-of-business data provided by CareAllies shows that the claim denial rates were significantly higher for MH/SUD claims in the Inpatient IN (23.45% denied) and Inpatient OON (31.57% denied) compared to M/S claims in the Inpatient IN (11.43% denied) and Inpatient OON (23.95% denied) benefit classifications. However, without complete Plan-specific stringency test data, it is not possible to fully analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Retrospective Review

The Retrospective Review NQTL applies to the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications. A comparison of the Plan's written requirements reveals the Plan applies the NQTL more stringently to MH/SUD in writing. The SPD states that only non-emergent admissions, hospice, and home health care require pre-certification while all MH/SUD services must be pre-certified. On an operational level, CareAllies offered alternative and incomplete stringency test data rather than the complete data that was requested by the Plan on multiple occasions.

Based on this evidence, the Plan concludes it does not meet parity standards regarding the application of the Retrospective Review NQTL in the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications.

6. Emergency Care Authorization

The Plan imposes an Emergency Care Authorization NQTL on certain types of care received following a medical emergency. These benefits can span both M/S and MH/SUD, and the NQTL applies to the Inpatient IN and OON benefit classifications. In applying this NQTL, the Plan requires participants (or their medical care providers) to contact the Plan if they are admitted to the hospital from an emergency department visit within 48 hours following admission (or the next business day following a weekend or federal holiday, whichever comes first.) to obtain certification from the Plan. According to the SPD "If you fail to do this, the Fund will reduce the amount of the benefit it would have paid by 20%, up to a maximum of $1,000. This 20% or $1,000 (whichever is less) is payable by you, in addition to any other Deductibles or Co-Payments you may be responsible for under the regular terms of your Plan."

Emergency Care Authorization as Written

The Plan contracts with CareAllies to conduct its emergency care authorizations. The Plan's Emergency Care Authorization NQTL as written is described below:

Emergency Care Authorization as Written		
MHPAEA Classification	*Inpatient IN, Inpatient OON*	
Applicable Benefits	M/S	Inpatient admission following an emergency
	MH/SUD	Inpatient admission following an emergency
Factor One	Certification	
Source	SPD, Pg 90	
Definition	See Section Two	
Evidentiary Standards	See Section Two	

Comparative Analysis of Emergency Care Authorization in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Emergency Care Authorization NQTL equally to both M/S and MH/SUD services in the Inpatient IN and Inpatient OON benefit classifications. The Plan also bases this NQTL on clear factors and evidence-based standards, which are the same for all affected MH/SUD and M/S benefits.

Emergency Care Authorization in Operations

Beyond reviewing how the Plan addresses the Emergency Care Authorization NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan, while working in concert with CareAllies, conducts emergency care authorizations no

more stringently for MH/SUD care than it does for M/S care, the Plan compared M/S and MH/SUD claims that began through an emergency care visit but resulted in either an Inpatient IN or Inpatient OON admission. The Plan attempted to review the total number of relevant admissions, the number of admissions where the Plan was properly notified, and the instances of noncompliance penalty application. This section remains blank because the requested information was not provided.

Emergency Care Authorization in Operation

Scope		Number (#) of Claims		Percent (%) of Total Claims	
		M/S	MH/SUD	M/S	MH/SUD
Inpatient Admissions from Emergency Department	*Inpatient IN*			N/A	N/A
	Inpatient OON			N/A	N/A
Claims Where the Plan was Notified within the Required Timeframe	*Inpatient IN*			N/A	N/A
	Inpatient OON			N/A	N/A
Claims Where the Plan was Not Timely Notified and Penalties were Applied for Noncompliance	*Inpatient IN*			N/A	N/A
	Inpatient OON			N/A	N/A

Comparative Analysis of Emergency Care Authorization in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Emergency Care Authorization NQTL. However, CareAllies did not provide the requested operational data despite multiple requests by the Plan. Without adequate stringency test data, it is not possible to analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Emergency Care Authorization

The Emergency Care Authorization NQTL applies to the Inpatient IN and Inpatient OON benefit classifications. A comparison of the Plan's written requirements reveals all factors and

evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, CareAllies was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity.

Based on this evidence, the Plan cannot determine if it meets parity standards for the Emergency Care Authorization NQTL in the benefit classifications of Inpatient IN and Inpatient OON.

7. Provider Credentialing

The Plan utilizes the Cigna HealthCare PPO network for providers and facilities. According to the SPD "Cigna HealthCare is a network of Physicians, Hospitals and other health care providers which offer medical and Hospital services at reduced rates." However, Plan Participants must use a Cigna HealthCare PPO provider in order to be covered with limited exceptions under the fund, for these exceptions see the Out-of-Network Access NQTL, Section Ten. The SPD states that "Cigna HealthCare discounts claims when you use a participating provider, but Cigna HealthCare is not your insurance carrier! Your benefits are provided through the Bakers Union & FELRA Health and Welfare Fund." Developing and maintaining the network includes ensuring that all providers and facilities who contract with or are in any way reimbursed by the Plan are qualified to receive in-network payment from the Plan. The Provider Credentialing NQTL applies to both M/S and MH/SUD providers who offer care in the Inpatient IN, Outpatient IN, and Emergency Care benefit classifications.

Provider Credentialing as Written

The Plan contracts with Cigna to manage its network of providers to be accessed by Plan participants. The Plan's Provider Credentialing NQTL as written is described below:

Provider Credentialing Standards as Written		
MHPAEA Classification	*Inpatient IN, Outpatient IN, Emergency Care*	
Applicable Benefits	M/S	All IN Benefits
	MH/SUD	All IN Benefits
Factor One	Meets Network Admission Criteria	
Source	Cigna NQTL Analysis, Pg 48-53	
Definition	Cigna maintains an open network for both M/S and MH/SUD providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's network admission criteria.	
Evidentiary Standards	Cigna credentialing standards for licensed physicians follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. Cigna does not maintain separate standards for MH/SUD providers. Credentialing criteria for both M/S and MH/SUD providers includes: (1) signed agreement to participate (2) signed application and provider attestation (3) verification of unrestricted state medical license with appropriate licensing agency; (4) verification of valid, unrestricted DEA certificate (if applicable); (5) verification of full,	

	unrestricted admitting privileges at a Cigna participating hospital; (6) verification Board certification, (if applicable); (7) verification of highest level of education and training, if not board certified; (8) review and verification of malpractice claims history; (9) review of work history; (10) verification of adequate malpractice insurance; and (11) verification of prior and current sanction activities. Cigna does not require that MH/SUD practitioners or facilities be licensed or accredited if such a license or accreditation would not be required by state law.

Comparative Analysis of Provider Credentialing in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Provider Credentialing NQTL equally to both M/S and MH/SUD providers, and the NQTL affects the Inpatient IN, Outpatient IN, and Emergency Care benefit classifications. The Plan also bases this NQTL on clear factors and evidence-based standards, which are the same for all affected MH/SUD and M/S providers.

Provider Credentialing in Operations

Beyond reviewing how the Plan addresses the Provider Credentialing NQTL in writing, the CAA requires the Plan to test how the NQTL applies credentialing standards during typical plan operations. To see if the application of the MH/SUD provider credentialing process and provider approval percentages are operationally in parity with the credentialing process and approval rates for M/S providers, the Plan attempted to compare its approval rate and average processing time by type of provider. This section remains blank because the requested information was not provided.

Initial Provider Credentialing Process in Operation

Type of Provider	# of Providers that Applied	# of Providers Approved	# of Providers Denied	% of Providers Approved	Average Processing Time (in days)
M/S Physicians				N/A	
Psychiatrists				N/A	
M/S Non-physician Providers				N/A	

MH/SUD Non-physician Providers				N/A	
All Credentialed Providers				N/A	

Comparative Analysis of Provider Credentialing in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Provider Credentialing NQTL. Cigna did not provide the necessary data despite multiple requests by the Plan. There is no evidence to suggest that the Plan does not operate as described through its written standards. However, without sufficient stringency test data, it is not possible to adequately analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Provider Credentialing

The Provider Credentialing NQTL applies to the Inpatient IN, Outpatient IN, and Emergency Care benefit classifications. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, Cigna was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity.

Based on this evidence, the Plan cannot determine if it meets parity standards for the Provider Credentialing NQTL in the benefit classifications of Inpatient IN, Outpatient IN, and Emergency Care.

8. Network Reimbursement

The Plan utilizes the Cigna HealthCare PPO network for providers and facilities. According to the SPD "Cigna HealthCare is a network of Physicians, Hospitals and other health care providers which offer medical and Hospital services at reduced rates." However, Plan Participants must use a Cigna HealthCare PPO provider in order to be covered with limited exceptions under the fund, for these exceptions see the Out-of-Network Access NQTL, Section Ten. The SPD states that "Cigna HealthCare discounts claims when you use a participating provider, but Cigna HealthCare is not your insurance carrier! Your benefits are provided through the Bakers Union & FELRA Health and Welfare Fund." Developing and maintaining the network includes setting payment rates for accommodations, services, drugs, and other devices and equipment provided to Plan participants by network providers and facilities serving both M/S and MH/SUD patients spanning the benefit classifications of Inpatient IN, Outpatient IN, and Emergency Care. Applying the Network Reimbursement NQTL is the process by which provider reimbursement rates are established for in-network practitioners, group practices, and facilities.

Network Reimbursement as Written

The Plan contracts with Cigna to manage its network of providers to be accessed by Plan participants. The Plan's Network Reimbursement NQTL as written is described below:

Network Reimbursement Standards as Written		
MHPAEA Classification	*Inpatient IN, Outpatient IN, Emergency Care*	
Applicable Benefits	M/S	All IN Benefits
	MH/SUD	All IN Benefits
Factor One	Geographic Market	
Source	Cigna NQTL Analysis, Pg 57-62	
Definition	Market rate and payment type for provider type and/or specialty	
Evidentiary Standards	Medicare Geographical Practice Cost Index ("GPCI")	
Factor Two	Type of Provider and/or Specialty	
Source	Cigna NQTL Analysis, Pg 57-62	
Definition	Hospital, clinic and practitioner and/or specialty	
Evidentiary Standards	State licensing and credentialing requirements as outlined by the applicable state or NCQA	

Factor Three	Supply of Provider Type and/or Specialty
Source	Cigna NQTL Analysis, Pg 57-62
Definition	Provider specific fee schedules are used for multi-specialty specialty groups or unique specialty groups where reimbursement terms must be customized to meet the needs of that group or specialty.
Evidentiary Standards	Providers are needed to meet network access requirements and/or increase membership.
Factor Four	Network Need
Source	Cigna NQTL Analysis, Pg 57-62
Definition	Network need and/or demand for provider type or specialty is defined by state adequacy requirements.
Evidentiary Standards	Cigna's Measuring Availability of Practitioners and Providers Policy
Factor Five	Medicare Reimbursement Rates
Source	Cigna NQTL Analysis, Pg 57-62
Definition	Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit ("RVU"). RVUs are the basis of the RBRVS system.
Evidentiary Standards	• Medicare's resource-based relative value scale (RBRVS) calculation • Medicare DRG calculations

Comparative Analysis of Network Reimbursement in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Network Reimbursement NQTL equally to both M/S and MH/SUD providers. The NQTL affects the Inpatient IN, Outpatient IN, and Emergency Care benefit classifications. The Plan also bases this NQTL on clear factors and evidence-based standards, which are the same for all affected MH/SUD and M/S providers.

Network Reimbursement in Operations

Beyond reviewing how the Plan addresses the Network Reimbursement NQTL in writing, the CAA requires the Plan to test how the NQTL applies during typical plan operations.

To see if the application of the provider network reimbursement methodologies for MH/SUD care is operationally in parity with the reimbursement rates methodologies used to set rates for M/S benefits, the Plan attempted to compare its average in-network reimbursement rates for certain MH/SUD and M/S services based on Current Procedural Terminology (CPT) codes. The Plan used a framework that is based on a comparison chart in Appendix II of the Department of Labor's *Mental Health Parity and Addiction Equity Act Self Compliance Tool* and utilizes national Medicare reimbursement rates as its benchmark for comparison.

To test the reimbursement methodology for Inpatient IN care reimbursement rates, the Plan obtained a list of the ten most common medical diagnoses yielding inpatient care stays on a national basis from the federal Healthcare Cost and Utilization Project (HCUP). HCUP is administered by the Department of Health and Human Services' Agency for Healthcare Research and Quality. Using this database, the Plan also obtained the most common diagnosis leading to an inpatient admission for mental health reasons and the most common substance use disorder diagnosis leading to inpatient care. For each diagnosis, the Plan attempted to compare its average IN reimbursement rate and the national average Medicare reimbursement rate for the following CPT codes:

99221 – The admitting physician uses this code when he or she performs the initial service upon the patient at the time of admission as inpatient. This code can be billed only ONCE per day.

99222 – This code is used for hospital care for the evaluation and management of a patient, which includes three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.

This section remains blank because the requested information was not provided.

Evaluation of the Plan's In-Network Inpatient Care Provider Reimbursement Rates

Primary Diagnosis	CPT Codes	Average Plan Reimbursement Rate	Average National Medicare Reimbursement Rate	Ratio of Plan Average to Medicare Average
Septicemia	99221 99222		$101.19 $136.08	
Heart failure	99221		$101.19	

	99222		$136.08	
Osteoarthritis	99221 99222		$101.19 $136.08	
Complications specified during childbirth	99221 99222		$101.19 $136.08	
Pneumonia	99221 99222		$101.19 $136.08	
Diabetes mellitus with complication	99221 99222		$101.19 $136.08	
Acute myocardial infarction	99221 99222		$101.19 $136.08	
Cardiac dysrhythmias	99221 99222		$101.19 $136.08	
Chronic obstructive pulmonary disease and bronchiectasis	99221 99222		$101.19 $136.08	
Mood Disorder	99221 99222		$101.19 $136.08	
Alcohol Use Disorder	99221 99222		$101.19 $136.08	

To test the reimbursement methodology for Outpatient IN care reimbursement rates, the Plan obtained a list of common outpatient visit CPT codes for a range of providers from Appendix II of the Department of Labor's *Mental Health Parity and Addiction Equity Act Self Compliance Tool*. For each type of provider, the Plan compared its average in-network reimbursement rate and the national average Medicare reimbursement rate for the following CPT codes:

99203 – Office or other outpatient visit for the evaluation and management of a new patient.

99213 – Office or other outpatient visit for the evaluation and management of an established patient, which requires a low level of medical decision making.

90832 – Individual psychotherapy services rendered for 30 minutes by a licensed mental health provider.

90791 – Integrated biopsychosocial assessment, including history, mental status, and recommendations.

97161 – Physical therapy evaluation of low complexity. Typically, 30 minutes are spent face to face with the patient and/or family.

97162 – Physical therapy evaluation, moderate complexity. Typically, 45 minutes are spent face to face with the patient and/or family.

97163 – Physical therapy evaluation, high complexity. Typically, 60 minutes are spent face to face with the patient and/or family.

97164 – Re-evaluation of physical therapy established plan of care. Typically, 30 minutes are spent face to face with the patient and/or family.

97165 – Occupational therapy evaluation, low complexity. Typically, 30 minutes are spent face to face with the patient and/or family.

97166 – Occupational therapy evaluation, moderate complexity. Typically, 45 minutes are spent face to face with the patient and/or family.

97167 – Occupational therapy evaluation, high complexity. Typically, 60 minutes are spent face to face with the patient and/or family.

97168 – Re-evaluation of occupational therapy established plan of care. Typically, 30 minutes are spent face to face with the patient and/or family.

The results are as follows:

Evaluation of the Plan's In-Network Outpatient Care Provider Reimbursement Rates

Primary Diagnosis	CPT Codes	Average Plan Reimbursement Rate	Average National Medicare Reimbursement Rate	Ratio of Plan Average to Medicare Average
Orthopedic Surgery	99203	$156.36	$113.75	137.5%
	99213	$104.69	$68.04	153.9%
Cardiologists	99203	$153.39	$113.75	134.8%
	99213	$95.21	$68.04	139.9%

Internists MD	99203 99213	$136.80 $93.08	$113.75 $68.04	120.3% 136.8%
Endocrinologists	99203 99213	$164.44 $102.61	$113.75 $68.04	144.6% 150.8%
Gastroenterologist	99203 99213	$140.83 $92.74	$113.75 $68.04	123.8% 136.3%
Neurologists	99203 99213	$158.58 $101.38	$113.75 $68.04	139.4% 149%
Pediatrician	99203 99213	$157.50 $93.87	$113.75 $68.04	138.5% 138%
Dermatologists	99203 99213	$127.73 $85.97	$113.75 $68.04	112.3% 126.4%
Psychiatrists	99203 99213	$126.72 $74.90	$113.75 $68.04	111.4% 110.1%
Psychologists	90832 90791	$71.33 $131.34	$68.74 $156.32	103.8% 84%
LCSW	90832 90791	$56.95 $108.86	$68.74 $156.32	82.8% 69.6%
Podiatrists	99203 99213	$120.93 $77.51	$113.75 $68.04	106.3% 113.9%
Chiropractor	99203 99213	$79.78 $61.20	$113.75 $68.04	70.1% 89.9%
Occupational Therapy	97165 97166 97167 97168	$113.02 $111.66 $131.11 $65.12	$98.75 $98.75 $98.75 $98.75	114.5% 113.1% 132.8% 65.9%
Physical Therapy	97161	$104.59	$101.89	102.6%

	97162	$98.61	$101.89	96.8%
	97163	$104.99	$101.89	103%
	97164	$63.83	$69.79	91.5%

Comparative Analysis of Network Reimbursement in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Network Reimbursement NQTL. However, Cigna did not provide all the necessary data needed to conduct a complete analysis despite multiple requests by the Plan to obtain the full scope of information. Based on the information provided, it appears the Plan may have parity concerns. The Plan's reimbursement rates for M/S and MH/SUD providers were comparable, although non-physician providers were reimbursed at lower rates than M.D. and D.O. providers when compared to Medicare rates. Review of this data shows that Licensed Clinical Social Workers (LCSWs), a master's level MH/SUD provider, were reimbursed at significantly lower rates than any other CPT code at 70-83% of the Medicare rate. Comparably all M/S master's level degree providers were reimbursed at 66-133% of Medicare rates. All M.D. and D.O. outpatient providers were reimbursed at comparable rates at or above the Medicare rate for the given CPT code, though psychiatrists were the lowest. While the outpatient rates appear to show parity concerns for the specific CPT codes listed, similar inpatient reimbursement rates were not provided for review. Without complete stringency test data, it is not possible to fully analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Network Reimbursement

The Network Reimbursement NQTL applies to the Inpatient IN, Outpatient IN, and Emergency Care benefit classifications. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. However, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. Unfortunately, Cigna only provided incomplete operational stringency test data despite multiple attempts by the Plan to obtain complete information. Based on the information provided, it appears the Plan may have parity concerns. The Plan's reimbursement rates for M/S and MH/SUD providers were comparable, although non-physician providers were reimbursed at lower rates than M.D. and D.O. providers when compared to Medicare rates. Review of this data shows that Licensed Clinical Social Workers (LCSWs), a master's level MH/SUD provider, were reimbursed at significantly lower rates than any other CPT code at 70-83% of the Medicare rate. Comparably all M/S master's level degree providers were reimbursed at 66-133% of Medicare rates. All M.D. and D.O. outpatient providers were reimbursed at comparable rates at or above the Medicare rate for the given CPT code, though psychiatrists were the lowest. While the outpatient rates appear to show parity concerns for the specific CPT codes listed, similar inpatient reimbursement rates were not provided for

review. Without complete stringency test data, it is not possible to fully analyze the NQTL operationally for parity purposes.

Based on this evidence, the Plan concludes that it does not meet parity standards for the Outpatient IN benefit classification, but the Plan cannot determine if it meets parity standards for the Network Reimbursement NQTL in the Inpatient IN or Emergency Care benefit classifications.

9. Network Adequacy

The Plan utilizes the Cigna HealthCare PPO network for providers and facilities. According to the SPD "Cigna HealthCare is a network of Physicians, Hospitals and other health care providers which offer medical and Hospital services at reduced rates." However, Plan Participants must use a Cigna HealthCare PPO provider in order to be covered with limited exceptions under the fund, for these exceptions see the Out-of-Network Access NQTL, Section Ten. The SPD states that "Cigna HealthCare discounts claims when you use a participating provider, but Cigna HealthCare is not your insurance carrier! Your benefits are provided through the Bakers Union & FELRA Health and Welfare Fund." Part of developing and maintaining the Plan network includes ensuring an adequate number of practitioners, group practices, and facilities for both M/S and MH/SUD services. A related concern is demonstrating the adequacy of the network to Plan participants through the network directory. The Network Adequacy NQTL applies to all in-network providers and facilities providing both M/S and MH/SUD care spanning the benefit classifications of Inpatient IN, Outpatient IN, and Emergency Care.

Network Adequacy as Written

The Plan contracts with Cigna to manage its network of providers to be accessed by Plan participants. The Plan's Network Adequacy NQTL as written is described below:

Network Adequacy as Written		
MHPAEA Classification	*Inpatient IN, Outpatient IN, Emergency Care*	
Applicable Benefits	M/S	All IN Benefits
	MH/SUD	All IN Benefits
Factor One	Provider/Customer Ratio	
Source	Cigna NQTL Analysis, Pg 54-56	
Definition	Provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions.	
Evidentiary Standards	• Census (membership) data • Customer satisfaction surveys • Customer complaint data • NCQA and NAIC network adequacy and access standards • Internal annual analysis of Cigna's medical and behavioral networks to see if they meet the company's established access to care standards in urban, suburban, and rural areas.	

	• Annual review of network adequacy policies and procedures to ensure the continued sufficiency of the standards in meeting enrollees' needs.
Factor Two	Time/Distance Standards
Source	Cigna NQTL Analysis, Pg 54-56
Definition	Time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions,
Evidentiary Standards	See Factor One
Factor Three	Wait Times
Source	Cigna NQTL Analysis, Pg 54-56
Definition	Appointment wait times for emergency care, urgent care and routine outpatient care for the various provider types and/or specialties.
Evidentiary Standards	See Factor One

Comparative Analysis of Network Adequacy in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Network Adequacy NQTL equally to both M/S and MH/SUD providers and facilities. The NQTL affects the Inpatient IN, Outpatient IN, and Emergency Care benefit classifications. The Plan also bases this NQTL on clear factors and evidence-based standards, which are the same for all affected MH/SUD and M/S providers and facilities.

Network Adequacy in Operations

Beyond reviewing how the Plan addresses the Network Adequacy NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan's network is as sufficient for MH/SUD care as it is for M/S care, the Plan compared the percentage of total OON claims Plan participants submitted for both M/S and MH/SUD and recorded the results as follows:

In-Network Versus Out-of-Network Claims Test

	Number (#) of Claims		Percent (%) of Total Claims that were OON	
	M/S	MH/SUD	M/S	MH/SUD
Inpatient IN	188	7	N/A	N/A
Inpatient OON	n/a	n/a	0%	0%
Outpatient IN	1332	46	N/A	N/A
Outpatient OON	n/a	n/a	0%	0%

To further test the adequacy of the network in practice, the Plan analyzed its online network directory. To compare facility adequacy, the Plan reviewed the number of Urgent Care and Substance Use Disorder facilities within a 10-mile radius of 21152. This zip code was selected as the benchmark since it is the zip code of the Plan's headquarters. Urgent Care and Substance Use Disorder facilities were selected for comparison because various industry surveys indicate that there are approximately 10,000-15,000 of both types of facilities located in the United States.

To compare specialist provider adequacy, the Plan reviewed the number of Cardiologists and Psychiatrists within a 10-mile radius of 21152. This zip code was selected as the benchmark since it is the zip code of the Plan's headquarters. Psychiatrists and Cardiologists were selected for comparison because according to the U.S. Bureau of Labor Statistics, the number of practicing physicians in each of these specialties are relatively close in number as compared to other provider specialties. There are approximately 26,000 Psychiatrists and approximately 33,000 Cardiologists.

Network Adequacy Test as of May 2024

Urgent Care Centers (M/S Care)	
Providers	16
Accepting New Patients	
Non-English Language Capabilities	
Behavioral Health/SUD Clinic	
Providers	11
Accepting New Patients	

Non-English Language Capabilities	
Cardiologists (M/S Care)	
Providers	73
Accepting New Patients	73
Psychiatrists (MH/SUD Care)	
Providers	86
Accepting New Patients	86

Additionally, to test whether the Network Adequacy NQTL is being applied operationally in parity, the Plan posed the following spot check questions to its network provider, Cigna, and recorded the answers as follows:

Does the network directory note if providers are accepting new patients? Does it specify non-English language capabilities, if applicable?
Yes states if accepting new patients and non-english language capabilities

Does your Plan offer standalone telemedicine services, meaning a telemedicine benefit beyond any telemedicine coverage that may be included as part of the major medical plan?
No

If yes, who is your telemedicine provider?
n/a

Does your telemedicine benefit include MH/SUD services or just M/S services?
n/a

Does the Plan sponsor offer telemedicine services outside of any services provided directly through its major medical plan? If so, who is the telemedicine provider and are MH/SUD benefits included?
No.

Comparative Analysis of Network Adequacy in Operation

When tested in practice, the Plan appears to apply the same operational standards to M/S and MH/SUD providers and facilities concerning the Network Adequacy NQTL, which affects the

Inpatient IN, Outpatient IN, and Emergency Care benefit classifications. A detailed review of information provided by Cigna about the day-to-day operational procedures applied when developing the Plan's network indicates parity. A test of the network's directory inclusion of a similar number of M/S and MH/SUD providers and facilities indicates parity. The application of the NQTL is not impacted by whether the services provided are for the treatment of a M/S or MH/SUD condition.

Overall Comparison and Conclusions Regarding Network Adequacy

The Network Adequacy NQTL applies to the Inpatient IN, Outpatient IN, and Emergency Care benefit classifications. A comparison of the Plan's written requirements, as well as a test of the Plan's operational procedures, reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. Whether a condition is MH/SUD or M/S related is not relevant to how the Plan applies the Network Adequacy NQTL to any classification of benefits.

Based on this evidence, the Plan concludes it meets parity standards regarding the application of the Network Adequacy NQTL in the benefit classifications of Inpatient IN, Outpatient IN, and Emergency Care.

10. Out-of-Network Access

While the Plan utilizes the Cigna HealthCare PPO network. There are very limited situation exceptions to when OON services will be covered under the Plan. This imposes an Out-of-Network Access NQTL on both M/S and MH/SUD care in the Inpatient OON, Outpatient OON, and Emergency Care benefit classifications.

The limits to OON access are:

- Emergencies (inpatient or outpatient) which occur outside the Cigna HealthCare area.
- Eligible Dependent students who attend a school outside the Cigna HealthCare network area are not required to use a Cigna HealthCare provider.
- Anesthesiology claims from non-Cigna HealthCare providers ONLY if: (1) the Participant uses a participating surgeon/Physician, (2) the service is performed at a participating facility/Hospital and (3) the member followed all other Fund rules for coverage of the service.
- When this Plan's coverage is secondary, a Cigna HealthCare PPO provider is not required.
- Ambulance transport in emergency situations.

Out-of-Network Access as Written

The Plan contracts with Cigna and uses Associated Administrators to manage its claims payments. The Plan's Out-of-Network Access NQTL as written is described below:

Out-of-Network Access as Written		
MHPAEA Classification	*Inpatient OON, Outpatient OON, Emergency Care*	
Applicable Benefits	M/S	• Emergencies (inpatient or outpatient) which occur outside the Cigna HealthCare area. • Eligible Dependent students who attend a school outside the Cigna HealthCare network area are not required to use a Cigna HealthCare provider. • Anesthesiology claims from non-Cigna HealthCare providers ONLY if: (1) the Participant uses a participating surgeon/Physician, (2) the service is performed at a participating facility/Hospital and (3) the member followed all other Fund rules for coverage of the service. • When this Plan's coverage is secondary, a Cigna HealthCare PPO provider is not required.

		• Ambulance transport in emergency situations.
	MH/SUD	• Emergencies (inpatient or outpatient) which occur outside the Cigna HealthCare area. • Eligible Dependent students who attend a school outside the Cigna HealthCare network area are not required to use a Cigna HealthCare provider. • Anesthesiology claims from non-Cigna HealthCare providers ONLY if: (1) the Participant uses a participating surgeon/Physician, (2) the service is performed at a participating facility/Hospital and (3) the member followed all other Fund rules for coverage of the service. • When this Plan's coverage is secondary, a Cigna HealthCare PPO provider is not required. • Ambulance transport in emergency situations.
Factor One	Provider/Customer Ratio	
Source	Cigna NQTL Analysis, Pg 54-56	
Definition	Provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions.	
Evidentiary Standards	• Census (membership) data • Customer satisfaction surveys • Customer complaint data • NCQA and NAIC network adequacy and access standards • Internal annual analysis of Cigna's medical and behavioral networks to see if they meet the company's established access to care standards in urban, suburban, and rural areas. • Annual review of network adequacy policies and procedures to ensure the continued sufficiency of the standards in meeting enrollees' needs.	
Factor Two	Time/Distance Standards	
Source	Cigna NQTL Analysis, Pg 54-56	
Definition	Time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions,	

Evidentiary Standards	See Factor One
Factor Three	Wait Times
Source	Cigna NQTL Analysis, Pg 54-56
Definition	Appointment wait times for emergency care, urgent care and routine outpatient care for the various provider types and/or specialties.
Evidentiary Standards	See Factor One

Comparative Analysis of Out-of-Network Access in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Out-of-Network Access NQTL equally to both M/S and MH/SUD providers and facilities. The NQTL affects the Inpatient OON, Outpatient OON, and Emergency Care benefit classifications. The Plan also bases this NQTL on clear factors and evidence-based standards, which are the same for all affected MH/SUD and M/S providers and facilities.

Out-of-Network Access in Operations

Beyond reviewing how the Plan addresses the Out-of-Network Access NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan applies standards no more stringently for MH/SUD care than it does for M/S care, the Plan posed the following spot test questions to Associated Administrators and recorded the answers below.

Are there any circumstances in which out-of-network benefits are covered outside of Emergency Care? If so, please explain the process for accessing coverage.
The No Surprise Act and Transparency Act have requirements that out of network providers and facilities are required to be paid. The Plan complies with covering out of network claims to comply with those requirements only.

Are there any differences related to accessing such care between M/S and MH/SUD?
No

Comparative Analysis of Out-of-Network Access in Operation

When tested in practice, the Plan appears to apply the same operational standards to M/S and MH/SUD benefits concerning the Out-of-Network Access NQTL, which affects the Inpatient OON, Outpatient OON, and Emergency Care benefit classifications. A detailed review of information provided by Cigna about the day-to-day operational procedures applied when executing the Plan's limitations to benefits and services outside of the Plan's designated provider network indicates parity. The application of the NQTL is not impacted by whether the services provided are for the treatment of a M/S or MH/SUD condition.

Overall Comparison and Conclusions Regarding Out-of-Network Access

The Out-of-Network Access NQTL applies to the Inpatient OON, Outpatient OON, and Emergency Care benefit classifications. A comparison of the Plan's written requirements, as well as a test of the Plan's operational procedures, reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. Whether a condition is MH/SUD or M/S related is not relevant to how the Plan applies the Out-of-Network Access NQTL to any classification of benefits.

Based on this evidence, the Plan concludes it meets parity standards regarding the application of the Out-of-Network Access NQTL in the benefit classifications of Inpatient OON, Outpatient OON, and Emergency Care.

11. Exclusions

According to the Plan, benefits are only payable for medically necessary services. The Plan also applies an Exclusions NQTL by specifying an extensive list of benefits that do not meet this definition. By nature, plan exclusion provisions are prepared with the intention of clearly delineating all potential circumstances in which charges could arise. This analysis focuses on the general principles underlying plan exclusions. The Exclusions NQTL applies to both M/S and MH/SUD benefits and services that span all MHPAEA benefit classifications.

Exclusions as Written

The Plan contracts with Associated Administrators to manage its benefits and pay related benefit claims. The Plan's Exclusions NQTL as written is described below:

Exclusions as Written		
MHPAEA Classification	*Inpatient IN, Inpatient OON, Outpatient IN, Outpatient OON, Emergency Care, Prescription Drugs*	
Applicable Benefits	M/S	• Ambulance transportation from one facility to another in nonemergency situations. • Hearing aids, unless the hearing aid is necessary as a result of an Injury sustained while the Participant is eligible for benefits under the Fund. • Treatment of sexual dysfunction (except for erectile dysfunction drugs, such as Viagra, as specified under the Prescription Drug benefit) or trans-sexual surgery • Reversal of sterilization • Injection treatment of hemorrhoids, hernias, and varicose veins, except that sclerotherapy will be covered if medically necessary for thrombophlebitis, phlebitis, leg ulcers or inflammation, but not for cosmetic purposes • Palliative or cosmetic foot care including, but not limited to, callus or corn paring; trimming or excision of toenails, except radical surgery for ingrown nails; treatment of chronic conditions of the foot such as fallen arches, weak feet, flat or pronated foot metatarsalgia, or foot strain • Orthopedic shoes (except when joined to braces) or supportive devices for the feet, including, but not limited to arch support, heel lifts, or orthotics

		• Treatment of temporomandibular joint dysfunction (TMJ) • Vision training of any kind • Radial keratotomy and refractive karatoplasty for vision that can be corrected to 20/80 with the aid of eyeglasses or contacts • Rehabilitative or occupational therapy not directly associated with an Illness or Injury or not required to restore a person to the activities of daily living following Illness or Injury • Hypnotism and stress management. Behavior modification unless medically necessary. • Private duty nursing while Participant is a Hospital inpatient • Losses resulting from an Injury sustained while operating or riding in or on an aircraft, or falling or in any other manner descending from an aircraft while the aircraft is in flight or motion, except as a fare-paying passenger of a commercial airline flying on a regularly scheduled route between established airports • Charges incurred outside the United States of America except those incurred in the event of an emergency while the covered person is on vacation and within the first 90 days of the person's absence from the United States. • Benefits are not payable for cosmetic or beautifying surgery unless required as the result of a non-occupational Injury • Complications arising from cosmetic surgery (unless the cosmetic surgery was required to treat a non-occupational Injury) • Custodial care which is not required to be performed by an RN or LPN. Custodial services include (but are not limited to) bathing, giving oral medication, acting as a companion or sitter, assisting with personal hygiene and daily living activities • Services, supplies, drugs, devices, medical treatment, procedures, or care of any kind which

		is experimental in nature or which is not accepted medical practice by the practicing medical community as determined by the Fund • Personal hygiene, beautification, comfort and convenience services and supplies are not covered • Air conditioners, humidifiers, purifiers and similar equipment are not covered • Expenses not medically necessary for the treatment of Illness or Injury including x-rays made without film • Meals-on-Wheels and similar food arrangements • Surrogate parenting, in-vitro fertilization, and all other treatments concerning infertility • Gastric by-pass or bubble, or similar procedures, to treat obesity • Treatment of obesity or weight loss, or physical fitness or exercise programs • Telephone consultations with patients or charges for failure to keep a regularly scheduled appointment • Pre-admission diagnostic testing relating to an inpatient admission which is not covered under the Plan • Nutritional counseling and services, supplies or medications primarily for dietary control • Domestic or housekeeping services • Pre-marital testing • Preventive care and vaccinations, unless specifically stated as being covered • Losses resulting from self-inflicted or self-induced Injury or Illness. • Newborn children of the Dependent daughters of Participants are not eligible for pediatric benefits.
	MH/SUD	• Ambulance transportation from one facility to another in nonemergency situations. • Treatment of sexual dysfunction (except for erectile dysfunction drugs, such as Viagra, as

		specified under the Prescription Drug benefit) or trans-sexual surgery • Rehabilitative or occupational therapy not directly associated with an Illness or Injury or not required to restore a person to the activities of daily living following Illness or Injury • Hypnotism and stress management. Behavior modification unless medically necessary. • Psychological Testing except for purposes of diagnosis. • Private duty nursing while Participant is a Hospital inpatient • Charges incurred outside the United States of America except those incurred in the event of an emergency while the covered person is on vacation and within the first 90 days of the person's absence from the United States. • Custodial care which is not required to be performed by an RN or LPN. Custodial services include (but are not limited to) bathing, giving oral medication, acting as a companion or sitter, assisting with personal hygiene and daily living activities • Services, supplies, drugs, devices, medical treatment, procedures, or care of any kind which is experimental in nature or which is not accepted medical practice by the practicing medical community as determined by the Fund • Personal hygiene, beautification, comfort and convenience services and supplies are not covered • Air conditioners, humidifiers, purifiers and similar equipment are not covered • Expenses not medically necessary for the treatment of Illness or Injury including x-rays made without film • Meals-on-Wheels and similar food arrangements • Treatment for learning disabilities, hyperkinetic syndromes, mental retardation, developmental delay, attention deficit disorders, autism or

		oppositional defiant disorders is not covered. This exclusion does not apply to diagnostic testing to determine the existence of such conditions • Gastric by-pass or bubble, or similar procedures, to treat obesity • Treatment of obesity or weight loss, or physical fitness or exercise programs • Telephone consultations with patients or charges for failure to keep a regularly scheduled appointment • Pre-admission diagnostic testing relating to an inpatient admission which is not covered under the Plan • Nutritional counseling and services, supplies or medications primarily for dietary control • Domestic or housekeeping services • Pre-marital testing • Preventive care and vaccinations, unless specifically stated as being covered • Losses resulting from self-inflicted or self-induced Injury or Illness.
Factor One	Medical Necessity	
Source	SPD, Pg 114-117	
Definition	See Section Two	
Evidentiary Standards	See Section Two	

Comparative Analysis of Exclusions in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Exclusions NQTL more stringently to MH/SUD services than to M/S services. The NQTL affects all MHPAEA benefit classifications. The Plan's design and written documentation outline many excluded benefits, spanning both M/S and MH/SUD. However, the scope of certain MH/SUD exclusions is significantly broader than comparable M/S exclusions, presenting parity concerns. The following exclusions are of specific concern:

- Treatment of sexual dysfunction (except for erectile dysfunction drugs, such as Viagra, as specified under the Prescription Drug benefit) or trans-sexual surgery.

While it is technically permissible to exclude a complete category of coverage under a plan, such as sexual dysfunction, a Plan cannot limit coverage of a MH/SUD disorder to just certain kinds of treatments or exclude coverage for the MH/SUD diagnoses that require this treatment and remain in parity. Since the Plan covers erectile function drugs, the Plan has to cover the diagnosis in its entirety. Additionally, this condition is often comorbid with other MH/SUD disorders and excluding it could create parity concerns as it would be difficult to know when this condition was being treated in conjunction with other MH/SUD care.

- Psychological Testing except for purposes of diagnosis.

A Plan cannot exclude coverage of a specific type of treatment or exclude coverage for the MH/SUD diagnoses that require this treatment for an otherwise covered MH/SUD condition and remain in parity.

- Treatment for learning disabilities, hyperkinetic syndromes, mental retardation, developmental delay, attention deficit disorders, autism or oppositional defiant disorders is not covered. This exclusion does not apply to diagnostic testing to determine the existence of such conditions

While it is technically permissible to exclude a complete category of coverage under a plan, Autism Spectrum Disorder, ADD, and ADHD are MH/SUD diagnoses, and many forms of treatment for such diagnoses are covered under the Plan. A Plan cannot limit coverage of a MH/SUD disorder to just certain kinds of treatments or exclude coverage for the MH/SUD diagnoses that require this treatment and remain in parity. For example, behavior modification and rehabilitative therapies are both noted as covered if medically necessary for illnesses and both are common treatments for the aforementioned MH/SUD disorders. Covering these services for M/S illness, but not MH/SUD diagnosis is an inherent parity concern.

- Nutritional counseling and services, supplies or medications primarily for dietary control

The Plan covers MH/SUD services, but specifically excludes coverage of nutritional counseling which could include MH/SUD conditions such as eating disorder treatments. While the Plan can limit coverage of care to medically necessary services, the Plan cannot exclude coverage of a specific type of treatment such as nutritional counseling or dietary control for an otherwise covered MH/SUD condition and remain in parity.

- Losses resulting from self-inflicted or self-induced Injury or Illness.

This exclusion is concerning because self-inflicted or self-induced injuries are commonly linked with MH/SUD conditions. The Plan should consider carving out MH/SUD conditions from this exclusion to remain in parity.

Exclusions in Operations

Beyond reviewing how the Plan addresses the Exclusions NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan applies its exclusions no more stringently for MH/SUD care than it does for M/S care, the Plan posed the following spot test questions to both the Plan Sponsor and its TPA, Associated Administrators, and recorded the answers below.

When you as the Plan sponsor were developing your Plan design, did you receive a standard list of Plan exclusions from your third-party administrator? If yes, from who?
No

If you as the Plan sponsor were given a standard list of exclusions, were you able to modify that list of exclusions?
The Board of Trustees establishes all Plan guidelines and they alone can only unanimously approve any Plan exclusions. Over time there have been exclusion removed due to federal guidelines requiring certain services to be covered (ie: ACA and Mental Health Parity)

If yes, what modifications did you make to the standardized list?
See last response.

How did you determine these modifications? What factors played into your decision(s)?
Federal guidelines are required to be followed. Fund Consultant (Segal) always provides a cost analysis and review of any Plan changes.

Did you use any outside sources (e.g., research studies, industry standards) to determine what benefits to include/exclude?
Fund Consultants prove that information to the Board prior to decisions being made however with Federal requirements the Plan is required to cover all Federal mandates. The Plan is an ERISA Plan and is not required to cover State mandates.

Did the TPA provide the Plan sponsor a standardized list of excluded services?
The TPA does not generate or provide this list. The Plan sponsor holds authority over this function. The Plan and Board of Trustees determine all benefits and excluded services with the assistance of Fund consultants (ie. Segal at the time the Plan was developed)

If yes, what was the source of this list and how was it developed?
N/A

If yes, did the Plan sponsor have the option to make any changes to that list?
The Board of Trustees are the only entity that can makes changes other then Federal Government and they always have the option to make changes to the Plan.

If yes, what changes did the Plan sponsor make?
Changes to the Plan have been made as needed since the Plan was established. Major changes were made with the Affordable Care Act and Mental Health Parity. These changes were removing exceptions not adding them to the Plan.

Comparative Analysis of Exclusions in Operation

When tested in practice, the Plan appears to apply the same operational standards to M/S and MH/SUD benefits concerning the Exclusions NQTL, which affects all MHPAEA benefit classifications. A detailed review of information provided by Associated Administrators about the day-to-day operational procedures applied when executing the Plan's exclusions indicates that they follow the exclusions list as determined by the Plan's Board of Trustees. As noted in the as written section, there are parity concerns regarding specific exclusions outlined in the SPD.

Overall Comparison and Conclusion Regarding Exclusions

The Exclusions NQTL applies to all MHPAEA benefit classifications. A comparison of the Plan's written requirements, as well as a test of the Plan's operational procedures, demonstrates that the NQTL applies more stringently to MH/SUD benefits than to M/S. The following exclusions are of specific concern:

- Treatment of sexual dysfunction (except for erectile dysfunction drugs, such as Viagra, as specified under the Prescription Drug benefit) or trans-sexual surgery.
- Psychological Testing except for purposes of diagnosis.
- Treatment for learning disabilities, hyperkinetic syndromes, mental retardation, developmental delay, attention deficit disorders, autism or oppositional defiant disorders is not covered. This exclusion does not apply to diagnostic testing to determine the existence of such conditions
- Nutritional counseling and services, supplies or medications primarily for dietary control
- Losses resulting from self-inflicted or self-induced Injury or Illness.

Based on this evidence, the Plan concludes it does not meet parity standards regarding the application of the Exclusions NQTL for all MHPAEA benefit classifications.

12. Experimental/Investigational Determinations

The Plan excludes coverage of "Services, supplies, drugs, devices, medical treatment, procedures, or care of any kind which is experimental in nature or which is not accepted medical practice by the practicing medical community as determined by the Fund". The SPD defines experimental treatment as "A drug, device, medical treatment, or procedure is considered experimental or investigative unless:

1. Approved by the U.S. Food and Drug Administration prior to the time the drug or device is furnished;
2. The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment, or procedure, was reviewed and approved by the treating facility's institutional review board or other such body serving a similar function, if federal law requires such review or approval;
3. Reliable evidence shows that the drug, device, medical treatment, or procedure is not the subject of on-going Phase I or Phase II clinical trials, or the research, experimental study, or investigational arm of ongoing Phase III clinical trials, or is not otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

The term "Experimental Treatment" shall not include an Approved Clinical Trial."

The Experimental/Investigational Determinations NQTL could apply to either M/S or MH/SUD benefits or services spanning all MHPAEA benefit classifications.

Experimental/Investigational Determinations as Written

The Plan contracts with CareAllies and uses Associated Administrators to manage its claims payments. The Plan's Experimental/Investigational Determinations NQTL as written is described below:

Experimental/Investigational Standards as Written		
MHPAEA Classification	*Inpatient IN, Inpatient OON, Outpatient IN, Outpatient OON, Emergency Care, Prescription Drugs*	
Applicable Benefits	M/S	All Covered Benefits
	MH/SUD	All Covered Benefits
Factor One	Existing Evidence	
Source	Cigna NQTL Analysis, Pg 44-48	
Definition	Adequate volume of existing peer-reviewed, evidence-based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed	
Evidentiary Standards	• Clinical literature • FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven. • FDA approval or clearance • English language peer reviewed publications including documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality.	
Factor Two	Regulatory Approval	
Source	Cigna NQTL Analysis, Pg 44-48	
Definition	Approved to be lawfully marketed for the proposed use by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review	
Evidentiary Standards	See Factor One	
Factor Three	Board Review Status	
Source	Cigna NQTL Analysis, Pg 44-48	
Definition	Experimental, investigational, or unproven services are the subject of review or approval by an Institutional Review Board for the	

	proposed use except as provided in the in a clinical trial, or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.
Evidentiary Standards	See Factor One

Comparative Analysis of Experimental/Investigational Determinations in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Experimental/Investigational Determinations NQTL equally to both M/S and MH/SUD benefits. The NQTL affects all MHPAEA benefit classifications. The Plan also bases this NQTL on clear factors and evidence-based standards, which are the same for all affected MH/SUD and M/S benefits.

Experimental/Investigational Determinations in Operations

Beyond reviewing how the Plan addresses the Experimental/Investigational Determinations NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan applies experimental/investigational treatment standards no more stringently for MH/SUD care than it does for M/S care, the Plan compared experimental/investigational care denial rates and percentages. The Plan tested experimental/investigational care determinations in practice for all benefits as follows:

	Number (#) of Claims Denied as Experimental/Investigational		Percent (%) of Total Claims Denied as Experimental/Investigational	
	M/S	MH/SUD	M/S	MH/SUD
Inpatient IN	0	0	0%	0%
Inpatient OON	n/a	n/a	N/A	N/A
Outpatient IN	2	0	0.2%	0%
Outpatient OON	n/a	n/a	N/A	N/A

In addition, the Plan also posed the following operational spot test questions to CareAllies recorded the answers below.

> **Does the Plan place limitations on coverage for any experimental/investigational treatments specifically for MH/SUD conditions?**
> CareAllies did not respond to this question.

If yes, explain what they are and the rationale for setting the limits.
CareAllies did not respond to this question.

Is the rationale in any way different for limitations related to M/S experimental/investigational treatments?
CareAllies did not respond to this question.

Comparative Analysis of Experimental/Investigational Determinations in Operation

When tested in practice, the Plan appears to apply the same operational standards to M/S and MH/SUD benefits concerning the Experimental/Investigational Determinations NQTL, which affects all MHPAEA benefit classifications. A detailed review of information provided by Associated Administrators about the day-to-day operational procedures applied when executing the Plan's claims decisions related to experimental and/or investigational treatment services indicates parity. While CareAllies did not respond to the spot check questions, the claims data provided by Associated Administrators and the CareAllies as written materials confirms that the application of the NQTL is not impacted by whether the services provided are for the treatment of a M/S or MH/SUD condition.

Overall Comparison and Conclusions Regarding Experimental/Investigational Determinations

The Experimental/Investigational Determinations NQTL applies to all benefit classifications. A comparison of the Plan's written requirements, as well as a test of the Plan's operational procedures, reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. Whether a condition is MH/SUD or M/S related is not relevant to how the Plan applies the Experimental/Investigational Determinations NQTL to any classification of benefits.

Based on this evidence, the Plan concludes it meets parity standards regarding the application of the Experimental/Investigational Determinations NQTL in all benefit classifications.

13. Formulary Design

The Plan provides prescription drug benefits to Plan participants and structures those benefits with the goal of helping Plan participants get the most cost-effective medication appropriate for their condition. To do so, it offers a formulary of medications to ensure that Plan participants can access a full range of quality prescriptions at a fair price. The Plan's formulary is broken down into tiers, and participant cost-sharing for a specific medication and other coverage requirements may vary by tier. The SPD states that "Generic drugs are preferred. If you request a brand name drug when a generic is available, you must pay the difference in cost between the generic and brand name in addition to the appropriate Co-Payment." The Formulary Design NQTL applies to both M/S and MH/SUD medications in the Prescription Drugs benefit classification.

Formulary Design as Written

The Plan contracts with Optum to manage its prescription drug benefit offerings. The Plan's Formulary Design NQTL as written is described below:

Formulary Design as Written		
MHPAEA Classification	*Prescription Drugs*	
Applicable Benefits	M/S	All Rx Benefits
	MH/SUD	All Rx Benefits
Factor One	Safety	
Source	OptumRx NQTL Analysis, Pg 10-13	
Definition	A formulary is a list of prescribed medications or other pharmacy care products, services or supplies chosen for their safety.	
Evidentiary Standards	• Food and Drug Administration (FDA) information (e.g., product prescribing information, approval packages, advisory committee review documents, safety alerts, etc.) • Peer-reviewed medical/pharmacy literature, including randomized clinical trials, meta-analyses, review articles, comparative effectiveness research, evidence-based medicine reviews, healthcare technology assessments, and pharmacoeconomic and outcomes research (e.g., AHRQ- EHC Program, TRIP Database, CMS National Coverage Determinations/Technology Assessments, DARE, DERP, etc.) • Treatment Guidelines, Practice Parameters, Policy Statements, Consensus Statements created/endorsed by reputable	

	governmental, medical, and/or pharmacy organizations (e.g., CDC, WHO, CMS, APA, etc.) • Pharmaceutical, Device, and/or Biotech company information (response to medical information inquiries, AMCP dossiers, posters, presentations, reprints, etc.) • Medical and pharmacy tertiary resources, including those recognized by CMS (e.g., AHFS- DI, Thomson Micromedex DrugDex, Clinical Pharmacology, etc.) • Relevant and reputable Medical and Pharmacy textbooks and or websites (e.g., MDConsult, Merck Manuals, Medscape, MedPage Today, etc.)
Factor Two	Cost
Source	OptumRx NQTL Analysis, Pg 10-13
Definition	A formulary is a list of prescribed medications or other pharmacy care products, services or supplies chosen for their cost.
Evidentiary Standards	See Factor One
Factor Three	Effectiveness
Source	OptumRx NQTL Analysis, Pg 10-13
Definition	A formulary is a list of prescribed medications or other pharmacy care products, services or supplies chosen for their effectiveness.
Evidentiary Standards	See Factor One

Comparative Analysis of Formulary Design in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Formulary Design NQTL equally to both M/S and MH/SUD medications in the Prescription Drugs benefit classification. The Plan also bases this NQTL on clear factors and evidence-based standards, which are the same for all affected MH/SUD and M/S prescriptions.

Formulary Design in Operations

Beyond reviewing how the Plan addresses the Formulary Design NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the formulary design procedures written by the Plan and its pharmacy benefit manager, Optum,

meet their stated goal of ensuring to access quality prescriptions at a fair price for both M/S and MH/SUDs, the Plan conducted an operational test.

The Plan obtained a list of the 250 most prescribed medications divided by drug classification that was developed by the federal Agency for Healthcare Research and Quality using data from the *Medical Expenditure Panel Survey (MEPS) 2008-2018*. With that information, the Plan was able to examine how all the MH/SUD drugs on the list were addressed by its formulary. Then the Plan performed a similar examination of how all the neurological drugs on the list are addressed. The results of the operational test are as follows:

Scope of Plan Formulary

	Neurological Pharmaceuticals	Mental Health/ Substance Use Disorder Pharmaceuticals
No Coverage	13 out of 42 Total Medications (31%)	0 out of 34 Total Medications (0%)
Excluded	0 out of 42 Total Medications (0%)	0 out of 34 Total Medications (0%)
Coverage Tier One	26 out of 42 Total Medications (61.9%)	29 out of 34 Total Medications (85.3%)
Coverage Tier Two	2 out of 42 Total Medications (4.8%)	5 out of 34 Total Medications (14.7%)
Coverage Tier Three	1 out of 42 Total Medications (2.4%)	0 out of 34 Total Medications (0%)
Specialty Drug	0 out of 42 Total Medications (0%)	0 out of 34 Total Medications (0%)

Additionally, to test whether the Formulary Design NQTL is being applied operationally in parity, the Plan posed the following spot check questions to Optum and recorded the answers as follows:

How many and what types of tiers are included in your prescription drug Plan?
Optum did not respond to this question.

What does each tier include/cover?
Optum did not respond to this question.

Are there any types of medication that fall outside of the tiers?
Optum did not respond to this question.

If so, what are they and why?
Optum did not respond to this question.

Does the Plan have a dispense as written (DAW) policy as part of your Prescription Drug Plan?
Optum did not respond to this question.

Does the PBM allow for exceptions to the DAW policy?
Optum did not respond to this question.

If so, how are they handled?
Optum did not respond to this question.

If there are no generic drug options, explain how brand drugs are covered.
Optum did not respond to this question.

How does the specialty drug benefit work?
Optum did not respond to this question.

How are drugs deemed a specialty drug?
Optum did not respond to this question.

Are there any different standards for determining if a MH/SUD drug is covered as a specialty drug benefit versus a M/S drug?
Optum did not respond to this question.

Comparative Analysis of Formulary Design in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Formulary Design NQTL. However, Optum did not provide all the necessary data needed to conduct a complete analysis despite multiple requests by the Plan to obtain the full scope of information. Based on the information provided, it appears the Plan is operating in parity. The Scope of the Plan Formulary indicates that more MH/SUD pharmaceuticals are available in Tiers One and Two with no excluded pharmaceuticals compared to the tested M/S pharmaceuticals, 31% of which are excluded. However, without complete stringency test data, it is not possible to fully analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Formulary Design

The Formulary Design NQTL only applies to the Prescription Drugs benefit classification. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through

operational stringency testing. However, Optum only provided incomplete operational stringency test data despite multiple attempts by the Plan to obtain complete information. Therefore, it is not possible to fully assess the Plan for operational parity. Based on the information provided, it appears the Plan is operating in parity. The Scope of the Plan Formulary indicates that more MH/SUD pharmaceuticals are available in Tiers One and Two with no excluded pharmaceuticals compared to the tested M/S pharmaceuticals, 31% of which are excluded.

Based on this evidence, the Plan cannot determine if it meets parity standards for the Formulary Design NQTL in the Prescription Drugs benefit classification.

14. Approval of Prescription Coverage

The Plan, via Optum, requires Plan participants to get prior approval of certain pharmaceuticals before they can be disbursed by a pharmacy. This NQTL only applies to the Prescription Drugs benefit classification.

Approval of Prescription Coverage as Written

The Plan contracts with Optum to manage its prescription drug benefit offerings. The Plan's Approval of Prescription Coverage NQTL as written is described below:

Approval of Prescription Coverage as Written		
MHPAEA Classification	*Prescription Drugs*	
Applicable Benefits	M/S	Covered Drugs That Require Prior Authorization
	MH/SUD	Covered Drugs That Require Prior Authorization
Factor One	Safety	
Source	OptumRx NQTL Analysis	
Definition	The likelihood that the specific drug would cause danger, risk, or injury.	
Evidentiary Standards	• Food and Drug Administration (FDA) information (e.g., product prescribing information, approval packages, advisory committee review documents, safety alerts, etc.) • Peer-reviewed medical/pharmacy literature, including randomized clinical trials, meta-analyses, review articles, comparative effectiveness research, evidence-based medicine reviews, healthcare technology assessments, and pharmacoeconomic and outcomes research (e.g., AHRQ- EHC Program, TRIP Database, CMS National Coverage Determinations/Technology Assessments, DARE, DERP, etc.) • Treatment Guidelines, Practice Parameters, Policy Statements, Consensus Statements created/endorsed by reputable governmental, medical, and/or pharmacy organizations (e.g., CDC, WHO, CMS, APA, etc.) • Pharmaceutical, Device, and/or Biotech company information (response to medical information inquiries, AMCP dossiers, posters, presentations, reprints, etc.)	

	• Medical and pharmacy tertiary resources, including those recognized by CMS (e.g., AHFS- DI, Thomson Micromedex DrugDex, Clinical Pharmacology, etc.) • Relevant and reputable Medical and Pharmacy textbooks and or websites (e.g., MDConsult, Merck Manuals, Medscape, MedPage Today, etc.)
Factor Two	Cost
Source	OptumRx NQTL Analysis
Definition	Price
Evidentiary Standards	How expensive the drug is compared to other drugs.
Factor Three	Appropriate For the Level of Care
Source	OptumRx NQTL Analysis
Definition	Is the requested prescription appropriate or could an alternative be used?
Evidentiary Standards	See Factor One
Factor Four	Duration
Source	OptumRx NQTL Analysis
Definition	How long a specific medication is being prescribed for.
Evidentiary Standards	See Factor One
Factor Five	Monitor and Prevent Potential Overutilization/Underutilization
Source	OptumRx NQTL Analysis
Definition	The frequency that certain drugs are prescribed.
Evidentiary Standards	See Factor One

Comparative Analysis of Approval of Prescription Coverage in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Approval of Prescription Coverage NQTL equally to both M/S and MH/SUD medications in the Prescription Drugs benefit classification. The Plan also bases this NQTL on clear factors and evidence-based standards, which are the same for all affected MH/SUD and M/S prescriptions.

Approval of Prescription Coverage in Operations

Beyond reviewing how the Plan addresses the Approval of Prescription Coverage NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan applies standards no more stringently for MH/SUD care than it does for M/S care, and to test whether the Approval of Prescription Coverage NQTL is being applied operationally in parity, the Plan attempted to complete the following test. This section remains blank because the requested information was not provided.

Prescription Drug Coverage Approval Process

	Number (#) of Claims		Percent (%) of Total Claims	
	M/S	MH/SUD	M/S	MH/SUD
Prior authorization requests received			N/A	N/A
Prior authorization requests initially denied			N/A	N/A
Prior authorization denials appealed			N/A	N/A
Prior authorization appeals denied			N/A	N/A

Additionally, to test whether the Approval of Prescription Coverage NQTL is being applied operationally in parity, the Plan posed the following spot check questions to Optum and recorded the answers as follows:

Does the PBM allow the plan sponsor to make any prescription benefit exceptions?
Optum did not respond to this question.

Please explain how the exception process works in practice.
Optum did not respond to this question.

Does the PBM track coverage prescription benefit exceptions?
Optum did not respond to this question.

If so, how many in the past plan year apply to M/S drugs?
Optum did not respond to this question.

If so, how many in the past plan year apply to MH/SUD drugs?
Optum did not respond to this question.

Is prior authorization required for methadone, naloxone, any or other medicine used to treat opioid use disorder?
Optum did not respond to this question.

Comparative Analysis of Approval of Prescription Coverage in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Approval of Prescription Coverage NQTL. However, Optum did not provide the requested operational data despite multiple requests by the Plan. Additionally, the Plan's SPD includes a list noting the drugs that require prior authorization which is significantly shorter than the list of drugs that require prior authorization as noted in the formulary provided by Optum. The Plan and Optum should work together to confirm which drugs are subject to the NQTL to avoid any confusion for Plan Participants. Without adequate stringency test data, it is not possible to analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Approval of Prescription Coverage

The Approval of Prescription Coverage NQTL only applies to the Prescription Drugs benefit classification. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, Optum was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity. Additionally, the Plan's SPD includes a list

noting the drugs that require prior authorization which is significantly shorter than the list of drugs that require prior authorization as noted in the formulary provided by Optum. The Plan and Optum should work together to confirm which drugs are subject to the NQTL to avoid any confusion for Plan Participants.

Based on this evidence, the Plan cannot determine if it meets parity standards for the Approval of Prescription Coverage NQTL in the Prescription Drugs benefit classification.

15. Prescription Benefit Limitations

The Plan limits coverage of certain pharmaceuticals based on the duration of the covered prescription. Higher quantities require either prior authorization or approval by the Board of Trustees. The Prescription Benefit Limitations NQTL applies to both M/S and MH/SUD medications in the Prescription Drugs benefit classification.

Prescription Benefit Limitations as Written

The Plan contracts with Optum to manage its plan and pay related benefit claims. The Plan's Prescription Benefit Limitations NQTL as written is described below:

Prescription Benefit Limitations as Written		
MHPAEA Classification	*Prescription Drugs*	
Applicable Benefits	M/S	<u>Migraine Medication (Triptans):</u> • Axert = 12 /30 days • Amerge, Imitrex = 9 /30days • Relpax, Zomig = 6/30days • Imitrex nasal spray 20mg = 12 /30days • Imitrex Kit= 4 / 30days <u>Sedative / Hypnotic Medication:</u> • Ambien, Sonata, Lunesta = 15 /30 days <u>Anti-Emetics Medication (for Nausea):</u> • Anzemet = 5 /30days • Kytril= 10 /30days • Zofran 4 & 8mg = 15 /30 days • Zofran 24mg = 5/30 days <u>Analgesic Medication:</u> • Stadol Nasal Spray = 4 sprays/ 30 days • Toradol 20 / 5days <u>Erectile Dysfunction Medication:</u> • Cialis, Levitra, Viagra = 6/30 days <u>Anti-inflammatory Drugs (COX-2 Inhibitors):</u> • Celebrex 100 mg., 200 mg = 30 pills/30 days

	MH/SUD	<u>Sedative / Hypnotic Medication:</u> • Ambien, Sonata, Lunesta = 15 /30 days <u>Erectile Dysfunction Medication:</u> • Cialis, Levitra, Viagra = 6/30 days <u>Anti-inflammatory Drugs (COX-2 Inhibitors):</u> • Celebrex 100 mg., 200 mg = 30 pills/30 days
Factor One	Quality of Care	
Source	SPD, Pg 121-122 and OptumRx NQTL Analysis, Pg 5-8	
Definition	Improved quality of member care through prevention of excessive dosages	
Evidentiary Standards	• Food and Drug Administration (FDA) information (e.g., product prescribing information, approval packages, advisory committee review documents, safety alerts, etc.) • Peer-reviewed medical/pharmacy literature, including randomized clinical trials, meta-analyses, review articles, comparative effectiveness research, evidence-based medicine reviews, healthcare technology assessments, and pharmacoeconomic and outcomes research (e.g., AHRQ- EHC Program, TRIP Database, CMS National Coverage Determinations/Technology Assessments, DARE, DERP, etc.) • Treatment Guidelines, Practice Parameters, Policy Statements, Consensus Statements created/endorsed by reputable governmental, medical, and/or pharmacy organizations (e.g., CDC, WHO, CMS, APA, etc.) • Pharmaceutical, Device, and/or Biotech company information (response to medical information inquiries, AMCP dossiers, posters, presentations, reprints, etc.) • Medical and pharmacy tertiary resources, including those recognized by CMS (e.g., AHFS- DI, Thomson Micromedex DrugDex, Clinical Pharmacology, etc.) • Relevant and reputable Medical and Pharmacy textbooks and or websites (e.g., MDConsult, Merck Manuals, Medscape, MedPage Today, etc.)	

Factor Two	Reduce Misuse
Source	OptumRx NQTL Analysis, Pg 5-8 and SPD, Pg 121-122
Definition	Minimized potential misuse of certain medications
Evidentiary Standards	See Factor One
Factor Three	Reduce Costs
Source	OptumRx NQTL Analysis, Pg 5-8 and SPD, Pg 121-122
Definition	Reduced pharmacy plan medication costs through dose optimization.
Evidentiary Standards	See Factor One

Comparative Analysis of Prescription Benefit Limitations in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Prescription Benefit Limitations NQTL equally to both M/S and MH/SUD medications in the Prescription Drugs benefit classification. The Plan also bases this NQTL on clear factors and evidence-based standards, which are the same for all affected MH/SUD and M/S prescriptions.

Prescription Benefit Limitations in Operations

Beyond reviewing how the Plan addresses the Prescription Benefit Limitations NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan applies standards no more stringently for MH/SUD care than it does for M/S care, the Plan posed the following spot test questions to Optum and recorded the answers below.

Are there any instances other than FDA dosage safety rules that you limit access to quantities of prescription drugs? If so, please explain.
Optum did not respond to this question.

If yes, do these limitations apply to M/S and MH/SUD drugs?
Optum did not respond to this question.

Are there any differences between limitations placed on M/S drugs versus MH/SUD drugs? If so, what are they and why are they in place?
Optum did not respond to this question.

Does the Plan limit coverage of specific prescription drugs to certain types of plan participants or diagnoses, such as limiting coverage of certain drugs to plan participants of specific ages or not covering medications used to treat specified conditions other than as indicated by FDA guidelines?
Optum did not respond to this question.

If yes, do any of these limitations apply to any MH/SUD medications? If so, which ones and why?
Optum did not respond to this question.

If yes, do any of these limitations apply to any M/S medications? If so, which ones and why?
Optum did not respond to this question.

Comparative Analysis of Prescription Benefit Limitations in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Prescription Benefit Limitations NQTL. However, Optum did not provide requested operational data despite multiple requests by the Plan. Additionally, the Plan's SPD includes a list noting specific drugs and their quantity limitations which is significantly shorter than the list of drugs that have quantity limitations as noted in the formulary provided by Optum. The Plan and Optum should work together to confirm which drugs are subject to the NQTL to avoid any confusion for Plan Participants. Without adequate stringency test data, it is not possible to analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Prescription Benefit Limitations

The Prescription Benefit Limitations NQTL only applies to the Prescription Drugs benefit classification. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, Optum was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity.

Based on this evidence, the Plan cannot determine if it meets parity standards for the Prescription Benefit Limitations NQTL in the Prescription Drugs benefit classification.

16. Step Therapy

The Plan may require Plan participants to try treatment with specific pharmaceuticals first, before approving coverage of other medications under certain conditions. Step therapy protocols may apply to medications used to treat both M/S and MH/SUD conditions. The use of these protocols is intended to ensure that Plan participants try the range of safe and effective medications in a medically appropriate order. The Step Therapy NQTL applies to both M/S and MH/SUD medications in the Prescription Drugs benefit classification.

Step Therapy as Written

The Plan contracts with Optum to apply its step therapy methodologies. The Plan's Step Therapy NQTL as written is described below:

Step Therapy as Written		
MHPAEA Classification	*Prescription Drugs*	
Applicable Benefits	M/S	Certain Rx Benefits
	MH/SUD	Certain Rx Benefits
Factor One	Safety	
Source	OptumRx NQTL Analysis, Pg 8-10	
Definition	A formulary is a list of prescribed medications or other pharmacy care products, services or supplies chosen for their safety.	
Evidentiary Standards	• Food and Drug Administration (FDA) information (e.g., product prescribing information, approval packages, advisory committee review documents, safety alerts, etc.) • Peer-reviewed medical/pharmacy literature, including randomized clinical trials, meta-analyses, review articles, comparative effectiveness research, evidence-based medicine reviews, healthcare technology assessments, and pharmacoeconomic and outcomes research (e.g., AHRQ- EHC Program, TRIP Database, CMS National Coverage Determinations/Technology Assessments, DARE, DERP, etc.) • Treatment Guidelines, Practice Parameters, Policy Statements, Consensus Statements created/endorsed by reputable governmental, medical, and/or pharmacy organizations (e.g., CDC, WHO, CMS, APA, etc.)	

	• Pharmaceutical, Device, and/or Biotech company information (response to medical information inquiries, AMCP dossiers, posters, presentations, reprints, etc.) • Medical and pharmacy tertiary resources, including those recognized by CMS (e.g., AHFS- DI, Thomson Micromedex DrugDex, Clinical Pharmacology, etc.) • Relevant and reputable Medical and Pharmacy textbooks and or websites (e.g., MDConsult, Merck Manuals, Medscape, MedPage Today, etc.)
Factor Two	Appropriate
Source	OptumRx NQTL Analysis, Pg 11-13
Definition	Determine the appropriate level of care.
Evidentiary Standards	See Factor One
Factor Three	Medically Necessary
Source	OptumRx NQTL Analysis, Pg 11-13
Definition	Determine whether the service or item is medically necessary, as determined by definition in Plan's SPD.
Evidentiary Standards	See Factor One

Comparative Analysis of Step Therapy in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Step Therapy NQTL equally to both M/S and MH/SUD medications in the Prescription Drugs benefit classification. The Plan also bases this NQTL on clear factors and evidence-based standards, which are the same for all affected MH/SUD and M/S prescriptions.

Step Therapy in Operations

Beyond reviewing how the Plan addresses the Step Therapy NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. The Plan posed the following questions to its pharmacy benefit manager, Optum, and recorded the answers as follows:

Does the Prescription Drug Plan include a step therapy program?
Optum did not respond to this question.

If so, please explain.
Optum did not respond to this question.

Do you have any different standards for determining if a MH/SUD drug is subject to a step therapy program versus a M/S drug? If so, please explain.
Optum did not respond to this question.

Comparative Analysis of Step Therapy in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Step Therapy NQTL. However, Optum did not provide the requested operational data despite multiple requests by the Plan. Additionally, the Plan's SPD includes a list noting the drugs that require step therapy which is significantly shorter than the list of drugs that require step therapy as noted in the formulary provided by Optum. The Plan and Optum should work together to confirm which drugs are subject to the NQTL to avoid any confusion for Plan Participants. Without adequate stringency test data, it is not possible to analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Step Therapy

The Step Therapy NQTL only applies to the Prescription Drugs benefit classification. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, Optum was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity. Additionally, the Plan's SPD includes a list noting the drugs that require step therapy which is significantly shorter than the list of drugs that require step therapy as noted in the formulary provided by Optum. The Plan and Optum should work together to confirm which drugs are subject to the NQTL to avoid any confusion for Plan Participants.

Based on this evidence, the Plan cannot determine if it meets parity standards for the Step Therapy NQTL in the Prescription Drug benefit classification.

17. Pharmacy Limitations

The Plan provides prescription drug benefits to Plan participants, but in doing so may require them to access their prescription benefits through specific pharmacy sources. Specialty medications must be provided through Briova Rx and not through a retail pharmacy. The Pharmacy Limitations NQTL applies to both M/S and MH/SUD medications in the Prescription Drugs benefit classification.

Pharmacy Limitations as Written

The Plan contracts with Optum to manage the Pharmacy Limitations NQTL. Optum did not provide the Plan with written documentation regarding the factors and evidentiary standards involved in developing and applying this NQTL on behalf of the Plan. The Plan's SPD also does not address the factors and evidentiary standards used to develop and apply the NQTL.

Comparative Analysis of Pharmacy Limitations in Writing

Analysis of the Plan's written documentation shows the Plan developed and applies the Pharmacy Limitations NQTL to both M/S and MH/SUD medications, which affects the Prescription Drugs benefits classification. However, the Plan was unable to provide clear written factors and evidentiary standards to support the creation and application of the NQTL. Without the opportunity to review the factors and evidentiary standards required by the MHPAEA, there is no way to conclude that the Plan meets parity standards.

Pharmacy Limitations in Operations

Beyond reviewing how the Plan addresses the Pharmacy Limitations NQTL in writing, the CAA requires the Plan to test how its NQTLs apply during typical plan operations. To see if the Plan applies its pharmacy limitation standards no more stringently for MH/SUD prescriptions than it does for M/S medications, the Plan posed the following spot test questions to the Plan's pharmacy benefit management vendor, Optum, and recorded the answers below.

Are plan participants ever limited to specific pharmacies/pharmacy network/mail-order facilities?
Optum did not respond to this question.

If so, please describe the limitations.
Optum did not respond to this question.

In practice what happens if a plan participant attempts to fill an Rx a different way?
Optum did not respond to this question.

Does the PBM make any exceptions for emergency circumstances or different types of drugs? If so, please explain.
Optum did not respond to this question.

Comparative Analysis of Pharmacy Limitations in Operation

The Plan attempted to conduct operational stringency testing regarding the day-to-day application of the Pharmacy Limitations NQTL. However, Optum did not provide the requested operational data despite multiple requests by the Plan. Without adequate stringency test data, it is not possible to analyze the NQTL operationally for parity purposes.

Overall Comparison and Conclusions Regarding Pharmacy Limitations

The Pharmacy Limitations NQTL applies to the Prescription Drugs benefit classification. A comparison of the Plan's written requirements reveals the Plan has not documented sufficient factors and evidentiary standards to support the application of the NQTL. The Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, Optum was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity.

Based on this evidence, the Plan cannot determine if it meets parity standards for the Pharmacy Limitations NQTL in the Prescription Drugs benefit classification.

18. Overall Findings and Conclusions

The CAA requires the Plan to perform, document, and maintain comparative analyses of the design and application of all its NQTLs with respect to both M/S and MH/SUD benefits. The comparative analysis must examine all Plan NQTLs both as written in Plan documents and as applied in operation, and then make reasoned conclusions about how the Plan achieves parity. The Plan conducted a thorough and comparative review and analysis of each of the NQTLs listed in this document. Based on our comparative review and analysis of the specified NQTLs, the Plan has made the findings identified below.

The chart below contains a high-level review of each NQTL in this report and the findings. Note that this is for summary purposes only and merely simplifies the conclusions drawn within this report. Please refer to the specific NQTL section for any questions pertaining to this summary:

Executive Summary

NQTL	Written Determination	Operational Determination	Overall Determination
Medical Management Standards	In Parity	In Parity	In Parity
Prior Authorization	Not in Parity	Inconclusive- Incomplete Data	Not in Parity
Concurrent Review	Not in Parity	Inconclusive- Incomplete Data	Not in Parity
Retrospective Review	Not in Parity	Inconclusive- Incomplete Data	Not in Parity
Emergency Care Authorization	In Parity	Inconclusive- No Data	Inconclusive
Provider Credentialing	In Parity	Inconclusive- No Data	Inconclusive
Network Reimbursement	In Parity	Inconclusive- Incomplete Data	Inconclusive
Network Adequacy	In Parity	In Parity	In Parity
Out-of-Network Access	In Parity	In Parity	In Parity
Exclusions	Not in Parity	Not in Parity	Not in Parity
Experimental/Investigational	In Parity	In Parity	In Parity
Formulary Design	In Parity	Inconclusive- Incomplete Data	Inconclusive
Approval of Prescription Coverage	In Parity	Inconclusive- No Data	Inconclusive
Prescription Benefit Limitations	In Parity	Inconclusive- No Data	Inconclusive
Step Therapy	In Parity	Inconclusive- No Data	Inconclusive

Pharmacy Limitations	Inconclusive- Missing Written Information	Inconclusive- No Data	Inconclusive

Overall Findings

- The Medical Management Standards NQTL applies to all MHPAEA benefit classifications. A comparison of the Plan's written requirements, as well as a test of the Plan's operational procedures, reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. Whether a condition is MH/SUD or M/S related is not relevant to how the Plan applies the Medical Management Standards NQTL to any classification of benefits.
- The Prior Authorization NQTL applies to the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications. A comparison of the Plan's written requirements reveals the Plan applies the NQTL more stringently to MH/SUD in writing. The SPD states that only non-emergent admissions, hospice, and home health care require pre-certification while all MH/SUD services must be pre-certified. On an operational level, CareAllies offered alternative and incomplete stringency test data rather than the complete data that was requested by the Plan on multiple occasions.
- The Concurrent Review NQTL applies to the Inpatient IN, Inpatient OON, Outpatient IN, and Outpatient OON benefit classifications. A comparison of the Plan's written requirements reveals the Plan applies the NQTL more stringently to MH/SUD in writing. The SPD states that only non-emergent admissions, hospice, and home health care require pre-certification while all MH/SUD services must be pre-certified. On an operational level, CareAllies offered alternative and incomplete stringency test data rather than the complete data that was requested by the Plan on multiple occasions.
- The Emergency Care Authorization NQTL applies to the Inpatient IN and Inpatient OON benefit classifications. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, CareAllies was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity.
- The Provider Credentialing NQTL applies to the Inpatient IN, Outpatient IN, and Emergency Care benefit classifications. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, Cigna was unable to provide any operational testing data despite multiple

attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity.

- The Network Reimbursement NQTL applies to the Inpatient IN, Outpatient IN, and Emergency Care benefit classifications. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. However, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. Unfortunately, Cigna only provided incomplete operational stringency test data despite multiple attempts by the Plan to obtain complete information. Based on the information provided, it appears the Plan may have parity concerns. The Plan's reimbursement rates for M/S and MH/SUD providers were comparable, although non-physician providers were reimbursed at lower rates than M.D. and D.O. providers when compared to Medicare rates. Review of this data shows that Licensed Clinical Social Workers (LCSWs), a master's level MH/SUD provider, were reimbursed at significantly lower rates than any other CPT code at 70-83% of the Medicare rate. Comparably all M/S master's level degree providers were reimbursed at 66-133% of Medicare rates. All M.D. and D.O. outpatient providers were reimbursed at comparable rates at or above the Medicare rate for the given CPT code, though psychiatrists were the lowest. While the outpatient rates appear to show parity concerns for the specific CPT codes listed, similar inpatient reimbursement rates were not provided for review. Without complete stringency test data, it is not possible to fully analyze the NQTL operationally for parity purposes.
- The Network Adequacy NQTL applies to the Inpatient IN, Outpatient IN, and Emergency Care benefit classifications. A comparison of the Plan's written requirements, as well as a test of the Plan's operational procedures, reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. Whether a condition is MH/SUD or M/S related is not relevant to how the Plan applies the Network Adequacy NQTL to any classification of benefits.
- The Out-of-Network Access NQTL applies to the Inpatient OON, Outpatient OON, and Emergency Care benefit classifications. A comparison of the Plan's written requirements, as well as a test of the Plan's operational procedures, reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. Whether a condition is MH/SUD or M/S related is not relevant to how the Plan applies the Out-of-Network Access NQTL to any classification of benefits.
- The Exclusions NQTL applies to all MHPAEA benefit classifications. A comparison of the Plan's written requirements, as well as a test of the Plan's operational procedures, demonstrates that the NQTL applies more stringently to MH/SUD benefits than to M/S. The following exclusions are of specific concern:
    - Treatment of sexual dysfunction (except for erectile dysfunction drugs, such as Viagra, as specified under the Prescription Drug benefit) or trans-sexual surgery.
    - Psychological Testing except for purposes of diagnosis.

  - Treatment for learning disabilities, hyperkinetic syndromes, mental retardation, developmental delay, attention deficit disorders, autism or oppositional defiant disorders is not covered. This exclusion does not apply to diagnostic testing to determine the existence of such conditions
  - Nutritional counseling and services, supplies or medications primarily for dietary control
  - Losses resulting from self-inflicted or self-induced Injury or Illness.
- The Experimental/Investigational Determinations NQTL applies to all benefit classifications. A comparison of the Plan's written requirements, as well as a test of the Plan's operational procedures, reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. Whether a condition is MH/SUD or M/S related is not relevant to how the Plan applies the Experimental/Investigational Determinations NQTL to any classification of benefits.
- The Formulary Design NQTL only applies to the Prescription Drugs benefit classification. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, Optum only provided incomplete operational stringency test data despite multiple attempts by the Plan to obtain complete information. Therefore, it is not possible to fully assess the Plan for operational parity. Based on the information provided, it appears the Plan is operating in parity. The Scope of the Plan Formulary indicates that more MH/SUD pharmaceuticals are available in Tiers One and Two with no excluded pharmaceuticals compared to the tested M/S pharmaceuticals, 31% of which are excluded.
- The Approval of Prescription Coverage NQTL only applies to the Prescription Drugs benefit classification. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, Optum was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity. Additionally, the Plan's SPD includes a list noting the drugs that require prior authorization which is significantly shorter than the list of drugs that require prior authorization as noted in the formulary provided by Optum. The Plan and Optum should work together to confirm which drugs are subject to the NQTL to avoid any confusion for Plan Participants.
- The Prescription Benefit Limitations NQTL only applies to the Prescription Drugs benefit classification. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on

a practical level through operational stringency testing. However, Optum was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity.

- The Step Therapy NQTL only applies to the Prescription Drugs benefit classification. A comparison of the Plan's written requirements reveals all factors and evidentiary standards were developed and are applied to MH/SUD and M/S benefits in parity. To make a determination of parity, the Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, Optum was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity. Additionally, the Plan's SPD includes a list noting the drugs that require step therapy which is significantly shorter than the list of drugs that require step therapy as noted in the formulary provided by Optum. The Plan and Optum should work together to confirm which drugs are subject to the NQTL to avoid any confusion for Plan Participants.
- The Pharmacy Limitations NQTL applies to the Prescription Drugs benefit classification. A comparison of the Plan's written requirements reveals the Plan has not documented sufficient factors and evidentiary standards to support the application of the NQTL. The Plan also needs to demonstrate parity on a practical level through operational stringency testing. However, Optum was unable to provide any operational testing data despite multiple attempts by the Plan to collect it. Therefore, it is not possible to fully assess the Plan for operational parity.

Overall Conclusion

The MHPAEA statute and its related rules establish that the Plan's NQTLs must be comparable and applied no more stringently to MH/SUD benefits than they are to M/S benefits in the same classification. The Plan should continue requesting information periodically to demonstrate fiduciary level of prudence. Additionally, based on its review, MZQ recommends that prior to its next NQTL analysis, the Plan complete and thoroughly document the following next steps:

1. The Plan includes provisions with respect to the following NQTLs are not in parity:

    - Prior Authorization
    - Concurrent Review
    - Retrospective Review

    To address this, the Plan should:

    a. Update its SPD to address and eliminate the limitations that are not in parity.
    b. Make all necessary Plan document modifications resulting from this change. The Plan may wish to consult legal counsel regarding the timing of this change.

2. The Plan was unable to collect sufficient operational data from CareAllies with respect to the following NQTLs:

- Prior Authorization
- Concurrent Review
- Retrospective Review
- Emergency Care Authorization

To address this, the Plan should:

a. Continue to coordinate with CareAllies in regards to providing the necessary data for each NQTL. Maintain documentation of your requests of this information. It is our understanding that CareAllies continues to work towards developing the operational data to ensure compliance with the aforementioned NQTLs.
b. Continue requesting information periodically to demonstrate fiduciary level of prudence.

3. The Plan was unable to collect sufficient operational data from Optum with respect to the following NQTLs:

- Formulary Design
- Approval of Prescription Coverage
- Prescription Benefit Limitations
- Step Therapy
- Pharmacy Limitations

To address this, the Plan should:

a. Continue to coordinate with Optum in regards to providing the necessary data for each NQTL. Maintain documentation of your requests of this information. It is our understanding that Optum continues to work towards developing the operational data to ensure compliance with the aforementioned NQTLs.
b. Continue requesting information periodically to demonstrate fiduciary level of prudence.

4. The Plan was unable to collect sufficient operational data from Cigna with respect to the following NQTLs:

- Provider Credentialing
- Network Reimbursement

To address this, the Plan should:

a. Continue to coordinate with Cigna in regards to providing the necessary data for each NQTL. Maintain documentation of your requests of this information. It is our understanding that Cigna continues to work towards developing the operational data to ensure compliance with the aforementioned NQTLs.

b. Continue requesting information periodically to demonstrate fiduciary level of prudence.

5. The following NQTLs were identified as lacking sufficient written factors/evidentiary standards:

   - Pharmacy Limitations

To address this, the Plan should:

a. Review each NQTL where clear factors and clinical evidence were not used as part of its development and determine if: (1) the Plan currently imposes the NQTL on a day-to-day basis, and (2) if the Plan would like to continue to impose the NQTL in writing and in practice.
b. If the Plan would like to keep the NQTL, conduct a thorough examination of the NQTL's appropriateness and the fairness of its potential application to MH/SUD services as compared to M/S benefits.
c. If the review determines the NQTL is appropriate and can be applied in parity, then document the factors and evidentiary standards that shaped its decision and will be used to apply the NQTL.
d. Confirm with any applicable vendors that they will be able to implement the NQTL as outlined.
e. Make any necessary Plan document modifications effective as soon as practicable.

6. The Plan has parity concerns regarding the Exclusions NQTL. The following exclusions are problematic:

   - Treatment of sexual dysfunction (except for erectile dysfunction drugs, such as Viagra, as specified under the Prescription Drug benefit) or trans-sexual surgery.
   - Psychological Testing except for purposes of diagnosis.
   - Treatment for learning disabilities, hyperkinetic syndromes, mental retardation, developmental delay, attention deficit disorders, autism or oppositional defiant disorders is not covered. This exclusion does not apply to diagnostic testing to determine the existence of such conditions
   - Nutritional counseling and services, supplies or medications primarily for dietary control
   - Losses resulting from self-inflicted or self-induced Injury or Illness.

To address this, the Plan should:

a. Update its SPD to address and eliminate the limitations that are not in parity.

b. Discuss the necessary plan changes with any appropriate plan vendors, to ensure that they do not continue to apply the exclusion(s)/coverage scope limitation(s) not in parity on an operational level.

7. The Plan appears to include quantitative treatment limitations (QTLs). While this analysis meets the Plan's fiduciary responsibility under MHPAEA for non-quantifiable treatment limitations (NQTLs), the Plan also needs to complete a QTL analysis to be in compliance with MHPAEA.

19. Statement of Informational Accuracy

With respect to the content of this analysis, all conclusions drawn, statements of fact or belief, and indications of Plan intents are the result of information provided by the Plan or its designee(s) to the entities performing this analysis. Additionally, this analysis is based on current written standard information provided by the Plan, operational information provided by the Plan's vendors, and any historical information the Plan was able to provide concerning the original development of each NQTL. The content of this analysis and any warranty of accuracy is contingent upon having received complete, current, and otherwise correct information. In the event any information provided by the Plan or its designee(s) is inaccurate or incomplete in any way, the content of this analysis and any conclusions drawn may in turn be rendered inaccurate or incomplete.