Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

Mental Health/Substance Use Disorder – Supporting Documentation Template
TO BE COMPLETED BY COMPANY
Company Name:
SERFF TOI:
SERFF SUB TOI:
SERFF Tracking #:
ELECTRONIC REFERENCES - FEDERAL
Code of Federal Regulations
United States Code
ELECTRONIC REFERENCES - ILLINOIS
Illinois Insurance Code
Administrative Rules
Illinois Company Bulletins

Supporting Documentation Template Directions

- The template must be completed to support the information included in all filings for individual, small group, or large group major medical, Health Maintenance Organization (HMO), or Point-of-Service (POS) products.
- This document is to be downloaded and submitted with this filing in SERFF. Alteration of this document will result in rejection of the filing.

As part of the policy filing review process, the Illinois Department of Insurance (DOI) will conduct a review and analysis of plan mental health/substance use disorder benefits to ensure compliance with State and federal regulations, standards, and to confirm any financial requirement or treatment limitation applied to mental health or substance use disorder benefits is not more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification.

(Note: Illinois required supporting documentation must be submitted in addition to any template/supporting documentation required by CMS/CCIIO. The DOI understands that there may be some overlap in information provided; however, the State's additional submission requirements for mental health/substance use disorder parity are needed to support the State's independent review for compliance with federal and state standards and regulations.)
Please respond to the following questions and/or request for information:

Aggregate Lifetime and Annual Dollar Limits - 45 CFR 146.136(b)

1) How does your plan comply with the aggregate lifetime and annual dollar limit requirements set forth in 45 CFR 146.136(b)?

If a plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

If a plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either— (i) Apply the aggregate lifetime or annual dollar limit both to the medical/ surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/ surgical benefits and mental health or substance use disorder benefits; or (ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.

Financial/Quantitative Treatment Limitations - 45 CFR 146.136(c)(2)

2) How does your plan comply with the financial and quantitative treatment limitation requirements set forth in 45 CFR 146.136(c)?

A plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation.

Non-quantitative Treatment Limitations - 45 CFR 146.136(c)(4)

3) How does your plan comply with the non-quantitative treatment limitation requirements set forth in 45 CFR 146.136(c)(4)?

It is not required that the same non-quantitative treatment limitations are used for mental health/substance use disorder benefits as for medical/surgical benefits. However, processes, strategies, evidentiary standards and other factors, used to determine when a mental health/substance use disorder benefit is subject to a non-quantitative treatment limitation must be comparable to and not more stringent than those used for medical/surgical benefits in each classification. Also, a non-quantitative treatment limitation must not be designed to restrict access to mental health/substance use disorder benefits. Non-quantitative treatment limitations can include, but are not limited to, the following:

a. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
b. Formulary design for prescription drugs;
c. For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
d. Standards for provider admission to participate in a network, including reimbursement rates;
e. Plan methods for determining usual, customary, and reasonable charges;
f. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
g. Exclusions based on failure to complete a course of treatment; and
h. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

Medical Necessity - 45 CFR 146.136(d)

4) How does your plan make the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits available to any current or potential participant, beneficiary, or contracting provider upon request in accordance with 45 CFR 146.136(d)?