



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

<b>Cigna HealthCare</b>	<b>Last Revised:</b> January 10, 2023
<b>Health Plan Products:</b> Health Maintenance Organization (HMO)	<b>Prescription Drug Coverage:</b> Yes
<b>Utilization Management Model:</b> Inpatient & Outpatient	<b>Funding Types:</b> Insured

<b>Non-Quantitative Treatment Limitation (NQL)</b>	<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>	<b>Comparative Analysis Conclusions</b>
<b>Medical Necessity</b>			
All M/S and MH/SUD services, whether in-network or out-of-network must be medically necessary. Services determined by Cigna not to be medically necessary would be excluded under the terms of the plan unless otherwise dictated by regulatory requirement or specific plan design.	<p>Cigna Health Management, Inc., an affiliate of Cigna HealthCare performs utilization reviews for most medical/surgical (M/S) benefits. A separate entity, eviCore, reviews certain M/S services for Cigna, American Specialty Health, reviews physical therapy and occupational therapy on behalf of Cigna HealthCare and both national and regional vendors to perform UM. All entities adhere to Cigna’s policies and procedures when performing utilization reviews, and all of the data provided is inclusive of utilization reviews of certain M/S services.</p> <p>Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the</p>	<p>Evernorth Behavioral Health (“Evernorth,” “EBH” or “Behavioral Health” formerly Cigna Behavioral Health) an affiliate of Cigna HealthCare, performs utilization reviews for MH/SUD benefits. No separate entities review MH/SUD services for Cigna HealthCare.</p> <p>Cigna employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna's standard definition of “medical necessity” is as follows:</p> <p><b>“Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness,</p>	<p>A review of Cigna’s written policies and processes reveals the comparable application of Medical Necessity to M/S and MH/SUD services within the applicable benefit classification. Cigna's Medical Necessity coverage policy development and application process is consistent between M/S and MH/SUD. Cigna applies comparable evidence-based guidelines to define established standards of effective care in both M/S and MH/SUD benefits. Compliance is further demonstrated through Cigna’s uniform definition of Medical Necessity for M/S and MH/SUD benefits. Consistency in policy development, process and application evidences compliance with the NQTL requirement that the medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services.</p> <p><b><i>Peer to Peer Review Variation</i></b></p>

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	<p>above, Cigna's standard definition of “medical necessity” is as follows:</p> <p><b>“Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review</li></ul>	<p>Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. 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.</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative</li></ul>	<p>With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, Cigna ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee’s clinical situation warrants an approval for medically necessary care yet the provider’s request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials.</p> <p>Cigna’s medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and Cigna’s Clinical Coverage policies and plan documents approved for use in care management determinations. Cigna’s Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and Cigna’s Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care</p>

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	<p>Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.</p> <p>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.</p> <p>In determining whether health care services, supplies, or medications are Medically Necessary, the Cigna Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies 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.”</p> <p><b>Development of Clinical Criteria</b> Cigna utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of M/S services, procedures, devices, equipment, imaging, diagnostic interventions and its own internally developed Coverage Policies and the MCG™ Care Guidelines.</p>	<p>services, supplies, medications or settings when determining least intensive setting.</p> <p>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.</p> <p>In determining whether health care services, supplies, or medications are Medically Necessary, the Cigna Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies 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.”</p> <p><b>Development of Clinical Criteria</b> Cigna utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of MH services, procedures, devices, equipment, imaging, diagnostic interventions and the ASAM criteria for conducting medical necessity reviews of SUD services.</p> <p>The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published</p>	<p>where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer.</p> <p>The Peer-to-Peer review is available for any coverage request for which Cigna anticipates issuing a denial Cigna incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a Cigna clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the Cigna Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the Cigna Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the Cigna clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request.</p> <p>If Cigna’s pro-active, <i>volunteer</i> Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or</p>

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	<p>The Medical Technology Assessment Committee (MTAC) 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 M/S services determined to be experimental and investigational.</p> <p>Clinical coverage policies 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.</p> <p>While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies.</p> <p>Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies</p>	<p>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 MH/SUD services determined to be experimental and investigational.</p> <p>Clinical coverage policies 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.</p> <p>While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies.</p> <p>Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to</p>	<p>discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. Cigna's pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to Cigna.</p> <p>Cigna has not identified any additional discrepancies in operational policies between MH/SUD and M/S benefits where the discrepancies present a comparability or stringency problem within the context of the NQL requirement. Instances where discrepancies between the process of administering MH/SUD and M/S benefits do not present an NQL issue include, for example, situations where a discrepancy in process is <i>more</i> advantageous to the administration of MH/SUD benefits than M/S benefits such as the pro-active behavioral health peer-to-peer review process outlined herein. The Peer-to-Peer analysis is addressed in the "in operation" section of this submission set forth below.</p> <p>Cigna regularly reviews utilization management data to evaluate and ensure operational compliance of the medical management suite of NQLs, including Medical Necessity and Appeals, Prior Authorization</p>

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	<p>that may be warranted. Of note, the company’s most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.</p> <p><b>Factors</b> Cigna maintains medical necessity criteria (also referred to as clinical criteria) for all medical health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG or are developed by Cigna from the comparison of national, scientific and evidenced based criteria sets. Cigna’s Medical Technology Assessment Committee (“MTAC”) reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. Cigna reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process.</p> <p>Cigna requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all M/S benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. Clinical coverage policies may incorporate, without</p>	<p>revise its coverage policies governing reviews of MH/SUD benefits.</p> <p><b>Factors</b> Cigna maintains medical necessity criteria (also referred to as clinical criteria) for all behavioral health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG, the American Society of Addiction Medicine (“ASAM”) or are developed by Cigna from the comparison of national, scientific and evidenced based criteria sets. Cigna’s Medical Technology Assessment Committee (“MTAC”) reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. Cigna reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process.</p> <p>Cigna requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all MH/SUD benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S.</p>	<p>and Concurrent Review. Data is reviewed by benefit classification and sub-classification to calculate denial rates to ensure comparability. Cigna’s application of the medical necessity</p> <p>NQL, specifically approvals and denials rates, for Prior Authorization, Retrospective Review, and Concurrent Review across benefit classifications for a sampling of Cigna plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits for the Cigna book of business including all commercial data Medical Necessity denial rates.</p> <p>Cigna utilizes appeals data to review the number of utilization review decisions across the book-of-business. Appeals data is delineated by pre and post services and includes prior authorization and concurrent review, overturned for the same time period relating to the utilization management data metrics included in Cigna’s book of business data. Data reflected overall comparable overturn rates across benefit classifications.</p> <p>While the rate of appeals, where the original denial for lack of medical necessity was upheld, is higher for MH/SUD than for M/S claims for the Cigna book of business. This appeal rate, coupled with the utilization management data reflecting higher Medical Necessity denial rates for M/S claims than for MH/SUD claims is representative of Cigna’s proactive approach to</p>

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	<p>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.</p> <p><b>Sources and Evidentiary Standards</b> The use of the various guidelines for clinical criteria/medical necessity (both external and internal) <u>do not overlap</u> and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific Cigna medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee ("MTAC"), 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.</p> <p>MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons,</p>	<p>Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.</p> <p><b>Sources and Evidentiary Standards</b> The use of the various guidelines for clinical criteria/medical necessity (both external and internal) <u>do not overlap</u> and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific Cigna medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee ("MTAC"), 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.</p> <p>MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists.</p>	<p>peer-to-peer review. Approximately 37% of all pre-service MH/SUD peer-to-peer reviews inclusive of read only reviews, which includes a Medical Director review of the medical file without discussion when a peer-to-peer is scheduled but the requesting provider does not attend, in Cigna's book-of-business data resulted in approvals that may have otherwise have resulted in a medical necessity denial.</p> <p>Additionally, Cigna conducts routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) testing is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Corrective action is initiated if a score falls below 85% and if the results are below 90% the Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.</p> <p>The number of utilization review decisions across the Cigna book of business data, reflects comparable average denial rates based upon Medical Necessity across all benefit classifications for utilization management programs including prior authorization, concurrent review and retrospective review with medical necessity denials for M/S services on average higher than medical necessity denials of MH/SUD</p>

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	<p>urologists, pulmonologists cardiologists, psychologists and psychiatrists.</p> <p>The Cigna-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the “Behavioral Health” clinicians listed in the “Coverage Policy SME” tab – consulted when drafting or reviewing coverage policies).</p> <p>The MTAC’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna’s Medical</p>	<p>The Cigna-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the “Behavioral Health” clinicians listed in the “Coverage Policy SME” tab – consulted when drafting or reviewing coverage policies).</p> <p>The MTAC’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna’s Medical</p>	<p>services. The sample size for Georgia specific data did not allow for a statistically significant sample in any category. While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement.</p> <p>Cigna concludes the Medical Necessity NQTL is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. In performing the ‘as written’ comparative analysis Cigna reviewed applicable policies, processes and procedures to ensure comparability of the application of Medical Necessity to M/S and MH/SUD services which revealed the application of Medical Necessity to be applied to MH/SUD services no more stringently than M/S Services. In performing the operational analysis of the application of UM, Cigna reviewed denial rates for both M/S and MH/SUD within each classification of benefits and for benefits subject to prior authorization, concurrent review, and retrospective review.</p>

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	<p>Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48):</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p>	<p>Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48) ):</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p>	





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	<p>The MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes.</p> <p><b>Medical Necessity Appeals</b> Cigna uses the same factors, sources and evidentiary standards applicable to the medical necessity NQL for the Medical Necessity Appeals.</p> <p><b>Internal Appeals.</b> Cigna follows the same internal appeal process for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits for both M/S and MH/SUD. For medical necessity reviews a second health care professional, who was not involved in any previous decision and is not a subordinate of the individual in the previous decision, performs an appeal, whether expedited or standard.</p> <p>Expedited appeals are completed within 72 hours. Standard level 1 and level 2 pre-service medical necessity appeals are completed within 15 calendar days and standard post-service level 1 and level 2 medical necessity appeals are completed within 30 calendar days, post-service administrative appeals are completed within 30 calendar days. The assigned appeal processor notes the adverse determination as a denial in our system and communicates the</p>	<p>The MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes.</p> <p><b>Medical Necessity Appeals</b> Cigna uses the same factors, sources and evidentiary standards applicable to the medical necessity NQL for the Medical Necessity Appeals.</p> <p><b>Internal Appeals.</b> Cigna follows the same a single-level internal appeal process for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits for both M/S and MH/SUD. For medical necessity reviews a second health care professional, who was not involved in any previous decision and is not a subordinate of the individual in the previous decision, performs an appeal, whether expedited or standard.</p> <p>Expedited appeals are completed within 72 hours receipt. Standard level 1 and level 2 pre-service medical necessity appeals are completed within 15 calendar days and standard post-service level 1 and level 2 medical necessity appeals are completed within 30 calendar days, post-service administrative appeals are completed within 30 calendar days. The assigned appeal processor notes the adverse determination as a denial in our system and</p>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>determination by phone to the requesting party if the appeal was handled as expedited. At each step in the process, Cigna provides written notification of the outcome and resolution, including the clinical rationale for the determination to the member and the treating provider or facility.</p> <p><b>External Appeals.</b> Cigna informs customers of their right to request an external appeal to an IRO, at no cost to the Customer, in the final internal appeal denial letter for both M/S and MH/SUD external appeals. The communication provides the Customer with all information regarding the right of appeal, applicable time limitations and specific instructions on the initiation of an appeal by the Customer or the Customer’s designate. The National Appeals Organization will facilitate the appeal through the provision of program information and IRO program description.</p> <p>All records and materials relevant to the adverse determination and included in the previous appeal files are presented for review to an Independent Review Organization (IRO). New information and documentation submitted with the external review request is forwarded to the IRO to consider. The decision of the IRO is final and is binding on us and the plan. Relevant portions of the Customer’s contract (e.g., Certificate of Coverage, Summary Plan Description) are included in the materials for external review. The IRO will render a decision without</p>	<p>communicates the determination by phone to the requesting party if the appeal was handled as expedited. At each step in the process, Cigna provides written notification of the outcome and resolution, including the clinical rationale for the determination to the member and the treating provider or facility.</p> <p><b>External Appeals.</b> Cigna informs customers of their right to request an external appeal to an IRO, at no cost to the Customer, in the final internal appeal denial letter for both M/S and MH/SUD external appeals. The communication provides the Customer with all information regarding the right of appeal, applicable time limitations and specific instructions on the initiation of an appeal by the Customer or the Customer’s designate. The National Appeals Organization will facilitate the appeal through the provision of program information and IRO program description.</p> <p>All records and materials relevant to the adverse determination and included in the previous appeal files are presented for review to an Independent Review Organization (IRO). New information and documentation submitted with the external review request is forwarded to the IRO to consider. The decision of the IRO is final and is binding on us and the plan. Relevant portions of the Customer’s contract (e.g., Certificate of Coverage, Summary Plan Description) are included in the materials for external review. The IRO will render a decision without</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	deference to the previous decisions. Standard external appeals are completed within 45 days and expedited external appeals are completed within 72 hours.	deference to the previous decisions. Standard external appeals are completed within 45 days and expedited external appeals are completed within 72 hours.	
<b>Prior Authorization/Pre-Certification Review</b>			
<b>Process – Include all services for which prior authorization/pre-certification review is required. Describe any step-therapy or “fail first” requirements and requirements for submission of treatment request forms or treatment plans.</b>			
<b>Inpatient, In-Network</b>  Prior Authorization is applied to all non-emergent inpatient benefits, including residential services. The MH/SUD and M/S services assigned to the inpatient classification include non-emergent MH/SUD and M/S services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other facility and non-emergent MH/SUD services. This specifically includes, for MH/SUD and M/S benefits.  <b>M/S Inpatient Services :</b> <ul style="list-style-type: none"><li>Acute Inpatient Services,</li><li>Subacute Inpatient Services, i.e. Skilled Nursing Care, physical</li></ul>	<b>Inpatient, In-Network Services Subject to Prior Authorization</b>  All non-emergent M/S inpatient services are subject to pre-service medical necessity review (i.e., prior authorization, precertification review (PCR) including Inpatient, In-Network benefits.  <b>Process</b> For a service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. If the request cannot be authorized using an approved algorithm, the case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse	<b>Inpatient, In-Network Services Requiring Prior Authorization</b>  All non-emergent MH/SUD inpatient services are subject to pre-service medical necessity review (i.e., prior authorization, precertification review (PCR)) including Inpatient, In-Network benefits  <b>Process</b> For a service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. . If the request cannot be authorized using an approved algorithm, the case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse	Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria.  A review of Cigna’s written policies and processes reveals the comparable process by which MH/SUD and M/S services are selected for application of prior authorization within the applicable benefit classification the evidences comparability and equivalent stringency in-writing and in-operation.  First, a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD services shall be subject to prior authorization or concurrent review. To the extent any MH/SUD services within the inpatient or outpatient

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<p>rehabilitation hospitals, etc.</p> <ul style="list-style-type: none"><li>Inpatient Professional Services</li></ul> <p><b>MH/SUD Inpatient Services:</b></p> <ul style="list-style-type: none"><li>Mental Health Acute Inpatient Services</li><li>Mental Health Subacute Residential Treatment</li><li>Mental Health Inpatient Professional Services</li><li>SUD Acute Inpatient Services</li><li>SUD Acute Inpatient Detoxification</li><li>SUD Subacute Residential Treatment</li><li>SUD Inpatient Professional Services</li></ul> <p>No MH/SUD inpatient benefits are subject to fail-first and/or step therapy requirements.</p>	<p>reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e., peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S or MH/SUD inpatient days upon pre-service review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Factors</b></p> <p>Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna (clinical appropriateness) the value of the service exceeds the administrative costs, and verification that a service will be rendered for a covered benefit.</p> <p>All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification</p>	<p>reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e., peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S or MH/SUD inpatient days upon pre-service review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Factors</b></p> <p>Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna (clinical appropriateness) the value of the service exceeds the administrative costs, and verification that a service will be rendered for a covered benefit.</p> <p>All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification</p>	<p>classifications are considered for inclusion on the “precertification list” a Cigna-employed Medical Director with former practice experience as a psychiatrist and expertise in, and dedicated support for, behavioral health matters is consulted to ensure appropriate evaluation of MH/SUD services that may be considered for application of prior authorization and concurrent review.</p> <p>Cigna's MTAC – which includes representation across a number of disciplines, including MH/SUD expertise – approves any implementation of, or changes to, coverage policies used to make medical necessity determinations to ensure the appropriateness of the same. The inclusion of appropriate representation of MH/SUD expertise in the coverage policy development process ensures that coverage policies for MH/SUD benefits appropriately incorporate generally-accepted standards of practice, including consideration of type or duration of treatment or level of care for patients with specific MH/SUD conditions.</p> <p>Comparable representation of expertise in MH/SUD services is therefore ensured to the extent any MH/SUD benefits may be considered for inclusion on the precertification list, thus ensuring comparable reviews of MH/SUD benefits. Moreover, the list of services subject to prior authorization and concurrent review is reviewed no less frequently than annually to determine if any services, whether MH/SUD or M/S,</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>based upon high cost, high risk and complexity for members receiving the service.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Internal claims data</li><li>• UM program operating costs</li><li>• UM authorization data</li><li>• Expert Medical Review</li><li>• Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b></p> <p>The evidentiary standard relied on to determine whether to apply prior authorization to inpatient M/S 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 M/S 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:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• For services for which Cigna maintains historic claims data, Cigna calculates the</li></ul>	<p>based upon high cost, high risk and complexity for members receiving the service.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Internal claims data</li><li>• UM program operating costs</li><li>• UM authorization data</li><li>• Expert Medical Review</li><li>• Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b></p> <p>The evidentiary standard relied on to determine whether to apply prior authorization to inpatient MH/SUD 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 MH/SUD 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:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• For services for which Cigna maintains</li></ul>	<p>should be removed or added to the list, so the frequency of review of the continued appropriateness of application of prior authorization is comparable across MH/SUD and M/S benefits.</p> <p>Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the prior authorization list. Because the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization).</p> <p>An “in operation” review of Cigna’s application of the Prior Authorization NQL, specifically approvals and denial information, in the In-Patient, In-Network classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business data. The sample size for Georgia specific data did not allow for a statistically significant sample for inpatient prior authorization. While operational outcomes are not determinative of NQL compliance, and an insurer may comply with the NQL requirement notwithstanding a disparate outcome for an NQL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>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.</p> <p>Clinical Appropriateness is defined as those services that as determined in the exercise of the professional judgement of Cigna's internal medical experts, are in accordance with generally accepted standards of care and nationally recognized guidelines. Nationally recognized guidelines are included in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 as outlined in the development of clinical criteria of Medical Necessity.</p>	<p>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.</p> <p>Clinical Appropriateness is defined as those services that as determined in the exercise of the professional judgement of Cigna's internal medical experts, are in accordance with generally accepted standards of care and nationally recognized guidelines. Nationally recognized guidelines are included in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 as outlined in the development of clinical criteria of Medical Necessity.</p>	<p>component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>Cigna also reviewed the ROIs for both MH/SUD and M/S non-emergent inpatient admissions. For the purposes of the ROI calculation, the estimated costs to perform a coverage review, which is informed by costs/expenses for personnel salaries and time to review. Cigna reviewed the ROI for both M/S and MH/SUD non-emergent inpatient admissions. M/S services for non-emergent inpatient admissions calculated at 9:1 for 2019, 8:0 for 2020 and 10:1 for partial year 2021 and ROIs for MH/SUD services for non-emergent inpatient admissions calculated at 2.93:1 for 2019, 2.05:1 for 2020 and 2.03:1 for partial year 2021 respectively. These calculations are consistent with the factor/evidentiary standard outlined in Steps 2 and 3, namely that the application of prior authorization to inpatient M/S benefits produces a positive savings for both MH/SUD and M/S benefits, as measured in the aggregate across the Cigna-administered book-of-business. To be clear, if the number preceding the colon is greater than 1 (e.g., 2.93), then the application of prior authorization produces a positive ROI and thus meets the evidentiary standard for application of the same to MH/SUD or M/S inpatient benefits.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			The process by which services are considered for application of Prior Authorization is comparable in writing and in operation across MH/SUD and M/S benefits, as evidenced by Cigna’s assessment of several components of the prior authorization determination process in the overall context of its utilization management programs.
<b>Outpatient Office Visits, In-Network</b>	<b>Not Applicable.</b>	<b>Not Applicable.</b>	Cigna sub-classifies the outpatient benefit classification into Outpatient-Office Visit and Outpatient-All Other for MH/SUD and M/S benefits. The Prior Authorization NQTL does not apply to MH/SUD or M/S services assigned to the Outpatient-Office Visits sub-classification.
<b>All Other Outpatient Services, In-Network</b>  The Prior Authorization NQTL is applied to certain Outpatient-All Other MH/SUD and M/S services sub-classification including:  <b>M/S Outpatient-All Other Services</b> Advanced imaging services (e.g., CT scans, PET scans, MRIs, diagnostic cardiology) Certain outpatient surgical procedures Certain cardiology procedures Clinical trials	<b>All Other Outpatient, In-Network Services Subject to Prior Authorization</b>  The Prior Authorization NQTL is applied to certain Outpatient, In-Network M/S services in the All Other sub-classification (typically those subject to higher cost and/or utilization).  <b>Process</b> For an All Other Outpatient, In Network service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an outpatient service electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse	<b>All Other Outpatient, In-Network Services Subject to Prior Authorization</b>  The Prior Authorization NQTL is applied to certain Outpatient In-Network MH/SUD services in the All Other sub-classification (typically those subject to higher cost and/ or utilization).  <b>Process</b> For an All Other Outpatient, In Network service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an outpatient service electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse	Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria.  <b>As Written</b> A review of Cigna’s written policies and processes reveals the comparable process by which MH/SUD and M/S services are selected for application of prior authorization within the applicable benefit classification the evidences comparability and equivalent stringency in-writing and in-operation.

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
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	<p>reviewer/care manager determines the enrollee meets criteria for the outpatient service requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the outpatient service at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the outpatient service at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Pre-Certification List</b> Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.</p> <p>When determining which M/S All Other Outpatient benefits are subject to pre-service medical necessity review (prior authorization/ precertification), Cigna conducts at least annually, a Precertification Code Review Procedure by the Total Health and Network</p>	<p>reviewer/care manager determines the enrollee meets criteria for the outpatient service requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the outpatient service at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the outpatient service at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Pre-Certification List.</b> Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.</p> <p>When determining which MH/SUD All Other Outpatient benefits are subject to pre-service medical necessity review (prior authorization/precertification), Cigna conducts at</p>	<p>First, a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD services shall be subject to prior authorization or concurrent review. To the extent any MH/SUD services within the inpatient or outpatient classifications are considered for inclusion on the “precertification list” a Cigna-employed Medical Director with former practice experience as a psychiatrist and expertise in, and dedicated support for, behavioral health matters is consulted to ensure appropriate evaluation of MH/SUD services that may be considered for application of prior authorization and concurrent review.</p> <p>Cigna's MTAC – which includes representation across a number of disciplines, including MH/SUD expertise – approves any implementation of, or changes to, coverage policies used to make medical necessity determinations to ensure the appropriateness of the same. The inclusion of appropriate representation of MH/SUD expertise in the coverage policy development process ensures that coverage policies for MH/SUD benefits appropriately incorporate generally-accepted standards of practice, including consideration of type or duration of treatment or level of care for patients with specific MH/SUD conditions.</p> <p>Comparable representation of expertise in MH/SUD services is therefore ensured to the extent any MH/SUD benefits may be considered for inclusion on</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<p>procedure or service is billed as “unlisted,” meaning that no existing CPT code exists for the procedure or service)</p> <p><b>MH/SUD Outpatient-All Other Services</b> Partial Hospitalization Applied Behavior Analysis (ABA) Transcranial Magnetic Stimulation</p>	<p>Operations and Medical Economics Coverage Policy, Precertification Team (“Precertification Team”). Precertification Team workgroup leaders include Coding Team Supervisors, the Total Health and Network Operations (“THN”) Medical Director and ad hoc members including Cigna Medical Directors and subject matter expertise with the ability to exercise professional judgement. The Precertification Team makes a final recommendation to the THN medical and clinical leadership, a final determination is made and the Precertification List is updated, operationalized and provider notifications are communicated.</p> <p><b>Factors</b> 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 <i>first</i>, then a Return on Investment (“ROI”) threshold must be established for the service to be subject to prior authorization/concurrent review.</p> <p>The factors used to determine that the Prior</p>	<p>least annually, a Precertification Code Review Procedure by the Total Health and Network Operations and Medical Economics Coverage Policy, Precertification Team (“Precertification Team”). Precertification Team workgroup leaders include Coding Team Supervisors, the Total Health and Network Operations (“THN”) Medical Director and ad hoc members including Cigna Medical Directors and subject matter expertise with the ability to exercise professional judgement. The Precertification Team makes a final recommendation to the THN medical and clinical leadership, a final determination is made and the Precertification List is updated, operationalized and provider notifications are communicated.</p> <p><b>Factors</b> 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 <i>first</i>, then a Return on Investment (“ROI”) threshold must be established for the service to be subject to prior authorization/concurrent review.</p>	<p>the precertification list, thus ensuring comparable reviews of MH/SUD benefits. Moreover, the list of services subject to prior authorization and concurrent review is reviewed no less frequently than annually to determine if any services, whether MH/SUD or M/S, should be removed or added to the list, so the frequency of review of the continued appropriateness of application of prior authorization is comparable across MH/SUD and M/S benefits.</p> <p>Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the prior authorization list. The factor and its accompanying evidentiary standard used to determine whether prior authorization will apply to an outpatient service pursuant to the processes described herein, namely the ROI metric, is likewise uniform for MH/SUD and M/S benefits.</p> <p><b>In Operation</b> An “in operation” review of Cigna’s application of the Prior Authorization NQTL, specifically approvals and denial information, in the Outpatient All Other, In-Network classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. The sample size for Georgia specific data did not allow for a statistically significant sample for outpatient prior authorization.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>Authorization NQL will apply to either M/S benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• 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.</li><li>• Expert Medical Review</li><li>• Input from national vendors</li><li>• Medical Economics biannual provider and facility analyses report for codes not included on precertification list</li><li>• Nationally recognized evidence-based guidelines and CMS and HCPS updates</li><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li><li>○ American Formulary Association (AFA) publication of codes</li></ul></li></ul>	<p>The factors used to determine that the Prior Authorization NQL will apply to either MH/SUD benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• 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.</li><li>• Expert Medical Review</li><li>• Input from national vendors</li><li>• Medical Economics biannual provider and facility analyses report for codes not included on precertification list</li><li>• Nationally recognized evidence-based guidelines and CMS and HCPS updates</li><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li></ul></li></ul>	<p>Cigna reviewed the ROIs for both MH/SUD and M/S outpatient services subject to prior authorization/concurrent review and confirmed that the MH/SUD outpatient services subject to prior authorization/concurrent review revealed sufficiently positive ROIs to warrant continued application of prior authorization/concurrent review without further consideration.</p> <p>Cigna regularly reviews utilization management data to evaluate and ensure operational compliance of the NQL as referenced in the Medical Necessity Section of this document. Data is reviewed by benefit classification and sub-classification to calculate denial rates to ensure comparability. Cigna’s application of the medical necessity NQL, specifically approvals and denials rates for Concurrent Review across benefit classifications for a sampling of Cigna plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits.</p> <p>In the outpatient benefit classification, including the All Other sub-classification, denial rates for MH/SUD were on average lower than M/S services for the In Network Outpatient All Other sub-classification for the Cigna book of business data.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<div>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</div> <div><b>Evidentiary Standard</b> The evidentiary standards for factors that must be established to trigger a ROI evaluation for the application of Prior Authorization in the Outpatient All Other sub-classification.  All Other classification are as follows:</div> <div>(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 Evidence<sup>1</sup>;</div> <div>(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</div>	<div>○ American Formulary Association (AFA) publication of codes ○ Centers for Medicare and Medicaid Services (CMS) publication of codes</div> <div><b>Evidentiary Standard</b> The evidentiary standards for factors that must be established to trigger a ROI evaluation for the application of Prior Authorization in the Outpatient All Other sub-classification.  All Other classification are as follows:</div> <div>(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 Evidence<sup>2</sup>;</div> <div>(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</div>	

<sup>1</sup> **Clinical evidence** includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.

<sup>2</sup> **Clinical evidence** includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>warning or recall (e.g. FDA recall for a device or pharmaceutical product);</p> <p>(iii) 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.</p> <p>(iv) 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</p>	<p>detoxification under anesthesia, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product);</p> <p>(iii) 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.</p> <p>(iv) 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</p>	





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>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).</p> <p>(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:</p> <p>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)</p>	<p>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).</p> <p>(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:</p> <p>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</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>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.</p> <p>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.</p> <p>The evidentiary standard used for the ROI factor in the application of Prior Authorization of M/S services the Outpatient-All Other benefit classification is a ratio of 3.0. Codes not meeting the 3.0 ROI threshold are assessed for potential removal from the prior authorization/concurrent review program, with an emphasis placed on identifying ways to improve the cost-effectiveness of the reviews themselves by reducing administrative cost/expense (e.g., time to review). Cigna reviews the ROI of codes requiring precertification based on data contained in Cigna’s Precertification Dashboard. Codes with ROI greater than 3 are considered as operationally effective and are not typically considered for removal, while codes with ROI less than 3 are considered for removal.</p>	<p>healthcare benefit plan/program. (18 U.S.C. § 1347)</p> <p>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.</p> <p>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.</p> <p>The evidentiary standard used for the ROI factor in the application of Prior Authorization of MH/SUD services the Outpatient-All Other benefit classification is a ratio of 3.0. Codes not meeting the 3.0 ROI threshold are assessed for potential removal from the prior authorization/concurrent review program, with an emphasis placed on identifying ways to improve the cost-effectiveness of the reviews themselves by reducing administrative cost/expense (e.g., time to review). Cigna reviews the ROI of codes requiring precertification based on data contained in Cigna’s Precertification Dashboard. Codes with ROI greater than 3 are considered as operationally</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>Codes are removed with low ROI/savings and codes are included that have a higher ROI/savings based upon utilization review and cost trends.</p> <p>The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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.</li></ul> <p>Cigna imposes step therapy and/or fail first requirements on certain M/S services including for example, MRI, gastric bypass, lumbar spine fusion where higher-cost therapies may be denied unless it can be shown that a lower-cost therapy is not effective</p>	<p>effective and are not typically considered for removal, while codes with ROI less than 3 are considered for removal. Codes are removed with low ROI/savings and codes are included that have a higher ROI/savings based upon utilization review and cost trends.</p> <p>The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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.</li></ul> <p>Cigna does not impose a Fail First/Step Therapy NQL on MH/SUD services where higher-cost therapies may be denied unless it can be shown that a</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	(also known as “fail-first” policies or “ step therapy” protocols).	lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy” protocols).	
<b>Concurrent Care Review</b>			
<b>Process – Include frequency and penalties for all services. Describe any step-therapy or “fail first” requirements and requirements for submission of treatment request forms or treatment plans.</b>			
<b>Inpatient, In-Network</b>  Concurrent Review is applied to all inpatient benefits, based upon high cost, high risk and complexity for members receiving the service with the exception of any services reimbursed to the provider on a case rate/Diagnostic Resource Group (DRG) basis, including non-emergent M/S and MH/SUD services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other facility and certain outpatient benefits, without service/procedure level distinctions for the inpatient benefit classification. Inpatient services subject to Concurrent Review include:  <b>M/S Inpatient Services :</b> <ul style="list-style-type: none"><li>Acute Inpatient Services,</li><li>Subacute Inpatient Services, i.e. Skilled Nursing Care,</li></ul>	Concurrent Review is applied to all non-emergent M/S services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other residential facility based upon high cost, high risk and complexity for members receiving the service.  <b>Process</b> Inpatient Concurrent Care Review occurs when a facility/provider requests to extend an inpatient stay beyond the previously authorized length of stay or more frequently based upon review of the level of care and clinical criteria. For M/S benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the	Concurrent Review is applied to all non-emergent MH/SUD services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other residential facility based upon high cost, high risk and complexity for members receiving the service.  <b>Process</b> Inpatient Concurrent Care Review occurs when a facility/provider requests to extend an inpatient stay beyond the previously authorized length of stay or more frequently based upon review of the level of care and clinical criteria. For MH/SUD benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a	Cigna applies the concurrent care review NQL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day. Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for Concurrent Review.  <b>DRG Variation</b> Inpatient services reimbursed on the basis of a DRG/case rate and otherwise authorized pursuant to a prior authorization review are not subject to concurrent review because, for the duration of the period for which the DRG/case rate applies, the amount of benefits the plan is obligated to pay for a facility stay does not depend on the duration of time that the individual received care in the facility. DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<p>physical rehabilitation hospitals, etc.</p> <ul style="list-style-type: none"><li>Inpatient Professional Services</li></ul> <p><b>MH/SUD Inpatient Services:</b></p> <ul style="list-style-type: none"><li>Mental Health Acute Inpatient Services</li><li>Mental Health Subacute Residential Treatment</li><li>Mental Health Inpatient Professional Services</li><li>SUD Acute Inpatient Services</li><li>SUD Acute Inpatient Detoxification</li><li>SUD Subacute Residential Treatment</li><li>SUD Inpatient Professional Services</li></ul>	<p>clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p>UM coverage determinations of M/S services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Cigna uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care, home care, and behavioral health care for coverage guidance in utilization review of services that are not addressed in a Cigna medical, or co-branded coverage policy.</p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Concurrent Review to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit. Services covered under a medical or behavioral benefit administered by Cigna that are on-going with multiple services over multiple dates of</p>	<p>peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-6 MH/SUD inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p>UM coverage determinations of MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Cigna uses MCG for non-SUD primary diagnosis of behavioral health level of care and Cigna uses ASAM Criteria for coverage guidance in utilization review level of care of SUD services.</p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Concurrent Review to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit. Services covered under a medical or behavioral</p>	<p>not exist for psychiatric hospitalizations. The lack of correlation between the length of stay and the plan's obligation to pay benefits for the same means that assessing the ongoing medical necessity of a continued facility stay for coverage/benefit purposes is unnecessary for such period of time.</p> <p>The case rate/DRG payment functions as payment in full for any and all services rendered to the individual for the pre-authorized course of treatment for the length of time covered by the case rate/DRG payment and over which the individual remains in the facility. The plan's liability for payment of benefits for services, and the individuals' cost-sharing obligation, does not increase or decrease depending on how long the individual remains in the facility receiving the pre-authorized treatment in question, unless the individual's stay extends beyond the time period that the DRG/case rate payment covers.</p> <p>DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. Concurrent Review by Cigna is clinically appropriate and permissible for psychiatric hospitalizations as general medical hospitalizations that are not reimbursed based on DRGs are also subject to concurrent review. Differences in utilization management of inpatient behavioral health is not a more stringent application because DRG-</p>

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Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>service beyond the initial period for which coverage was approved may be subject to Concurrent Review to confirm level of care and clinical appropriateness.</p> <p>A Service may be subject to Concurrent Review, when such Service requires (1) the ongoing assessment to determine or continue to establish the medical necessity of continued services; and (2) appropriateness of current level of care for the severity; or (3) one or more of the following:</p> <ul style="list-style-type: none"><li>• complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines</li><li>• Expected timeframe for clinical response/outcomes based on literature</li><li>• Efficacy of the treatment modality</li><li>• Progress toward goals of therapy</li><li>• Discharge / transition planning</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li><li>○ American Formulary Association (AFA) publication of codes</li></ul></li></ul>	<p>benefit administered by Cigna that are on-going with multiple services over multiple dates of service beyond the initial period for which coverage was approved may be subject to Concurrent Review to confirm level of care and clinical appropriateness.</p> <p>A Service may be subject to Concurrent Review, when such Service requires (1) the ongoing assessment to determine or continue to establish the medical necessity of continued services; and (2) appropriateness of current level of care for the severity; or (3) one or more of the following:</p> <ul style="list-style-type: none"><li>• complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines</li><li>• Expected timeframe for clinical response/outcomes based on literature</li><li>• Efficacy of the treatment modality</li><li>• Progress toward goals of therapy</li><li>• Discharge / transition planning</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li></ul></li></ul>	<p>based fees have not been established for psychiatric hospitalizations.</p> <p>An “in operation” review of Cigna’s application of the Concurrent Review NQTL, specifically approvals and denial information, in the “Inpatient, In-Network” classification revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. On average, denial rates for concurrent medical necessity review of In-Network Inpatient MH/SUD benefits were lower than M/S services. The sample size for Georgia specific data did not allow for a statistically significant sample for inpatient concurrent.</p> <p>A review of appeals data reveals comparable upheld and overturn rates and, on average, lower overturn rates for MH/SUD benefits in the out of-network outpatient and inpatient classifications for the Cigna book of business. Specifically, an analysis of the total out-of-network appeal overturn rate as-between inpatient MH/SUD and M/S services includes a 9 percent lower denial rate (about 30% to about 39%) for MH/SUD services concurrent review appeals for Out of Network, Out Patient, showed comparable appeal overturn rates (about 23% as-compared to about 27%) for MH/SUD and M/S services appeals to a concurrent review determination. The sample size for Georgia specific appeals data did not allow for a statistically significant sample.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</li><li>● Internal claims data</li><li>● UM program operating costs</li><li>● UM authorization data</li><li>● Expert Medical Review of Clinical Criteria</li><li>● Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b> The evidentiary standard relied on to determine whether to apply Concurrent Review to inpatient MH/SUD and M/S benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business. The value associated with inpatient benefit reviews, as calculated by reference to the expected financial savings relative to the costs to review benefit claims, is assessed at the classification level and not at a service/procedure level.</p> <p>Cigna has determined the value of subjecting all inpatient In-Network M/S services to Concurrent Review must exceed the administrative costs by at least 1:1. The Concurrent Review NQT applies to all M/S services. The administration is identical.</p> <p>Cigna imposes step therapy and/or fail first requirements on certain M/S services including for example, MRI, gastric bypass, lumbar spine fusion</p>	<ul style="list-style-type: none"><li>○ American Formulary Association (AFA) publication of codes</li><li>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</li><li>● Internal claims data</li><li>● UM program operating costs</li><li>● UM authorization data</li><li>● Expert Medical Review of Clinical Criteria</li><li>● Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b> The evidentiary standard relied on to determine whether to apply Concurrent Review to inpatient MH/SUD and M/S benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business. The value associated with inpatient benefit reviews, as calculated by reference to the expected financial savings relative to the costs to review benefit claims, is assessed at the classification level and not at a service/procedure level.</p> <p>Cigna has determined the value of subjecting all inpatient In-Network M/S and MH/SUD services to Concurrent Review must exceed the administrative costs by at least 1:1. The Concurrent Review NQT applies to all MH/SUD and M/S services. The administration is identical.</p>	Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	where higher-cost therapies may be denied unless it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy” protocols).	Cigna does not impose a Fail First/Step Therapy NQL on MH/SUD services where higher-cost therapies may be denied unless it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy” protocols).	
<b>Outpatient Office Visits, In-Network</b>	<b>Not Applicable</b>	<b>Not Applicable</b>	The Concurrent Review NQL does not apply to MH/SUD or M/S services assigned to the Outpatient-Office Visits sub-classification.
<b>All Other Outpatient Services, In-Network</b>  The Concurrent Review NQL is applied to certain Outpatient-All Other MH/SUD and M/S services sub-classification including:  <b>M/S Outpatient-All Other Services</b> 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)	<b>All Other Outpatient, In-Network Services Subject to Concurrent Review</b>  Certain non-routine outpatient services are subject to Concurrent Review for the ongoing assessment to determine medical necessity of the care provided.  <b>Process</b> Concurrent care reviews for M/S services are typically initiated by a provider telephonically a day or two before the last covered/authorized day.  <b>Factors</b> When determining which M/S benefits are subject to concurrent care medical necessity review, Cigna conducts a cost-benefit analysis based upon the following factors: <ul style="list-style-type: none"><li>• Cost of treatment/procedure</li></ul>	<b>All Other Outpatient, In-Network Services Subject to Concurrent Review</b>  Certain non-routine outpatient services are subject to Concurrent Review for the ongoing assessment to determine medical necessity of the care provided.  <b>Process</b> Concurrent care reviews for MH/SUD services are typically initiated by a provider telephonically a day or two before the last covered/authorized day.  <b>Factors</b> When determining which MH/SUD benefits are subject to concurrent care medical necessity review, Cigna conducts a cost-benefit analysis based upon the following factors: <ul style="list-style-type: none"><li>• Cost of treatment/procedure</li></ul>	Cigna applies the Concurrent Review NQL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day.  Coverage determinations of MS services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, Cigna's methodology for determining which MH/SUD services within a classification of benefits are subject to concurrent care review is comparable to, and applied no more stringently than, its methodology for determining which M/S services within the same classification of benefits are subject

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
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)	<ul style="list-style-type: none"><li>Whether treatment type is a driver of high cost growth</li><li>Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region</li><li>Treatment types subject to a higher potential for fraud, waste and/or abuse</li><li>Projected return on investment and/or savings if treatment type is subjected to concurrent care review</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>American Hospital Association (AHA) publication of revenue codes</li><li>American Formulary Association (AFA) publication of codes</li><li>Centers for Medicare and Medicaid Services (CMS) publication of codes</li></ul></li><li>Internal claims data</li><li>UM program operating costs</li><li>UM authorization data</li><li>Expert Medical Review</li><li>Nationally recognized evidence-based guidelines</li></ul>	<ul style="list-style-type: none"><li>Whether treatment type is a driver of high cost growth</li><li>Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region</li><li>Treatment types subject to a higher potential for fraud, waste and/or abuse</li><li>Projected return on investment and/or savings if treatment type is subjected to concurrent care review</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>American Hospital Association (AHA) publication of revenue codes</li><li>American Formulary Association (AFA) publication of codes</li><li>Centers for Medicare and Medicaid Services (CMS) publication of codes</li></ul></li><li>Internal claims data</li><li>UM program operating costs</li><li>UM authorization data</li><li>Expert Medical Review</li><li>Nationally recognized evidence-based guidelines</li></ul>	<p>to concurrent care review.</p> <p>An “in operation” review of Cigna’s application of the Concurrent Review NQTL, specifically approvals and denial information, in the “Outpatient, In-Network, Other Items and Services” classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business. The sample size for Georgia specific data did not allow for a statistically significant sample for outpatient concurrent.</p> <p>While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>A review of concurrent review appeals data reveals comparable upheld and overturn rates and, on average, lower overturn rates for MH/SUD benefits in the out of-network outpatient and inpatient classifications for the Cigna book of business. Specifically, an analysis of the total out-of-network appeal overturn rate as-between inpatient MH/SUD and M/S services includes a 9 percent lower denial</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>MH/SUD Outpatient-All Other Services</b> Partial Hospitalization Applied Behavior Analysis (ABA) Transcranial Magnetic Stimulation	<b>Evidentiary Standards</b> When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards: <ul style="list-style-type: none"><li>Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>Inadequate 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;</li><li>when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li></ul></li><li>Whether the service is/may be excluded from</li></ul>	<b>Evidentiary Standards</b> When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards: <ul style="list-style-type: none"><li>Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>Inadequate 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;</li><li>when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li></ul></li><li>Whether the service is/may be excluded from</li></ul>	rate (about 30% to about 39%) for MH/SUD services concurrent review appeals for Out of Network, Out Patient, and nearly identical appeal overturn rates (about 23% as-compared to about 27%) for MH/SUD and M/S services appeals to a concurrent review determination. The sample size for Georgia specific appeals data did not allow for a statistically significant sample.  Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>coverage: Cigna assesses whether the plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</p> <ul style="list-style-type: none"><li>• Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>• Whether the service demonstrates significant variations from evidence-based care: A variation in evidence-based care must reflect a statistically significant standard deviation from the standard</li></ul>	<p>coverage: Cigna assesses whether the plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</p> <ul style="list-style-type: none"><li>• Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>• Whether the service demonstrates significant variations from evidence-based care: A variation in evidence-based care must reflect a statistically significant standard deviation from the standard</li></ul>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>frequency or duration in treatment using the service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>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</li><li>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.</li></ul></li><li>• Performing coverage reviews for a service is</li></ul>	<p>frequency or duration in treatment using the service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>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</li><li>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.</li></ul></li><li>• Performing coverage reviews for a service is</li></ul>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>projected to meet or exceed a certain return on investment ratio. The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>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.</li><li>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.</li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in</p>	<p>projected to meet or exceed a certain return on investment ratio. The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>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.</li><li>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.</li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>the English language, peer reviewed, published, evidence-based scientific studies or literature.</p> <p>Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQTL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the factors relied on by Cigna to design its NQTLs in a numerical threshold or formula. By contrast, the quantitative factors that Cigna considers when deciding whether to apply prior authorization to MH/SUD and M/S benefits are defined by reference to specific thresholds at which the factor is met.</p>	<p>the English language, peer reviewed, published, evidence-based scientific studies or literature.</p> <p>Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQTL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the</p>	
Retrospective Review			
Process, including timeline and penalties			
<p><b>Inpatient, In-Network</b></p> <p><b>Outpatient, In-Network (including applicable sub-classifications)</b></p> <p>Cigna defines Retrospective Review of M/S services as its review of a claim after the service has already been provided, but before the claim for that service has been paid. Specifically, these are reviews of coverage authorizations that were not</p>	<p>All non-emergent M/S and MH/SUD inpatient and outpatient services are theoretically subject to a medical necessity review. Cigna also employs the same definition of medical necessity to M/S and MH/SUD benefits.</p> <p>Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity”</p>	<p>All non-emergent MH/SUD inpatient and outpatient services are theoretically subject to a medical necessity review. Cigna also employs the same definition of medical necessity to M/S and /SUD benefits.</p> <p>Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity”</p>	<p><b>As written:</b> Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for developing coverage criteria.</p> <p>Cigna's methodology for determining which M/S services and which MH/SUD services within a</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
approved prior to the service being rendered. Cigna does not incorporate language related to Retrospective Review in its certificate or benefits booklet.	<p>set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna's standard definition of "medical necessity" is as follows:</p> <p><b>“Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable,</li></ul>	<p>set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna's standard definition of "medical necessity" is as follows:</p> <p><b>“Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable,</li></ul>	<p>classification of benefits are subject to retrospective review as written and in operation, as well as its retrospective medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.</p> <p><b>In operation:</b> Cigna has conducted a review of its application of the Retrospective Review NQTL, specifically approvals and denial information, which revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business. The sample size for Georgia specific data did not allow for a statistically significant sample for inpatient and outpatient retrospective. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>The comparative analysis performed for application of Retrospective Review to inpatient and outpatient</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.”</p> <p>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. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.</p> <p><b>Factors</b> When developing coverage criteria to evaluate the medical necessity of services, Cigna's Coverage Policy Unit (CPU), 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 Medical Technology Assessment Committee’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to</p>	<p>the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.”</p> <p>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. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.</p> <p><b>Factors</b> When developing coverage criteria to evaluate the medical necessity of services, Cigna's Coverage Policy Unit (CPU), 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 Medical Technology Assessment Committee’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to</p>	<p>benefits evidences compliance with the MHPAEA NQL requirement, in writing and in operation. Cigna's analysis of the process and policies governing the application of Retrospective Review across MH/SUD and M/S benefits, as well as the process by which MH/SUD and M/S services are selected for application of Retrospective Review, evidences comparability and equivalent stringency, in writing and in operation. The written process, the trigger for application of Retrospective Review, and the medical necessity standard used to review services subject to Retrospective Review, comparable across MH/SUD and M/S benefits, but the assessment of denial rates across a sample of Cigna-administered benefit plans do not reveal any potential “warning signs” warranting further assessment and/or changes to how the Retrospective Review NQL is designed or applied to MH/SUD benefits.</p> <p>The factor and its accompanying evidentiary standard used to determine whether Retrospective Review will apply to an inpatient or outpatient service pursuant to the above-described process, namely the ROI metric, is likewise uniform for MH/SUD and M/S benefits. Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the list of services subject to Retrospective Review.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford:</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p>	<p>categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford:</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p>	<p>Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject Retrospective Review as written and in operation, as well as its medical necessity review processes, are no more stringent for MH/SUD services than for M/S services within the same classification of benefits.</p>



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p><b>Evidentiary Standards</b></p> <p>When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p> <ul style="list-style-type: none"><li>• Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>○ Inadequate 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;</li><li>○ when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>○ the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>○ the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical</li></ul></li></ul>	<p><b>Evidentiary Standards</b></p> <p>When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p> <ul style="list-style-type: none"><li>• Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>○ Inadequate 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;</li><li>○ when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>○ the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>○ the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical</li></ul></li></ul>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>trials.</p> <ul style="list-style-type: none"><li>Whether the service is/may be excluded from coverage: Cigna assesses whether the plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</li><li>Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>Whether the service demonstrates significant</li></ul>	<p>trials.</p> <ul style="list-style-type: none"><li>Whether the service is/may be excluded from coverage: Cigna assesses whether the plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</li><li>Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>Whether the service demonstrates significant</li></ul>	





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>variations from evidence-based care: A variation in evidence-based care must reflect a statistically significant standard deviation from the standard frequency or duration in treatment using the service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>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</li><li>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</li></ul></li></ul>	<p>variations from evidence-based care: A variation in evidence-based care must reflect a statistically significant standard deviation from the standard frequency or duration in treatment using the service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>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</li><li>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</li></ul></li></ul>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>the dollar threshold.</p> <ul style="list-style-type: none"><li>Performing coverage reviews for a service is projected to meet or exceed a certain return on investment ratio. The ROI ratio is calculated using the following formula:<ul style="list-style-type: none"><li>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.</li><li>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.</li></ul></li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate</p>	<p>the dollar threshold.</p> <ul style="list-style-type: none"><li>Performing coverage reviews for a service is projected to meet or exceed a certain return on investment ratio. The ROI ratio is calculated using the following formula:<ul style="list-style-type: none"><li>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.</li><li>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.</li></ul></li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.</p> <p>Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQTL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the factors relied on by Cigna to design its NQTLS in a numerical threshold or formula. By contrast, the quantitative factors that Cigna considers when deciding whether to apply prior authorization to MH/SUD and M/S benefits are defined by reference to specific thresholds at which the factor is met.</p>	<p>Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.</p> <p>Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQTL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the factors relied on by Cigna to design its NQTLS in a numerical threshold or formula. By contrast, the quantitative factors that Cigna considers when deciding whether to apply prior authorization to MH/SUD and M/S benefits are defined by reference to specific thresholds at which the factor is met.</p>	
<b>Emergency Services</b>			
<b>Process for emergency services</b>	<p>Emergency M/S services are not subject to prior authorization or Concurrent Review.</p> <p>Emergency services that are furnished by a provider qualified to provide emergency services to evaluate and stabilize an emergency medical condition, including ambulance services, are assigned to the emergency care classification of benefits. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a</p>	<p>Emergency MH/SUD services are not subject to prior authorization or Concurrent Review.</p> <p>Emergency services that are furnished by a provider qualified to provide emergency services to evaluate and stabilize an emergency medical condition, including ambulance services, are assigned to the emergency care classification of benefits. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a</p>	<p>Cigna's integrated medical and behavioral health plans have only one, single benefit for emergency room and urgent care. Accordingly, there are no differences between how coverage for M/S and MH/SUD emergency room and urgent care services.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:</p> <ul style="list-style-type: none"><li>• Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child;</li><li>• Serious impairment to bodily function; or</li></ul> <p>Serious dysfunction of any bodily organ or part.</p>	<p>prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:</p> <ul style="list-style-type: none"><li>• Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child;</li><li>• Serious impairment to bodily function; or</li></ul> <p>Serious dysfunction of any bodily organ or part.</p>	
<b>Pharmacy Services</b>			
<b>Include all services for which prior authorization is required, any step-therapy or “fail first” requirements, and any other NQTLs.</b>			
<b>Tier 1</b>	<p>Cigna requires prior authorization, step therapy, or quantity limits for certain prescription drugs to ensure the prescribed drugs are medically necessary to treat the enrollee’s condition. Cigna uses the same medical necessity standard when reviewing coverage for both M/S and MH/SUD drugs.</p> <p>Cigna's prior authorization, step therapy, or quantity limit requirements were developed without regard to whether the prescription drugs are prescribed to treat a medical condition or a MH/SUD condition.</p> <p>Some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be</p>	<b>Same as Medical/Surgical</b>	<p>Cigna has confirmed that its utilization management programs are applied comparably, and no more stringently, to MH/SUD drugs as compared to M/S drugs. Its written policies governing formulary placement and application of utilization management do not distinguish between the processes, factors or standards that inform design and application of the formulary placement and utilization management NQTLs. Indeed, Cigna uses one, combined policy to govern its formulary management and utilization management requirements across M/S and MH/SUD benefits, and, while uniformity in processes is not required by the NQTL requirements (only comparability), uniformity in processes for designing and applying an NQTL can evidence comparability in the NQTL as-written.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>designated as non-formulary because it is excluded from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it doesn't warrant coverage on the formulary. If the P&amp;T Committee identifies a drug as “Exclude” or “Optional,” for example, then the Cigna VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from claims/reimbursement information and available rebate revenue) to Cigna as compared to therapeutic alternatives.</p> <p>Notably, Cigna does not apply prior authorization or step therapy requirements to any drugs used to treat an opioid use disorder or alcohol use disorder. Cigna does apply prior authorization or quantity limits to several MH/SUD drugs. Mental health drugs are generally considered to be controlled substances under federal law and, with the exception of drugs generally used to treat opioid use disorder and alcohol use disorder, Cigna applies prior authorization to controlled substances such as opioids used for pain management. This approach is consistent with Cigna’s application of prior authorization to controlled substances on the basis of identified safety risks, and regardless of whether the controlled</p>		<p>In terms of operational parity compliance, Cigna confirmed that all drugs, whether MH/SUD or M/S drugs, that the P&amp;T Committee designates must be covered are, in fact, covered on the formulary, and all drugs’ coverage conform to other P&amp;T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes. Moreover, Cigna's coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status, and drugs subject to a utilization management requirement, including prior authorization, step therapy, and/or quantity limits, conform to the aforementioned standards established for inclusion in a utilization management program. That is, Cigna does not apply a utilization management requirement to an MH/SUD drug that does not exhibit the factors/standards described in the preceding columns that, as-written, justify application of a utilization management requirement to a drug, and in terms of stringency of application of the NQTL no M/S drugs are omitted from a utilization management requirement if they exhibit the same factors/standards.</p> <p>While operational outcomes are not determinative of</p>





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	substance is used to treat an M/S condition, such as pain management, or an MH/SUD condition such as ADHD or bipolar disorder. Cigna applies prior authorization to M/S drugs for other reasons, such as specialty drug/high cost status (i.e. specialty drugs are subject to prior authorization), but these are rationales in addition to, and not exclusive of, the safety risk factor based on a drug’s status as a controlled substance. Cigna also applies step therapy to a number of brand drugs in certain MH/SUD and M/S therapeutic classes in order to incentivize the use of lower net cost (inclusive of ingredient cost and available manufacturer revenue) generic and/or preferred brand alternatives as identified through an analysis of claims/reimbursement information for the brand drugs.		<p>NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the prescription drug classification of benefits.</p>
<b>Tier 2</b>	Same as Tier 1	Same as Tier 1	Same as Tier 1
<b>Tier 3</b>	Same as Tier 1	Same as Tier 1	Same as Tier 1
<b>Tier 4</b>	Same as Tier 1	Same as Tier 1	Same as Tier 1
<b>Prescription Drug Formulary Design</b>			
<b>How are formulary decisions made for the diagnosis and medically necessary treatment of medical, mental health, and substance use disorder conditions?</b>	<p>Cigna offers a multi-tiered formulary that includes covered MH/SUD and M/S drugs; a tiered formulary design is considered an NQTL and, as such, the methodology by which drugs are placed on specific formulary tiers is subject to the NQTL parity requirement.</p> <p>Cigna offers a variety of prescription drug formularies comprised of generic, preferred and non-preferred</p>	<b>Same as Medical/Surgical</b>	<p>Cigna does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design for its Standard, Value, Advantage, Performance, and Legacy formularies. Formulary tiers are designed based on reasonable factors, consistent with the requirements of 45 CFR §146.136.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>brand name drugs, and specialty drugs. The coverage of drugs covered on Cigna’s formularies are, subject to a client policyholder’s election, determined by two internal/affiliated committees that perform different, but interrelated, functions: the Pharmacy &amp; Therapeutics Committee ("P&amp;T Committee"); and, the Cigna Value Assessment Committee (a/k/a Business Decision Team).</p> <p>The coverage of drugs covered on Cigna’s formularies are, subject to a client policyholder’s election, as applicable, determined by two internal/affiliated committees that perform different, but interrelated, functions: the Pharmacy &amp; Therapeutics Committee (“P&amp;T Committee”); and, the Cigna Health Plan Value Assessment Committee (“CHP VAC”).</p> <p>The P&amp;T Committee is composed of voting external clinicians across a number of specialties that perform, among other responsibilities, clinical reviews of drugs to determine whether a drug must be covered on the formulary as a clinical matter. In rendering clinical findings on drugs, the P&amp;T Committee assesses the FDA labeling and, as appropriate and available, clinical practice standards/trends and documentation like clinical literature and guidelines.</p> <p>The CHP VAC is composed of representatives representing several functional areas of the combined company, including, for example, clinicians and</p>		<p>Cigna has confirmed that its formulary management and utilization management processes are applied comparably, and no more stringently, to MH/SUD drugs as compared to M/S drugs. Specifically, all drugs, whether MH/SUD or M/S drugs, that the P&amp;T Committee designates must be covered are, in fact, covered on the formulary, and all drugs conform to other P&amp;T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes.</p> <p>Moreover, Cigna's coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status, and Cigna's review evidences that the processes and standards used to determine whether to subject a drug to utilization review is not only comparable, but identical, across M/S and MH/SUD drugs. The same P&amp;T and CHP VAC committee structure reviews M/S and MH/SUD drugs for formulary placement and whether to subject a drug to a prior authorization requirement, and pursuant to common policies and procedures. The process for reviewing drugs for coverage does not differ by whether the drug is used to treat a M/S condition or a MH/SUD condition.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>representatives from our sales and economics areas, that have experience with formulary management or PBM/health plan operations, and is responsible for deciding - within the clinical parameters established by the P&amp;T Committee - which drugs will be covered on the formularies offered by Cigna. If the P&amp;T Committee finds that a drug must be covered on the formulary as a clinical matter, then the Value Assessment Committee must place the drug on the formulary. If the P&amp;T Committee determines that a drug may or may not be covered on the formulary as a clinical matter, then the CHP VAC may consider other factors, including economic factors, when deciding whether to place the drug on the formulary.</p> <p><b>Factors</b> In its decision criteria, the CHP VAC primarily considers the following factors:</p> <ol style="list-style-type: none"><li>1. Pharmacy and Therapeutics (“P&amp;T”) Committee clinical safety and efficacy evaluation and designation.</li><li>2. Economic implications to enrollees and plans.</li><li>3. Status of drug as a generic, brand, or specialty drug</li><li>4. Competitor/market practices</li><li>5. Legal and regulatory requirements.</li></ol> <p>When deciding whether to place a drug on a three-tiered formulary, and, if so, on which formulary tier, the formulary committee considers the following</p>		<p>In terms of operational parity compliance, Cigna has also assessed as follows across its formularies: a comparable percentage of MH/SUD drugs are covered on v. off-formulary as compared to M/S drugs; a comparable, and in some cases lower, percentage of MH/SUD drugs are subject to prior authorization or step therapy requirements as compared to M/S drugs; and a comparable, and, in fact, lower, percentage of MH/SUD drugs are covered on the non-preferred brand tier (Tier 3) of the formularies offered by Cigna as compared to the MH/SUD drugs covered on Tiers 1 and 2. Cigna confirmed that all drugs, whether MH/SUD or M/S drugs, that the P&amp;T Committee designates must be covered are, in fact, covered on the formulary, and all drugs’ coverage conform to other P&amp;T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes. Moreover, for its large group formularies Cigna’s coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status.</p> <p>Cigna has also assessed as follows across its group formularies. First, a comparable percentage of MH/SUD drug NDCs are covered on v. off-formulary as compared to M/S drug NDCs under such</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>factors: the brand or generic status of a drug; whether, as applicable, a brand drug has available generic alternatives; whether the drug is the lowest net cost drug as compared to therapeutic alternatives; and whether a rebate arrangement exists for the drug to offset its cost.</p> <p>The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the lowest net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information.</p> <p><b>Evidentiary Standards</b></p> <p>In its decision criteria, the CHP VAC considers the following factors as defined by the noted evidentiary standards:</p> <ul style="list-style-type: none"><li>Pharmacy and Therapeutics (“P&amp;T”) Committee clinical evaluation and designation. The clinical P&amp;T Committee’s designations are based on reviews of a drug’s safety and efficacy and place in therapy, using available clinical evidence such as FDA</li></ul>		<p>formularies (about 4% of MH/SUD and M/S drug NDCs each are covered off-formulary, with small variations to the tenths of a percent across the noted formularies). Second, a comparable, and, in fact, lower, percentage of MH/SUD drug NDCs are covered on the higher cost, non-preferred brand tier (Tier 3) of the group formularies offered by Cigna as compared to the MH/SUD drug NDCs covered on Tiers 1 and 2.</p> <p>While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>Cigna employs measures to ensure comparability in both design and application of the multi-tiered formulary NQTL to MH/SUD and M/S prescription drug benefits. The written policies governing how MH/SUD or M/S drugs are placed on the formulary and tiered are uniform (i.e., on/off-formulary and tiering factors/standards) to ensure that the in-writing process and factors/standards relied on are comparable irrespective of the underlying use of the</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>label information and available clinical literature and guidelines (e.g. federal regulatory publications or professional society publications). The P&amp;T Committee assigns one of several clinical designations to a drug based on the drug’s safety/efficacy and place in therapy: Access, Include, Optional, or Exclude. These designations dictate whether, from a clinical perspective a drug must be covered on the formulary, or, alternatively, may, but is not required to be, covered on the formulary, and whether a drug may be covered more favorably than therapeutically alternative drugs. A drug designated “Include” or “Access” must be covered to the extent medically necessary, and alternative drugs may not be preferred over it through application of tier placement or step therapy. A drug designated “Optional” may or may not be covered on the formulary, and may be subject to a step therapy protocol that requires the use of alternative drugs.</p> <p>These formulary placement designations are more specifically defined as follows, and are subject to any overriding plan exclusions such as exclusions of over-the-counter drugs or prescription drugs with over-the-counter alternatives:</p>		<p>drug. Moreover, Cigna assesses outcomes data, including incidence rates for the application of utilization management NQTLs (i.e., the proportion of MH/SUD and M/S drugs that are subject to utilization management), to ensure that there are no significant discrepancies in the outcomes of the NQTLs’ application across MH/SUD and M/S benefits that warrant further scrutiny of the formulary decision-making process. Finally, the P&amp;T Committee annually reviews the formularies to ensure that the CHP VAC adheres to its clinical designations, irrespective of whether they are MH/SUD or M/S drugs, when making formulary placement/tiering decisions for Cigna’s formularies.</p> <p>Moreover, as further evidence of comparability and equivalent stringency in-operation, Cigna has also assessed as follows across its formularies: a comparable percentage of MH/SUD drugs are covered on v. off-formulary as compared to M/S drugs; a lower absolute number of MH/SUD drugs are covered off-formulary as compared to M/S drugs; a comparable, and indeed a lower, percentage of MH/SUD brand drugs are covered on the non-preferred brand tier (Tier 3) relative to the total number of MH/SUD drugs covered on Tiers 1 and 2 of the formulary, as compared to the proportion of M/S drugs covered on Tier 3 relative to the total M/S drugs covered on Tiers 1 and 2 of the formulary. As all generic drugs covered on the formulary are placed on Tier 1 and no brand drugs are placed on Tier 1,</p>





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p><b>Include:</b> A drug may be given an include designation if it meets at least one of the clinical bases enumerated below and is anticipated, or validated via claims data, to treat relatively large patient population (i.e., greater than 1 in 50,000).</p> <p>The clinical bases include:</p> <ul style="list-style-type: none"><li>a. It has a unique indication for use addressing a clinically significant unmet treatment need;</li><li>b. Its efficacy is superior to that of existing therapy alternatives;</li><li>c. Its safety profile is superior to that of existing therapy alternatives, it has a unique place in therapy; and/or</li><li>d. It treats medical condition(s) that necessitate individualized therapy and for which there are multiple treatment options.</li></ul> <p>Include drugs must be placed on a tier of the applicable formulary by the Value Assessment Committee but may not be disadvantaged relative to other drugs in a drug grouping, as defined by the P&amp;T Committee, with a less favorable clinical designation. A drug grouping is a list of drugs that generally possess the same mechanism of action and a similar place in therapy.</p> <p><b>Access:</b> A drug may be given an access designation if it meets at least one of the clinical bases enumerated below AND the drug is either anticipated, or validated</p>		<p>whether MH/SUD or M/S benefits, the placement of drugs on Tier 1 of the formulary is deemed to meet the NQTL stringency and comparability requirements for formulary placement. Put differently, there are no differences in placement of covered generic drugs for MH/SUD or M/S drugs, as the evidentiary standard – which was consistently applied to the placement of MH/SUD and M/S drugs on the formulary – for Tier 1 placement is the generic status of a drug. Additionally, by including a psychiatrist on the clinical P&amp;T committee, Cigna ensures that comparable clinical expertise in treating MH/SUD conditions and M/S conditions is represented in the formulary decision-making process.</p> <p>While physicians, regardless of specialty, are qualified under their scope of licensure to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, Cigna acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&amp;T Committee. In the context of NQTL compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&amp;T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits.</p>

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Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>via claims data at the time the P&amp;T Committee renders a designation on the drug, to treat a relatively small sub-population. The clinical bases include:</p> <ul style="list-style-type: none"><li>a. It has a unique indication for use addressing a clinically significant unmet treatment need;</li><li>b. Its efficacy is superior to that of existing therapy alternatives;</li><li>c. Its safety profile is superior to that of existing therapy alternatives;</li><li>d. It has a unique place in therapy; and/or</li><li>e. It treats medical condition(s) that necessitate individualized therapy and for which there are multiple treatment options.</li></ul> <p>Access drugs are forwarded to the Value Assessment Committee for further analysis of whether the drug should be covered on the applicable formulary and, if covered on the formulary, on which tier. The Value Assessment Committee may either place the drug on the applicable formulary or designate the drug as non-formulary. If the Value Assessment Committee does not place the drug on the formulary, the P&amp;T Committee shall establish formulary exception clinical criteria.</p> <p><b>Optional:</b> A drug may be given an optional designation if a significant proportion of its use is similar in terms of safety and efficacy to other currently available drug alternatives. In certain instances, a drug designated as optional may have a unique use in a small subset of patients in relation to</p>		<p>Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and standards that inform Cigna's formulary management decisions. Moreover, Cigna does not distinguish, in writing, between M/S and MH/SUD benefits in its prescription drug formulary design for its large group plan formularies, and it takes steps to monitor the consistency of decision-making across MH/SUD and M/S drugs by performing policy reviews and assessing operational outcomes periodically. As described in detail under the narrative response to Steps 2 and 3, Cigna considers the same factors and accompanying evidentiary standards for MH/SUD and M/S drugs when designing its large group formularies pursuant to a uniform formulary decision-making process. The written process for reviewing drugs for coverage does not differ by whether the drug is used to treat an M/S condition or a MH/SUD condition, and in terms of the timing of decisions, the P&amp;T Committee and Value Assessment Committee typically review all new-to-market drugs, whether MH/SUD or M/S drugs, within six months of market availability, and typically reviews potential opportunities to make formulary changes of any kind outside the context of new-to-market drug entries up to twice per year.</p> <p>In summary, the comparative analyses documented here, which construe the application of the multi-tiered formulary design NQTL designed based on the</p>



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>the overall use of the drug. The P&amp;T Committee shall establish formulary exceptions to account for cases where the optional drug may have a unique use in a relatively small subset of patients. Optional drugs are forwarded to the Value Assessment Committee for further analysis of whether the drug should be covered on the applicable formulary and, if covered on the formulary, on which tier. The Value Assessment Committee may either place the drug on the formulary or designate the drug as non-formulary. If the drug is not placed on the formulary, the P&amp;T Committee shall establish formulary exception clinical criteria.</p> <p><b>Exclude:</b> Drugs may be given an exclude designation for one or more of the following clinical reasons: efficacy inferior to that of existing therapy alternatives, a safety profile inferior to that of existing therapy alternatives, and/or insufficient data to evaluate the drug. Drugs recalled from the market for safety reasons are automatically designated as “Exclude” drugs, pending further P&amp;T Committee review.</p> <ul style="list-style-type: none"><li>Economic implications to enrollees and Cigna. When assessing potential formulary placement decisions, the CHP VAC reviews based on projected drug expenditure information derived from available manufacturer revenue and claims costs whether a drug is a lower net cost option relative to any therapeutic alternatives.</li></ul>		<p>factors articulated above, demonstrate the compliance in-writing and in-operation of the NQTL. While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. In this case, there were comparable, and in some cases more advantageous, outcomes for the placement and tiering of MH/SUD drugs as compared to M/S drugs based on the absolute number of, and incidence of, non-formulary v. formulary and, for on-formulary drugs, Tier 2 v. Tier 3 drugs under large group formularies. These comparable outcomes, along with the confirmation that the evidentiary standards and factors were actually applied consistently to MH/SUD drugs as compared to M/S drugs in terms of the adherence to P&amp;T Committee clinical designations, evidence in-operation compliance in terms of comparability and equivalent stringency. Consequently, Cigna concludes that the NQTL of formulary management is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>• Status of drug as a generic, brand, or specialty drug. A drug is identified as generic or brand based on an algorithm that considers drug indicators made available by an external vendor called First DataBank. A drug is identified as a specialty drug based on the presence of one more of the following characteristics: the requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; the need for intensive patient training and compliance assistance to facilitate therapeutic goals; limited or exclusive specialty pharmacy distribution (if a drug is only available through limited specialty pharmacy distribution it is considered specialty, even if it doesn't have other specialty drug characteristics); or specialized product handling and/or administration requirements.</li><li>• Competitor/market practices. This factor refers to an assessment of how competitors are covering drugs on their formularies based on publicly available information, which, while never determinative, may be considered when making certain formulary decisions.</li><li>• Legal and regulatory requirements. This factor refers to any legal or regulatory requirements that mandate certain drug</li></ul>		



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>coverage, such as tier placement requirements.</p> <p>Cigna offers several formularies for its large group insured business. For most formularies, some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it doesn't warrant coverage on the formulary. If the P&amp;T Committee identifies a drug as "Exclude" or "Optional," for example, then the Cigna VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from claims/reimbursement information and available rebate revenue) to Cigna as compared to therapeutic alternatives.</p> <p>For large group insured plans, Tier 1 of the formulary includes covered generic drugs. Tier 2 of the formulary includes covered preferred brand drugs. Tier 3 of the formulary includes covered non-</p>		





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	preferred brand drugs. The brand or generic status of a drug is determined by reference to an algorithm that analyzes available drug indicators, currently including First DataBank’s drug indicator file, and not by reference to the drug’s status as an M/S or MH/SUD benefit. Once brand drug status is determined by application of the algorithm, a covered brand drug is typically placed on Tier 2 for one of several reasons, including, for example, if the drug lacks available generic alternatives or if Cigna maintains a rebate arrangement for the brand drug, even if the brand drug has generic alternatives. Conversely, a covered brand drug is typically placed on Tier 3 if it either has available generic alternatives or Cigna lacks a rebate arrangement for the brand drug. Tier 4, if elected by the client plan sponsor, includes specialty drugs identified based on application of the above-stated definition.		
Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.	Cigna applies, in addition to the formulary management and utilization management requirements in its prior responses regarding NQTL application to prescription drug benefits, several kinds of NQTLS. These include, as previously described, formulary placement/tiering, and application of step therapy, prior authorization, and quantity limits for medical necessity. Certain NQTLS, such as exclusions for drugs obtained outside of the United States, apply uniformly across M/S and MH/SUD drugs. Of note, and consistent with Connecticut insurance law, Cigna does not apply	Same as Medical/Surgical	<p>In addition to Cigna's explanations for how its formulary management decisions, and decisions to apply utilization management to certain drugs, complies with the cited parity standard, Cigna has also reviewed its utilization management process for compliance with the parity NQTL requirement.</p> <p>With respect to parity compliance as-written, Cigna employed the same medical necessity standard and operational policies and procedures for reviewing utilization management approval requests. Similarly to its process for formulary management, Cigna</p>



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	mandatory mail order requirements to any drugs, including M/S and MH/SUD drugs.		reviews coverage requests for MH/SUD and M/S drugs subject to a utilization management requirement using a uniform, consolidated process that leverages identical policies and procedures. A team called the Pharmacy Service Center reviews initial utilization review requests based on coverage criteria developed by a uniform approval process, and a team called the National Appeals Organization reviews any appeals of denied drug claims, regardless of whether a drug is an MH/SUD or M/S benefit. Both teams employ identical procedures, including turnaround time requirements for standard and expedited requests, the method by which prescribers can submit utilization management approval requests, the issuance of coverage approval or denial determinations to enrollees and prescribers, and quality/oversight protocols. Cigna reviews non-formulary and step therapy coverage exception requests for any drug, whether a M/S or MH/SUD benefit, that is non-formulary or subject to a step therapy requirement. The coverage exception process ensures that enrollees for which the covered, preferred alternative drugs are clinically inappropriate can obtain coverage for drugs otherwise subject to non-formulary status or a step therapy requirement. If the enrollee’s prescriber demonstrates that the non-formulary or, as applicable, drug subject to step therapy is medically necessary, generally by evidencing that the preferred drug(s) are inappropriate or were ineffective for treating the enrollee’s condition, then Cigna approves coverage of the



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			<p>requested drug as medically necessary regardless of the drug’s status as an MH/SUD or M/S benefit.</p> <p>In terms of operational parity compliance, a review of utilization management data across a sampling of Cigna-administered plans revealed comparable, and, in fact, lower, medical necessity denial rates for MH/SUD drugs subject to prior authorization, step therapy, a quantity limit, or non-formulary status, as compared to M/S drugs subject to the same utilization management requirements.</p> <p>While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the prescription drug classification.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health, and substance use disorder conditions?</b>	The clinical P&T committee assesses the utilization and appropriateness of therapeutic agents and provides the clinical parameters within which the CHP VAC's decisions regarding formulary placement and application of utilization management must occur. The P&T committee is comprised of 16 independent, external providers, including 14 physicians and two pharmacists representing the following clinical practice areas: internal medicine, pulmonology, geriatrics, pediatrics, OB/GYN, endocrinology, gastroenterology, oncology, dermatology, rheumatology, cardiology, pharmacy (geriatrics), pharmacy (general), psychiatry, and neurology.	The clinical P&T committee assesses the utilization and appropriateness of therapeutic agents and provides the clinical parameters within which the CHP VAC's decisions regarding formulary placement and application of utilization management must occur. The P&T committee is comprised of 16 independent, external providers, including 14 physicians and two pharmacists representing the following clinical practice areas: internal medicine, pulmonology, geriatrics, pediatrics, OB/GYN, endocrinology, gastroenterology, oncology, dermatology, rheumatology, cardiology, pharmacy (geriatrics), pharmacy (general), psychiatry, and neurology.	<p>By including a psychiatrist on the clinical P&amp;T committee, Cigna ensures that comparable clinical expertise in treating MH/SUD conditions and M/S conditions is represented in the formulary decision making process. While physicians, regardless of specialty, may be able to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, Cigna acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&amp;T Committee.</p> <p>In the context of NQL compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&amp;T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits. Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and standards that inform Cigna's formulary management decisions.</p>
<b>Case Management</b>			
<b>What case management services are available?</b>  Case Management does not impact the scope of care, treatment or benefits	For Cigna enrollees with complex medical and/or behavioral health conditions, Cigna provides voluntary case management services which includes providing educational information, assessment/evaluation, planning, facilitation, care	Cigna maintains active support and coaching programs for autism, eating disorders, intensive behavioral case management, opioid and pain management, substance use, and coaching support for parents and families with these disorders. Each	Participation in case management services is not required, and an enrollee's participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. Consequently, case management does not

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
delivered to MH/SUD services and does not function as an NQTL under the parity requirements.	coordination, discharge planning and other services to meet an individual’s and family’s comprehensive health care needs through communication and sharing available resources to promote optimal patient care.	program retains its own referral and eligibility criteria including self-referral which remains complimentary and voluntary.	function as an NQTL under the cited parity requirement.
<b>What case management services are required?</b>	Health plan enrollees are not required to participate in case management services.	Health plan enrollees are not required to participate in case management services.	Participation in case management services is not required, and an enrollee’s participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. . Consequently, case management does not function as an NQTL under the cited parity requirement.
<b>What are the eligibility criteria for case management services?</b>	Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex medical conditions.	Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex MH/SUD health conditions.	Participation in case management services is not required, and an enrollee’s participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. Consequently, case management does not function as an NQTL under the cited parity requirement. Notwithstanding the inapplicability of the NQTL requirement to Cigna's voluntary case management program, Cigna offers case management services to enrollees with either complex MH/SUD or M/S conditions.
<b>Assessment of New Technologies</b>			
<b>Definition of experimental/investigational</b>	<b>Services Subject to the Assessment of New Technologies (Experimental, Investigational and Unproven, EIU)</b>  The evaluation of Experimental, Investigational and Unproven (“EIU”) services are applicable to all M/S services, regardless of benefit classification.	<b>Services Subject to the Assessment of New Technologies (Experimental, Investigational and Unproven, EIU)</b>  The evaluation of Experimental, Investigational and Unproven (“EIU”) services are applicable to all	The definition of experimental/investigational /unproven services is the same for MS and MH/SUD. A single review committee, Cigna’s MTAC evaluates all new technologies for M/S and MH/SUD benefits. Cigna's methodology and processes for determining whether M/S interventions and MH/SUD interventions within a classification of benefits are

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>EIU services are medical, surgical, diagnostic, or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, to be:</p> <ul style="list-style-type: none"><li>not demonstrated through or an inadequate volume of, existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li><li>not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;</li><li>the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.</li></ul> <p><b>Process</b> Cigna's Medical Technology Assessment Committee (MTAC) applies a consistent process in the development of evidence-based Coverage Policies for</p>	<p>MH/SUD services, regardless of benefit classification.</p> <p>EIU services are psychiatric or substance abuse health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, to be:</p> <ul style="list-style-type: none"><li>not demonstrated through or an inadequate volume of, existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li><li>not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;</li><li>the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.</li></ul> <p><b>Process</b> Cigna's Medical Technology Assessment Committee (MTAC) applies a consistent process in the</p>	<p>experimental, investigational and/or unproven are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/s services within the same classification of benefits as written and in operation.</p> <p>Cigna collects, tracks and trends relevant metrics on a semi-annual basis for services within each classification of M/S and MH/SUD benefits. Metrics may include initial EIU coverage denials, coverage denials upheld and overturned upon internal appeal and coverage denials upheld and overturned upon external appeal/review.</p> <p>An "in operation" review of claims data from a sampling of Cigna-administered plans revealed no excessive denial rates for MH/SUD claims denied as experimental, investigational and unproven as compared to M/S claims denied as experimental, investigational and unproven. An "in operation" review of Cigna's application of the Experimental, Investigational, and Unproven NQTL, specifically approvals and denial information, in the "All Other Outpatient, Out-of-Network, Services" classification revealed no statistically significant discrepancies in EIU denial rates as-between MH/SUD and M/S benefits.</p> <p>While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>a wide variety of medical technologies. The MTAC committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC also consults with internal Cigna subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to, orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists, and psychiatrists.</p> <p>The committee reviews (i) FDA approval/clearance status, (ii) English language peer reviewed publications; and (iii) relevant documents prepared by specialty societies and evidence-based review centers and uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage policies. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven.</p> <p><b>Factors</b></p>	<p>development of evidence-based Coverage Policies for a wide variety of medical technologies. The MTAC committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC also consults with internal Cigna subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to, orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists, and psychiatrists.</p> <p>The committee reviews (i) FDA approval/clearance status, (ii) English language peer reviewed publications; and (iii) relevant documents prepared by specialty societies and evidence-based review centers and uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage policies. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven.</p>	<p>outcome for an NQL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQL requirement. Consequently, Cigna concludes that the NQL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>The application of the same NQL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.</p> <p>The use of MTAC for development of evidence based Coverage Policies for M/S and MH/SUD demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>Cigna considers the following factors in determining whether a services is experimental, investigational or unproven:</p> <ul style="list-style-type: none"><li>• inadequate 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;</li><li>• when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the in a clinical trial</li><li>• the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the clinical trials section below.</li></ul> <p><b>Sources</b> In approving new technology, MTAC uses principles of evidence-based medicine in its evaluation of the following sources:</p> <ul style="list-style-type: none"><li>• clinical literature</li><li>• FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven.</li><li>• FDA approval or clearance</li></ul>	<p><b>Factors</b> Cigna considers the following factors in determining whether a services is experimental, investigational or unproven:</p> <ul style="list-style-type: none"><li>• inadequate 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;</li><li>• when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the in a clinical trial</li><li>• the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the clinical trials section below.</li></ul> <p><b>Sources</b> In approving new technology, MTAC uses principles of evidence-based medicine in its evaluation of the following sources:</p> <ul style="list-style-type: none"><li>• clinical literature</li><li>• FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven.</li></ul>	



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>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.</li></ul> <p><b>Evidentiary Standard.</b> Levels of evidence are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes.</p> <p>Cigna considers other sources of internal and external information as part of its decision making process including input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed as part of the annual update process.</p>	<ul style="list-style-type: none"><li>FDA approval or clearance</li><li>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.</li></ul> <p><b>Evidentiary Standard.</b> Levels of evidence are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes.</p> <p>Cigna considers other sources of internal and external information as part of its decision making process including input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed as part of the annual update process.</p>	
Standards for Provider Credentialing and Contracting			



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
Is the provider network open or closed?	<p>Cigna maintains an open network for M/S Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria ("Credentialing Criteria").</p> <p>When determining whether to admit a provider into its provider network, Cigna takes into consideration an array of factors including, but not limited to provider type and/or specialty; geographic market; supply of provider type and/or specialty; demand for provider type and/or specialty; and provider licensure and/or certification.</p>	<p>Cigna maintains an open network for MH/SUD Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria ("Credentialing Criteria").</p> <p>When determining whether to admit a provider into its provider network, Cigna takes into consideration an array of factors including, but not limited to provider type and/or specialty; geographic market; supply of provider type and/or specialty; demand for provider type and/or specialty; and provider licensure and/or certification.</p>	<p>Cigna maintains an open network for both M/S and MH/SUD Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria ("Credentialing Criteria").</p> <p>Cigna conducts an annual directory audit which includes a valid random sample to meet NCQA accreditation requirements.</p>





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<p><b>What are the credentialing standards for physicians?</b></p> <p>Network Admissions standards are designed and maintained by the Quality Programs &amp; Accreditation (“QP&amp;A”) team, which serves as an Accreditation Center of Excellence working with independent agents, such as the National Committee for Quality Assurance (“NCQA”), Utilization Review Accreditation Commission (“URAC”), the Centers for Medicare and Medicaid Services (“CMS”) and the National Alliance of HealthCare Purchaser Coalitions (“NAHPC”). Accreditation, certification and recognition by these organizations provides us with the external validation needed to show that we maintain high quality and meet nationally recognized industry standards. Cigna’s mission is to improve the health, well-being and peace of mind of those we serve through an integrated approach to healthcare quality and affordability</p>	<p>Credentialing criteria for M/S Network Providers includes the following standard requirements:</p> <ol style="list-style-type: none"><li>1. signed agreement to participate;</li><li>2. signed application and provider attestation;</li><li>3. verification of unrestricted state medical license with appropriate licensing agency;</li><li>4. verification of valid, unrestricted DEA certificate (if applicable);</li><li>5. verification of full, unrestricted admitting privileges at a Cigna participating hospital;</li><li>6. verification Board certification, (if applicable);</li><li>7. verification of highest level of education and training, if not board certified;</li><li>8. review and verification of malpractice claims history;</li><li>9. review of work history;</li><li>10. verification of adequate malpractice insurance; and</li><li>11. verification of prior and current sanction activities Additional criteria may be applicable pursuant to state credentialing and licensing requirements.</li></ol> <p>Cigna HealthCare maintains NCQA and URAC accreditation, which requires a comprehensive and rigorous audit of the Quality Program documents, policies, and other materials regarding Quality Management, Utilization Management, Case Management, Care Coordination, Credentialing, and Members’ Rights &amp; Responsibilities (approximately</p>	<p>Credentialing criteria for both MH/SUD Network Providers includes the following standard requirements:</p> <ol style="list-style-type: none"><li>1. signed agreement to participate;</li><li>2. signed application and provider attestation;</li><li>3. verification of unrestricted state medical license with appropriate licensing agency;</li><li>4. verification of valid, unrestricted DEA certificate (if applicable);</li><li>5. verification of full, unrestricted admitting privileges at a Cigna participating hospital;</li><li>6. verification Board certification, (if applicable);</li><li>7. verification of highest level of education and training, if not board certified;</li><li>8. review and verification of malpractice claims history;</li><li>9. review of work history;</li><li>10. verification of adequate malpractice insurance; and</li><li>11. verification of prior and current sanction activities Additional criteria may be applicable pursuant to state credentialing and licensing requirements.</li></ol> <p>Evernorth maintains NCQA Managed Behavioral Healthcare Organization (“MBHO”) and URAC accreditation and conducts an annual directory audit which includes a valid random sample to ensure the network and directory meet all NCQA MBHO accreditation requirements. MBHO Accreditation includes standards for Behavioral Health Care,</p>	<p>Cigna's methodology for credentialing for M/S providers and MH/SUD physician providers are the same.</p> <p>Cigna maintains one credentialing committee for the review of providers entering the network. Cigna does not routinely track credentialing exceptions for either M/S or MH/SUD Network Providers. Network Providers are re-credentialed on a three-year cycle as required by NCQA.</p> <p>NCQA Accreditation standards require that the organization maintain sufficient numbers and types of behavioral health, primary care and specialty care practitioners in its network. NCQA does not specifically dictate what the appropriate number/type should be. As a result, Cigna conducts review of its Network Adequacy standards at least annually to ensure requirements are sufficient for customer needs. Such analysis reviews external benchmarks (e.g., state laws or CMS requirements) as well as internal review of supply/demand and network adequacy enrollee complaints.</p> <p>Cigna's methodology for credentialing for M/S and MH/SUD physician providers are the same. 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. Moreover, the standard</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	250 documents). This evidence spans a period of 2 years and the majority of the evidence has to be reviewed and approved by our Medical Management Quality Committee (“MMQC”), Integrated Health Management Quality Committee (“IHMQC”), and Clinical Advisory Committee (“CAC”). Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records).	Credentialing/Re-credentialing, Provider Accessibility and Availability Monitoring, and Provider Contracting and Satisfaction. Cigna conducts quality management activities for both medical and behavioral healthcare products. Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records).	<p>credentialing process is used for both licensed physician providers and licensed non-physician providers, whether they are M/S or MH/SUD providers. Re-credentialing is required every three years for all providers, and except for work history and education and training verification, requires providers to meet the same criteria as the initial credentialing process, unless a new specialty is being requested.</p> <p>The credentialing application process is consistent between physicians and facilities providing M/S and MH/SUD services and the required licensing, experience, CAQH application and verifications are indistinguishable. No additional Cigna-specific credentialing requirements are applied to either M/S or MH/SUD physician providers, and, as relevant for certain MH/SUD services or specialties, 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. Consistency in credentialing standards and process evidences compliance with the NQTL in-writing requirement.</p> <p>An “in operation” review of Cigna’s credentialing applications, approvals and denials of providers revealed no disparate outcomes in credentialing approvals or denials as between M/S and MH/SUD physician providers. The average time it took Cigna to review and approve a credentialing application for</p>



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			<p>both M/S and MH/SUD providers was 15.5 days, an 18 day approval average for M/S providers and a shorter 13 day approval average for MH/SUD providers. The average time it took Cigna to review and deny a credentialing application for both M/S and MH/SUD providers was 100 days; 99 day approval average for M/S providers and 101 day approval average for MH/SUD providers. These credentialing process metrics indicate a comparable process in-operation based on the time to review, a significantly lower amount of denials of MH/SUD provider credentialing applications, and comparable incidences of denials of MH/SUD and M/S provider credentialing denial overturns on appeal. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>Consistent with the NQTL requirement for comparability/stringency, Cigna has confirmed that standards for provider admission into the MH/SUD provider network, including credentialing, for inpatient and outpatient services are comparable to, and applied no more stringently than, that of the M/S provider network as written and in operation. Put differently, Cigna’s network has the ability to meet the MH/SUD services needs of our enrollees by providing reasonable access to a sufficient number of in-network providers for both inpatient and outpatient services.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards (e.g., nurse practitioners, physician assistants, psychologists, clinical social workers)</b>	Cigna follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. The standard credentialing process is used for both licensed physician providers and licensed non-physician providers. See process above.	Cigna follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. The standard credentialing process is used for both licensed physician providers and licensed non-physician providers. See process above.	Cigna’s credentialing standards for licensed non-physician providers follows NCQA, CMS and state and federal requirements and guidelines for MS and MH/SUD providers. The credentialing application process is consistent between M/S and MH/SUD and such required licensing, experience, CAQH application and verifications are distinguishable only by differences in regulatory requirements. No additional Cigna-specific credentialing requirements are applied to either M/S or MH/SUD providers. Consistency in standards and process evidences compliance with the NQTL requirement.
<b>What are the credentialing/contracting standards for unlicensed personnel? (e.g., home health aides, qualified autism service professionals and paraprofessionals)</b>	Unlicensed providers may not be directly contracted, but may render services under a fully contracted and credentialed individual (supervising provider) or entity. For example, Home Health Aides are not individually credentialed or contracted directly, the Home Health Agency is contracted and credentialed as an entity (facility or clinic). Cigna does not contract directly with most of these types of providers but rather, with the entity they work for. If certifications are available for paraprofessionals, it is reviewed for credentialing purposes.	Unlicensed providers may not be directly contracted, but may render services under a fully contracted and credentialed individual (supervising provider) or entity. For example, Home Health Aides are not individually credentialed or contracted directly, the Home Health Agency is contracted and credentialed as an entity (facility or clinic). Cigna does not contract directly with most of these types of providers but rather, with the entity they work for. If certifications are available for paraprofessionals, it is reviewed for credentialing purposes.	Cigna does not distinguish between M/S and MH/SUD for purposes of credentialing unlicensed professionals and paraprofessionals. For M/S and MH/SUD, unlicensed providers may not be directly contracted or credentialed but may render services under a fully contracted and credentialed individual (supervising provider) or entity (clinic or facility)  Cigna’s credentialing standards for unlicensed professionals and paraprofessionals follows applicable NCQA, CMS and state and federal requirements and guidelines for MS and MH/SUD providers. The credentialing application process is consistent between M/S and MH/SUD and such required licensing, experience, CAQH application and verifications are distinguishable only by differences in regulatory requirements. No additional Cigna-specific credentialing requirements are applied

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			to either M/S or MH/SUD providers.  Consistency in standards and process evidences compliance with the NQL requirement.
<b>Exclusions for Failure to Complete a Course of Treatment</b>			
<b>Does the plan exclude benefits for failure to complete a course of treatment?</b>	Cigna does not exclude benefits for failure to complete treatment.	Cigna does not exclude benefits for failure to complete treatment.	Cigna does not exclude benefits for failure to complete treatment for M/S or MH/SUD Benefits. Cigna's process is consistent between M/S and MH/SUD, so Cigna does not apply such an NQL to MH/SUD benefits that warrants analysis under the NQL requirement.
<b>Restrictions that Limit Duration or Scope of Benefits for Services</b>			
<b>Does the plan restrict the geographic location in which services can be received? (e.g., service area, within a specific State, within the U.S.)</b>	Cigna has a National Network that includes providers within the United States. Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna has a National Network that includes providers within the United States. Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna's geographic limitations on coverage for services apply uniformly across MH/SUD and M/S benefits.
<b>Does the plan restrict the type(s) of facilities in which enrollees can receive services?</b>	In Network facilities must meet applicable licensing, contracting/credentialing requirements. Services in facilities may need prior authorization and meet our medical necessity guidelines.	In Network facilities must meet applicable licensing, contracting/credentialing requirements. Services in facilities may need prior authorization and meet our medical necessity guidelines.	Cigna standardly covers medically necessary services rendered by licensed and/or certified healthcare providers for the treatment of M/S conditions and MH/SUD conditions. Services determined by Cigna not to be medically necessary would be excluded under the terms of the plan.
<b>Provider Specialties</b>			
<b>Does the plan restrict the types of provider specialties that can provide certain M/S or MH/SUD benefits?</b>	Providers are required to work within the scope of their licenses. No additional restrictions apply.	Providers are required to work within the scope of their licenses. No additional restrictions apply.	Cigna requires providers to work within the scope of their licenses for both M/S and MH/SUD benefits. The process is consistent between M/S and MH/SUD benefits. Cigna does not, in writing or in operation,

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			further restrict provision of MH/SUD benefits to certain types of specialties so long as the rendering provider is acting within the scope of the provider’s license, and, in terms of stringency, Cigna confirms that it does not waive for any M/S providers the requirement that the M/S provider act within the scope of the provider’s license in order for services to be covered.
<b>Network Adequacy</b>			
<b>Explain how the plan ensure the provider network provides sufficient availability of providers within the service area</b>	<p>Cigna establishes and monitors clinically appropriate: (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine outpatient care for the various provider types and/or specialties, as prescribed by NCQA.</p> <p>For both its M/S provider network and its MH/SUD provider network, Cigna establishes and monitors clinically appropriate: (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine</p>	<p>Cigna establishes and monitors clinically appropriate: (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine outpatient care for the various provider types and/or specialties, as prescribed by NCQA.</p> <p>For both its M/S provider network and its MH/SUD provider network, Cigna establishes and monitors clinically appropriate: (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine</p>	<p>Cigna maintains an open network and will contract with any MH/SUD or M/S provider or facility. Cigna does not limit parties with whom it will contract and negotiate rates. The Behavioral Health medical cost budget and M/S cost budgets are established using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally new negotiations are reviewed in order to set budget metrics. Cigna does negotiate rates with parties that represent groups or sets of providers. There is no difference in how this process is handled for MH/SUD vs. M/S providers or representatives. When applicable, Cigna uses the same Consultant Agreement for both MH/SUD and M/S.</p> <p><b>As Written</b></p> <p>Cigna conducts oversight and monitoring of the adequacy of its M/S provider network(s) and MH/SUD provider network to assess whether they are meeting its internal and regulatory driven network</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>outpatient care for the various provider types and/or specialties, as prescribed by NCQA.</p> <p>Assessing supply and demand of M/S facilities, provider types and/or specialties and MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to, NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.</p> <p>Cigna considers the composition of its current M/S network providers by provider type and/or specialty, in addition to census (membership) data, to ensure it maintains an adequate M/S provider network to meet the clinical needs of its customers. Network adequacy analysis considers: geographic area, time/distance standards, provider/enrollee ratio, provider type and/or specialty and supply/demand.</p> <p><b>Ratio of Providers to Customers:</b> Providers to customer ratios are normally calculated with the Provider count constant at 1, where the Provider count is based on unique Provider and the Customer count is based on customer's home zip code. To convert to a ratio in this format, Cigna</p>	<p>outpatient care for the various provider types and/or specialties, as prescribed by NCQA.</p> <p>Assessing supply and demand of M/S facilities, provider types and/or specialties and MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to, NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.</p> <p>Cigna considers the composition of its current M/ MH/SUD network providers by provider type and/or specialty, in addition to census (membership) data, to ensure it maintains an adequate MH/SUD provider network to meet the clinical needs of its customers. Network adequacy analysis considers: geographic area, time/distance standards, provider/enrollee ratio, provider type and/or specialty and supply/demand.</p> <p><b>Ratio of Providers to Customers:</b> Providers to customer ratios are normally calculated with the Provider count constant at 1, where the Provider count is based on unique Provider and the Customer count is based on customer's home zip code. To convert to a ratio in this format, Cigna</p>	<p>access standards. When access to care standards are not met, Cigna engages in active recruitment of the relevant provider type and/or specialty at issue.</p> <p>Enrollees are able to receive assistance in locating a provider or appointment by contacting the phone number on the back of their ID card. In the event the enrollee and/or a Cigna representative cannot locate a provider/appointment within the acceptable time/distance standards a request can be made for out-of-network care at the in-network benefit level for plans without out of network benefits.</p> <p><b>In Operation</b> A review of Cigna's Network Adequacy reports for Cigna's national network revealed sufficient access to M/S and MH/SUD providers. Cigna meets adequacy and accessibility requirements for M/S and MH/SUD providers using comparable standards, with M/S providers subject to more stringent standards.</p> <p>Cigna's Quality Programs and Accreditation team defines quality monitoring standards and provides guidance in initiating improvement initiatives when deficiencies are identified. Quality studies are designed and documented to objectively and systematically monitor, evaluate and improve the quality and appropriateness of care and service. Monitoring and driving improvements in quality of care and service to our customers is an integral component of Behavioral Accreditation, which</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>divides the customer count by the Provider count. For example, for an area with 3,000 customers and 30 Providers, – the ratio would be 1:100.</p> <p>In remote or rural areas, occasionally geographic availability guidelines are not able to be met due to lack of, or absence of, qualified Practitioners and/or Providers. The organization may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval. Annually, the Quality Management team reviews and assesses the behavioral health care professional network to determine if goals are met and if the network is robust enough to meet the needs of its customers. NCQA requires certain measures to assess availability for urban/suburban, rural, and ratios (behavioral health care professional to customers) across its networks. Likewise, the Network team reviews and assesses the medical health care professional network to determine if goals are met in 90% of the zip codes within the service area for each provider specialty category for PCPs, High Volume Specialist, High Impact Specialists, and Hospitals.</p>	<p>divides the customer count by the Provider count. For example, for an area with 3,000 customers and 30 Providers, – the ratio would be 1:100.</p> <p>In remote or rural areas, occasionally geographic availability guidelines are not able to be met due to lack of, or absence of, qualified Practitioners and/or Providers. The organization may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval. Annually, the Quality Management team reviews and assesses the behavioral health care professional network to determine if goals are met and if the network is robust enough to meet the needs of its customers. NCQA requires certain measures to assess availability for urban/suburban, rural, and ratios (behavioral health care professional to customers) across its networks. Likewise, the Network team reviews and assesses the medical health care professional network to determine if goals are met in 90% of the zip codes within the service area for each provider specialty category for PCPs, High Volume Specialist, High Impact Specialists, and Hospitals.</p>	<p>reflects the Cigna commitment to continuous quality improvement throughout the organization.</p> <p>At present, Cigna meets all provider ratio access requirements for Masters Level Clinicians, Psychologist/Nurse Practitioners with prescribing privileges, Physicians, Inpatient Facility and Residential Facility for the MH/SUD Network. Cigna also meets all provider ratio access requirements for adult and pediatric PCP; high volume specialty including cardiology, dermatology, ophthalmology, and orthopedics; and high impact specialty for hematology/oncology, infectious disease, nephrology, neurology and pulmonary. Holistically, when reviewing the current snapshot of both the M/S and MH/SUD networks, Cigna also meets provider access radius requirements. When reviewed individually by state, deficiencies are noted in rural areas such as Alaska, Idaho, Montana, South Dakota and Wyoming in both the M/S and MH/SUD Networks. Lastly, Cigna reviewed the percentages of exceptions for obtaining out-of-network M/S and MH/SUD services at the in-network benefit level to ensure operational parity compliance. Data revealed a significantly larger number of M/S network exceptions denied including both medical necessity and administrative denials than denials of MH/SUD network exceptions.</p>
In-Network Provider Reimbursement			



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>Explain the plan’s reimbursement approach for contracted providers</b>	<p>Cigna's in-network provider reimbursement methodology, exclusive of DRG reimbursement is based upon factors including, but not limited to: geographic market (i.e. market rate and payment type for provider type and/or specialty); type of provider (i.e. hospital, clinic and practitioner) and/or specialty; supply of provider type and/or specialty; network adequacy and current Medicare reimbursement rates.</p> <p><b>Factors and Evidentiary Standards.</b> Factors for reimbursement negotiation include:</p> <ol style="list-style-type: none"><li>1. Geographic market, which may be adjusted based upon Medicare Geographical Practice Cost Index (“GPCI”) Geographic Practice Cost Index (GPCI) reflects the relative cost of practicing in a locality against a national average. Each relative value is multiplied by the corresponding GPCI. The three component factors are then accumulated to arrive at an adjusted amount. This amount is then multiplied by the conversion factor to establish the Medicare full fee schedule amount in the Medicare Physician Fee Schedule Data Base (MPFSDB). CMS performs calculations on the fee schedule, with the exception of carrier-priced procedure codes, and provides fee schedule calculations to the Medicare Administrative Contractors (MACs). Geographic Practice Cost Index is not weighted for purposes of per diem reimbursement;</li><li>2. Type of provider and/or specialty (e.g. physician practitioner v. non-physician practitioner v.</li></ol>	<p>Cigna's in-network provider reimbursement methodology, exclusive of DRG reimbursement is based upon factors including, but not limited to: geographic market (i.e. market rate and payment type for provider type and/or specialty); type of provider (i.e. hospital, clinic and practitioner) and/or specialty; supply of provider type and/or specialty; network adequacy and current Medicare reimbursement rates.</p>	<p>All staff participating in a contract negotiation for M/S and MH/SUD Network Providers and facilities are trained on internal Cigna policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider specific reimbursement requests and escalate for justification and approval of any deviations.</p> <p><b>As Written.</b> Whether for initial negotiation or renegotiation, Cigna's Network Provider reimbursement methodology for MH/SUD and M/S Network Providers are based upon the same array of factors. Re-negotiations of reimbursement rates are conducted according to the terms of the contract, or if not specified in the contract, they are conducted at the request of either party. The number of Network Providers (Individual, Group or Facility) joining or already part of the network does not factor into initial rate offerings. M/S and MH/SUD facilities may be reimbursed per diem, Diagnosis Related Group or case rate. Per diem reimbursement involves a flat dollar amount for each day as reimbursement for the service.</p> <p>Cigna also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. In this process, variables including market demand, provider specialty and availability and frequency of requests</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>facility); Provider types are dependent upon state licensing and credentialing requirements as outlined by the applicable state or NCQA. Cigna does not weight provider types or designate any additional provider and/or specialty designations (e.g. physician practitioner v. non-physician practitioner);</p> <p>3. Supply of provider type and/or specialty. 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. Provider specific or specialty fee schedules are used to retain providers if the providers are needed to meet network access requirements and/or increase membership. Supply of provider type and/or specialty are not weighted in relation to the other evidentiary standards for purposes of per diem reimbursement;</p> <p>4. Network need and/or demand for provider type and/or specialty. Network need and/or demand for provider type or specialty is defined by state adequacy requirements. Cigna contracts with practitioners and providers across all networks and for all product lines to meet the availability and cultural needs and preferences of customers, establishes availability standards and assesses its networks against those standards articulated in Cigna's <i>Measuring Availability of Practitioners and Providers Policy</i>. Need and/or demand for provider type and/or specialty are not weighted in</p>		<p>for provider fee increases may result in differentials in reimbursement rates across M/S and MH/SUD provider types.</p> <p><b>In Operation</b> Whether for initial negotiation or renegotiation, Cigna uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region.</p> <p>Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. Cigna's preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, BH pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested.</p>

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Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>relation to the other evidentiary standards for purposes of per diem reimbursement;</p> <p>5. Training, experience and licensure of providers billing for professional services under the facility agreement. Training, experience and licensure of providers billing for professional services under the facility agreement are not specifically weighted in relation to the other evidentiary standards for purposes of per diem reimbursement;</p> <p>6. Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit (“RVU”). RVUs are the basis of the RBRVS system. Unit values are assigned to each service (CPT code) by area of specialty and for some codes, different RVUs for site of service: facility and non-facility. RVUs are not weighted for per diem reimbursement.</p> <p><b>Medicare Baseline.</b> Cigna utilizes the Medicare Pricing Tool to determine if the provider’s (current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard Medicare Resource Based Relative Value Scale (“RBRVS”), a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a</p>		<p><i>Provider Reimbursement – Outpatient</i> In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff participating in contract negotiation are trained on internal Cigna policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider-specific reimbursement requests and escalate for justification and approval any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting process ensures by policy the consideration of such</p>

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Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>baseline for commercial reimbursement rates. Cigna’s RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually:</p> $[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice RVU} \times \text{Practice GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})] \times \text{Conversion Factor} = \text{Reimbursement}$ <p>RVUs are the basis of the RBRVS system. Unit values are assigned to each service (CPT code) by area of specialty and for some codes, different RVUs for site of service: facility and non-facility. Three components are used to make up a total RVU (1) Physician’s work – This component accounts for the providers time, technical skill, mental effort, and physiological stress; (2) Practice expense – This component includes office rent, wages, supplies, equipment; (3) Malpractice Expense - This component includes professional liability insurance cost. To fill gaps for codes not covered by RBRVS methodology Cigna uses relative values assigned by Optum (Ingenix) for M/S services. Optum (Ingenix), is a third party health data company, that uses the same methodology originally used to develop the values for Medicare covered services. For those services that cannot be valued using a resource- based methodology, values have been developed using alternative</p>		<p>factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies.</p> <p><i>Facility Reimbursement – Inpatient</i> In-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient’s insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc.</p> <p>Cigna's methodology and process for negotiating in-network provider reimbursements for M/S and MH/SUD services within a classification of benefits</p>

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Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>methodologies proprietary to Optum (Ingenix). In an RBRVS calculation, each component of an RVU is multiplied by its GPCI then totaled and multiplied by the conversion factor to determine the fee or payment. Cigna uses the same GPCIs as Medicare. There are approximately 89 GPCIs. Cigna uses Optum (Ingenix) values to fill gaps for codes not covered by RBRVS methodology</p> <p>Facility rate categories are industry standard with the market and economy dictating rates for both M/S and MH/SUD facilities. Cigna utilizes Medicare’s resource-based relative value scale (RBRVS) calculation (OP- BH &amp; Med). This calculation is premised on the principle that payments for services should vary with the resource cost for providing the services. In each instance, the fee schedule is separately reviewed and negotiated.</p> <p>DRG reimbursement is based upon Medicare DRG calculations, which assign payment levels to each DRG based on the average cost of treatment. Case rates, also referred to as <i>flat rates</i>, describe a reimbursement structure in which providers receive a flat reimbursement rate for every patient visit, regardless of the service (most often utilized in urgent care). Cigna does not determine or mandate the reimbursement type; selection of reimbursement type is determined by the facility. Generally, M/S facility providers request DRG reimbursement, while</p>		<p>are comparable and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. Cigna also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, Cigna’s Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across M/S and MH/SUD provider types.</p> <p>An ‘in operation” review of Cigna’s M/S and MH/SUD reimbursement rates from a sampling of Cigna-administered plans revealed that M/S providers are reimbursed on average at a higher percentage of Medicare than MH/SUD providers. While there is a disparate outcome in the in-operational review of Cigna’s M/S and MH/SUD reimbursement rates that results from differences in local market dynamics, such outcome does not mean the in-practice NQTL standards are non-comparable or being applied more stringently to MH/SUD benefits. Because in-network provider reimbursement is a factor relevant to NQTL compliance insofar as it impacts accessibility to in-</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
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Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>MH/SUD facility providers request per diem reimbursement. More than 90% of MH/SUD Provider Network contracts reflect per diem reimbursement. The evidentiary factors taken into consideration in the negotiation of the per-diem rate are not weighted or prioritized one more than the other; however, additional consideration may be given to meet network adequacy standards.</p> <p>For DRG reimbursement, weighting is not calculated within the contract or at the time of contract rate negotiation, but instead occurs at the time of payment as DRG reimbursement is dependent on a variety of variable factors such as patient age and diagnosis. When behavioral contracts at a per diem rate, the population and type of care are distinguished in the contract and rates are negotiated separately. Cigna utilizes CMS grouping software (Optum) that takes the information from the claim and “groups it” into the correct DRG. Then that DRG information is used to calculate the reimbursement, based on the factor in the contract; by way of example: DRG 203 has a factor 17; CMS DRG weight x contracted factor = reimbursement.</p>		<p>network providers and Cigna's network admissions criteria, itself the relevant NQTL, Cigna emphasizes that the comparable out-of-network utilization over the recent measurement period across MH/SUD and M/S benefits and the achievement of applicable network adequacy requirements for MH/SUD and M/S providers, respectively, evidences that any discrepancies in rates offered to MH/SUD providers is not affecting Cigna's ability to admit a sufficient number of providers.</p>
Restrictions on Provider Billing Codes			



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Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>Explain any restrictions the plan places on provider billing codes</b>	<p>Cigna does not place restrictions on provider billing codes or place restrictions on M/S providers that would limit the scope of their practice.</p> <p>Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes or applicable Centers for Medicare &amp; Medicaid Services (CMS) medical reporting code requirements. Appropriate billing instructions are set forth in the provider’s contract.</p>	<p>Cigna does not place restrictions on provider billing codes or place restrictions on MH/SUD providers that would limit the scope of their practice.</p> <p>Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes or applicable Centers for Medicare &amp; Medicaid Services (CMS) medical reporting code requirements. Appropriate billing instructions are set forth in the provider’s contract.</p>	<p>Cigna requires claims to be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes for both M/S and MH/SUD providers. Cigna does not place any additional restrictions on provider billing codes for M/S or MH/SUD.</p> <p>Consistency in provider billing process evidences compliance with the NQTL requirement that the medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services.</p>
<b>Restrictions on Provider Specialty</b>			
<b>Explain any restrictions the plan places on services provided by specialty providers.</b>	<p>Cigna does not place any restrictions on provider</p>		
<b>Post Claim Payment Retrospective Review (Fraud, Waste and Abuse)</b>			
<p>Cigna maintains corporate-wide policies applicable to multiple business segments including Cigna Healthcare (M/S) and Behavioral Health (MH/SUD), and policies applicable to specific business segments only. Cigna defines Post-Payment Retrospective Review as its medical necessity review of a claim after a service has already been provided and after the claim for that service has already been paid.</p>	<p>Cigna does not routinely impose post payment medical necessity review on a retrospective basis. All M/S and MH/SUD services and providers are subject to fraud, waste and abuse compliance.</p> <p>Cigna Healthcare and Evernorth Behavioral Health maintain one Anti-Fraud Plan and one Special Investigations Unit (“SIU”), which is part of the Corporate Audit Department. SIU is responsible for anti-fraud detection and investigation, prepayment saving and post payment recovery services.</p>	<b>Same as Medical/Surgical</b>	<b>As written:</b> While Cigna maintains that the SIU’s programs do not constitute NQTLs because they do not in any way limit benefits, the overall process for identifying potentially fraudulent claims is identical for both MH/SUD and M/S services. As made clear in Cigna policies, different approaches may be taken for certain types of benefits that reflect the variance in the manner in which fraud, waste, and abuse might occur in any given setting. For example, overbilling related to IOP might be investigated in a manner that

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>The only instance in which a post-claim payment retrospective review might occur would be the result of application of the protocols implemented by Cigna's SIU program, which serves, as relevant here, to identify and prevent the payment of fraudulent claims. Only those benefits that are flagged through an SIU program, which are generally agnostic to whether the benefit is MH/SUD or M/S, would be subject to retrospective review to determine whether fraud was involved. Importantly, Cigna does not believe that its SIU program constitutes an NQTL because the program does not in any way limit the duration or scope of benefits that are available under the plan.</p> <p>To the extent fraud, waste, or abuse is identified and any overpayments are recovered, this is entirely outside the terms and conditions of the plan or coverage. By definition, this cannot be an NQTL, which is broadly defined as a limitation on benefits under the plan. Nevertheless, Cigna has prepared this NQTL comparative analysis to describe its Post-Payment Retrospective Review program, and therefore its SIU program.</p> <p>Cigna does not incorporate language related to fraud detection in its certificate or benefits booklet. There are no terms related to post-claim payment retrospective review contained in the GSA. Information related to Health Care Fraud is posted</p>		<p>differs from the way in which non-routine laboratory work is investigated.</p> <p><b>In Operation:</b> Cigna applies general policies without regard to whether a given service is a MH/SUD or M/S service. Cigna has developed specific written policies governing the investigation of substance use disorder benefits and laboratory services where potentially fraudulent activity is commonly reported. In operation, the SIU has investigated a significantly larger number of potentially fraudulent M/S claims as compared to MH/SUD claims.</p> <p>As noted herein, Cigna applies the same general principals to identifying and investigating potentially fraudulent claims behavior by providers and facilities without regard to whether the provider or facility is MH/SUD or M/S. The operation of Cigna's SIU, which results in retrospective review of claims, is identical for both MH/SUD and M/S services and therefore meets the comparability requirement. In operation, the SIU program is applied no more stringently to MH/SUD benefits as it is to M/S benefits, as evidenced by the significantly higher number of claims investigated for M/S services as compared to MH/SUD services.</p> <p>Cigna maintains that detection of fraud, waste, or abuse and claims overpayment recovery is outside the scope of MHPAEA and its NQTL requirements because these things are outside the scope of covered</p>

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Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>online including how to report health care fraud on the Cigna website: <a href="https://www.cigna.com/legal/members/report-fraud">https://www.cigna.com/legal/members/report-fraud</a>.</p> <p><b>Factors</b> The SIU provides anti-fraud detection and investigation, pre-payment savings, and post-payment recovery services. As part of Cigna’s corporate audit department, the SIU actively detects, investigates, and deters fraud. The SIU performs the following activities:</p> <ul style="list-style-type: none"><li>• conducting investigations and analyzing cases to determine the scope of potential fraud</li><li>• flagging health care providers/facilities/members in claim systems to ensure payments suspected of fraud are addressed prior to releasing funds</li><li>• obtaining evidence for referrals to law enforcement, regulatory agencies, and associations</li><li>• pursuing civil recoveries</li><li>• delivering anti-fraud training and communicating current fraud schemes to Cigna employees</li><li>• using advanced technology and data-mining techniques to identify suspect behavior or patterns of possible fraudulent providers/facilities</li><li>• serving as a founding member of the National Health Care Anti-Fraud Association (NHCAA), an organization made up of health care experts from the public and private sectors</li><li>• partnering with the Health Insurance Counter</li></ul>		<p>benefits under the plan, and NQTLs by definition only limit valid benefits under the plan. However, to the extent fraud, waste, and abuse detection and claims overpayment recovery could be considered an NQTL, Cigna concludes that the SIU process nevertheless meets the requirements of the NQTL rule in MHPAEA.</p>



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	<p>Fraud Group, which includes participants from 32 health insurance companies to prevent and detect health care fraud</p> <ul style="list-style-type: none"><li>working with clients and members who inform us of discrepancies that may reveal potential fraud</li></ul> <p>The SIU works in partnership with dedicated resources within our claim, legal, and clinical management teams to establish guidelines and controls to assist in the fight against fraud and abuse. While the SIU leads Cigna’s anti-fraud activities, its efforts are complemented by almost two million individual standards-based (e.g., National Correct Coding Initiative, CMS) claim edits incorporated as a part of the claim payment process and by multiple targeted prepayment programs to address areas of potential risk (DRGs, implantable devices, complex claims, and specialties).</p> <p><b>Evidentiary Standards</b> SIU relies on the following definitions:</p> <ul style="list-style-type: none"><li>Fraud: Knowingly and wilfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretences, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.</li><li>Waste: Practices that, directly or indirectly, result in unnecessary costs to the underlying health plan, such as overusing services. Waste is</li></ul>		



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
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Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>generally considered a misuse of resources.</p> <ul style="list-style-type: none"><li>Abuse: Actions that may, directly or indirectly, result in unnecessary costs such as paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.</li></ul> <p>Cigna does not establish thresholds for any one of these factors but instead utilizes analytics to identify areas of risk and those areas are analyzed for potential investigation. Analytics assess risk to the portfolio and risk to individual clients. SIU also maintains a fraud hotline and all referrals to the hotline or similar intake capability are assessed.</p>		



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<b>Cigna Health and Life Insurance Company (CHLIC)</b>	<b>Last Revised:</b> January 10, 2023
<b>Health Plan Products:</b> Indemnity	<b>Prescription Drug Coverage:</b> Yes
<b>Utilization Management Model:</b> Inpatient & Outpatient	<b>Funding Types:</b> Insured & Self-Funded

<b>Non-Quantitative Treatment Limitation (NQTL)</b>	<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>	<b>Comparative Analysis Conclusions</b>
<b>Medical Necessity</b>			
All M/S and MH/SUD services must be medically necessary. Services determined by Cigna not to be medically necessary would be excluded under the terms of the plan unless otherwise dictated by regulatory requirement or specific plan design.	<p>Cigna Health Management, Inc., an affiliate of CHLIC performs utilization reviews for most medical/surgical (M/S) benefits. A separate entity, eviCore, reviews certain M/S services for Cigna, American Specialty Health, reviews physical therapy and occupational therapy on behalf of CHLIC and both national and regional vendors to perform UM. All entities adhere to Cigna’s policies and procedures when performing utilization reviews, and all of the data provided is inclusive of utilization reviews of certain M/S services.</p> <p>Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna’s standard definition of “medical necessity” is as follows:</p>	<p>Evernorth Behavioral Health (“Evernorth,” “EBH” or “Behavioral Health” formerly Cigna Behavioral Health) an affiliate of CHLIC, performs utilization reviews for MH/SUD benefits. No separate entities review MH/SUD services for CHLIC.</p> <p>Cigna employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna’s standard definition of “medical necessity” is as follows:</p> <p><b>“Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that</p>	<p>A review of Cigna’s written policies and processes reveals the comparable application of Medical Necessity to M/S and MH/SUD services within the applicable benefit classification. Cigna’s Medical Necessity coverage policy development and application process is consistent between M/S and MH/SUD. Cigna applies comparable evidence-based guidelines to define established standards of effective care in both M/S and MH/SUD benefits. Compliance is further demonstrated through Cigna’s uniform definition of Medical Necessity for M/S and MH/SUD benefits. Consistency in policy development, process and application evidences compliance with the NQTL requirement that the medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services.</p> <p><b><i>Peer to Peer Review Variation</i></b></p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
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Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p><b>“Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services,</li></ul>	<p>are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. 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.</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. 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.</li></ul>	<p>With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, Cigna ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee’s clinical situation warrants an approval for medically necessary care yet the provider’s request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials.</p> <p>Cigna’s medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and Cigna’s Clinical Coverage policies and plan documents approved for use in care management determinations. Cigna’s Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and Cigna’s Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care</p>

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	<p>supplies, medications or settings when determining least intensive setting.</p> <p>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.</p> <p>In determining whether health care services, supplies, or medications are Medically Necessary, the Cigna Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies 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.”</p> <p><b>Development of Clinical Criteria</b> Cigna utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of M/S services, procedures, devices, equipment, imaging, diagnostic interventions and its own internally developed Coverage Policies and the MCG™ Care Guidelines.</p> <p>The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines</p>	<p>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.</p> <p>In determining whether health care services, supplies, or medications are Medically Necessary, the Cigna Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies 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.”</p> <p><b>Development of Clinical Criteria</b> Cigna utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of MH services, procedures, devices, equipment, imaging, diagnostic interventions and the ASAM criteria for conducting medical necessity reviews of SUD services.</p> <p>The Medical Technology Assessment Committee (MTAC) 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,</p>	<p>where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer.</p> <p>The Peer-to-Peer review is available for any coverage request for which Cigna anticipates issuing a denial Cigna incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a Cigna clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the Cigna Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the Cigna Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the Cigna clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request.</p> <p>If Cigna’s pro-active, <i>volunteer</i> Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or</p>

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	<p>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 M/S services determined to be experimental and investigational.</p> <p>Clinical coverage policies 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.</p> <p>While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies.</p> <p>Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to</p>	<p>devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address MH/SUD services determined to be experimental and investigational.</p> <p>Clinical coverage policies 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.</p> <p>While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies.</p> <p>Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.</p>	<p>discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. Cigna's pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to Cigna.</p> <p>Cigna has not identified any additional discrepancies in operational policies between MH/SUD and M/S benefits where the discrepancies present a comparability or stringency problem within the context of the NQL requirement. Instances where discrepancies between the process of administering MH/SUD and M/S benefits do not present an NQL issue include, for example, situations where a discrepancy in process is <i>more</i> advantageous to the administration of MH/SUD benefits than M/S benefits such as the pro-active behavioral health peer-to-peer review process outlined herein. The Peer-to-Peer analysis is addressed in the "in operation" section of this submission set forth below.</p> <p>Cigna regularly reviews utilization management data to evaluate and ensure operational compliance of the medical management suite of NQLs, including Medical Necessity and Appeals, Prior Authorization</p>

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Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>revise its coverage policies governing reviews of MH/SUD benefits.</p> <p><b>Factors</b> Cigna maintains medical necessity criteria (also referred to as clinical criteria) for all medical health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG or are developed by Cigna from the comparison of national, scientific and evidenced based criteria sets. Cigna's Medical Technology Assessment Committee ("MTAC") reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. Cigna reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process.</p> <p>Cigna requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all M/S benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the</p>	<p><b>Factors</b> Cigna maintains medical necessity criteria (also referred to as clinical criteria) for all behavioral health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG, the American Society of Addiction Medicine ("ASAM") or are developed by Cigna from the comparison of national, scientific and evidenced based criteria sets. Cigna's Medical Technology Assessment Committee ("MTAC") reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. Cigna reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process.</p> <p>Cigna requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all MH/SUD benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the</p>	<p>and Concurrent Review. Data is reviewed by benefit classification and sub-classification to calculate denial rates to ensure comparability. Cigna's application of the medical necessity</p> <p>NQTL, specifically approvals and denials rates, for Prior Authorization, Retrospective Review, and Concurrent Review across benefit classifications for a sampling of Cigna plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits for the Cigna book of business including all commercial data Medical Necessity denial rates.</p> <p>Cigna utilizes appeals data to review the number of utilization review decisions across the book-of-business. Appeals data is delineated by pre and post services and includes prior authorization and concurrent review, overturned for the same time period relating to the utilization management data metrics included in Cigna's book of business data. Data reflected overall comparable overturn rates across benefit classifications. The sample size for Georgia specific data did not allow for a statistically significant sample for appeals.</p> <p>While the rate of appeals, where the original denial for lack of medical necessity was upheld, is higher for MH/SUD than for M/S claims for the Cigna book of business. This appeal rate, coupled with the utilization management data reflecting higher Medical Necessity</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.</p> <p><b>Sources and Evidentiary Standards</b> The use of the various guidelines for clinical criteria/medical necessity (both external and internal) <u>do not overlap</u> and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific Cigna medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee ("MTAC"), 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.</p> <p>MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists.</p>	<p>reviewed, evidence-based scientific literature or guidelines.</p> <p><b>Sources and Evidentiary Standards</b> The use of the various guidelines for clinical criteria/medical necessity (both external and internal) <u>do not overlap</u> and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific Cigna medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee ("MTAC"), 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.</p> <p>MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists.</p>	<p>denial rates for M/S claims than for MH/SUD claims is representative of Cigna's proactive approach to peer-to-peer review. Approximately 37% of all pre-service MH/SUD peer-to-peer reviews inclusive of read only reviews, which includes a Medical Director review of the medical file without discussion when a peer-to-peer is scheduled but the requesting provider does not attend, in Cigna's book-of-business data resulted in approvals that may have otherwise have resulted in a medical necessity denial.</p> <p>Additionally, Cigna conducts routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) testing is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Corrective action is initiated if a score falls below 85% and if the results are below 90% the Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.</p> <p>The number of utilization review decisions across the Cigna book of business data, reflects comparable average denial rates based upon Medical Necessity across all benefit classifications for utilization management programs including prior authorization, concurrent review and retrospective review with</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>The Cigna-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the “Behavioral Health” clinicians listed in the “Coverage Policy SME” tab – consulted when drafting or reviewing coverage policies).</p> <p>The MTAC’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna’s Medical Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48):</p>	<p>The Cigna-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the “Behavioral Health” clinicians listed in the “Coverage Policy SME” tab – consulted when drafting or reviewing coverage policies).</p> <p>The MTAC’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna’s Medical Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48) :</p>	<p>medical necessity denials for M/S services on average higher than medical necessity denials of MH/SUD services. A review was completed with Georgia data across all benefit classifications and medical necessity denials for M/S services were on average higher than medical necessity denials of MH/SUD services. While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement.</p> <p>Cigna concludes the Medical Necessity NQTL is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. In performing the ‘as written’ comparative analysis Cigna reviewed applicable policies, processes and procedures to ensure comparability of the application of Medical Necessity to M/S and MH/SUD services which revealed the application of Medical Necessity to be applied to MH/SUD services no more stringently than M/S Services. In performing the operational analysis of the application of UM, Cigna reviewed denial rates for both M/S and MH/SUD within each classification of benefits and for benefits subject to prior authorization, concurrent review, and retrospective review.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p> <p>The MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD</p>	<p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p> <p>The MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes.</p> <p><b>Medical Necessity Appeals</b> Cigna uses the same factors, sources and evidentiary standards applicable to the medical necessity NQL for the Medical Necessity Appeals.</p> <p><b>Internal Appeals.</b> Cigna follows the same internal appeal process for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits for both M/S and MH/SUD. For medical necessity reviews a second health care professional, who was not involved in any previous decision and is not a subordinate of the individual in the previous decision, performs an appeal, whether expedited or standard.</p> <p>Expedited appeals are completed within 72 hours. Standard level 1 and level 2 pre-service medical necessity appeals are completed within 15 calendar days and standard post-service level 1 and level 2 medical necessity appeals are completed within 30 calendar days, post-service administrative appeals are completed within 30 calendar days. The assigned appeal processor notes the adverse determination as a denial in our system and communicates the determination by phone to the requesting party if the appeal was handled as expedited. At each step in the process, Cigna provides written notification of the</p>	<p>health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes.</p> <p><b>Medical Necessity Appeals</b> Cigna uses the same factors, sources and evidentiary standards applicable to the medical necessity NQL for the Medical Necessity Appeals.</p> <p><b>Internal Appeals.</b> Cigna follows the same a single-level internal appeal process for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits for both M/S and MH/SUD. For medical necessity reviews a second health care professional, who was not involved in any previous decision and is not a subordinate of the individual in the previous decision, performs an appeal, whether expedited or standard.</p> <p>Expedited appeals are completed within 72 hours. Standard level 1 and level 2 pre-service medical necessity appeals are completed within 15 calendar days and standard post-service level 1 and level 2 medical necessity appeals are completed within 30 calendar days, post-service administrative appeals are completed within 30 calendar days. The assigned appeal processor notes the adverse determination as a denial in our system and communicates the determination by phone to the requesting party if the appeal was handled as expedited. At each step in the process, Cigna provides written notification of the</p>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>outcome and resolution, including the clinical rationale for the determination to the member and the treating provider or facility.</p> <p><b>External Appeals.</b> Cigna informs customers of their right to request an external appeal to an IRO, at no cost to the Customer, in the final internal appeal denial letter for both M/S and MH/SUD external appeals. The communication provides the Customer with all information regarding the right of appeal, applicable time limitations and specific instructions on the initiation of an appeal by the Customer or the Customer’s designate. The National Appeals Organization will facilitate the appeal through the provision of program information and IRO program description.</p> <p>All records and materials relevant to the adverse determination and included in the previous appeal files are presented for review to an Independent Review Organization (IRO). New information and documentation submitted with the external review request is forwarded to the IRO to consider. The decision of the IRO is final and is binding on us and the plan. Relevant portions of the Customer’s contract (e.g., Certificate of Coverage, Summary Plan Description) are included in the materials for external review. The IRO will render a decision without deference to the previous decisions. Standard external appeals are completed within 45 days and expedited external appeals are completed within 72 hours.</p>	<p>outcome and resolution, including the clinical rationale for the determination to the member and the treating provider or facility.</p> <p><b>External Appeals.</b> Cigna informs customers of their right to request an external appeal to an IRO, at no cost to the Customer, in the final internal appeal denial letter for both M/S and MH/SUD external appeals. The communication provides the Customer with all information regarding the right of appeal, applicable time limitations and specific instructions on the initiation of an appeal by the Customer or the Customer’s designate. The National Appeals Organization will facilitate the appeal through the provision of program information and IRO program description.</p> <p>All records and materials relevant to the adverse determination and included in the previous appeal files are presented for review to an Independent Review Organization (IRO). New information and documentation submitted with the external review request is forwarded to the IRO to consider. The decision of the IRO is final and is binding on us and the plan. Relevant portions of the Customer’s contract (e.g., Certificate of Coverage, Summary Plan Description) are included in the materials for external review. The IRO will render a decision without deference to the previous decisions. Standard external appeals are completed within 45 days and expedited external appeals are completed within 72 hours.</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>Prior Authorization/Pre-Certification Review</b>			
<b>Process – Include all services for which prior authorization/pre-certification review is required. Describe any step-therapy or “fail first” requirements and requirements for submission of treatment request forms or treatment plans.</b>			
<b>Inpatient</b>  Prior Authorization is applied to all non-emergent inpatient benefits, including residential services. The MH/SUD and M/S services assigned to the inpatient classification include non-emergent MH/SUD and M/S services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other facility and non-emergent MH/SUD services. This specifically includes, for MH/SUD and M/S benefits.  <b>M/S Inpatient Services :</b> <ul style="list-style-type: none"><li>Acute Inpatient Services,</li><li>Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc.</li><li>Inpatient Professional Services</li></ul> <b>MH/SUD Inpatient Services:</b>	<b>Inpatient Services Subject to Prior Authorization</b>  All non-emergent M/S inpatient services are subject to pre-service medical necessity review (i.e., prior authorization, precertification review (PCR).  <b>Process</b> For a service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. If the request cannot be authorized using an approved algorithm, the case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the clinical information and determines	<b>Inpatient Services Requiring Prior Authorization</b>  All non-emergent MH/SUD inpatient services are subject to pre-service medical necessity review (i.e., prior authorization, precertification review (PCR).  <b>Process</b> For a service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. . If the request cannot be authorized using an approved algorithm, t the case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating	Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria.  A review of Cigna’s written policies and processes reveals the comparable process by which MH/SUD and M/S services are selected for application of prior authorization within the applicable benefit classification the evidences comparability and equivalent stringency in-writing and in-operation.  First, a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD services shall be subject to prior authorization or concurrent review. To the extent any MH/SUD services within the inpatient or outpatient classifications are considered for inclusion on the “precertification list” a Cigna-employed Medical Director with former practice experience as a

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<ul style="list-style-type: none"><li>• Mental Health Acute Inpatient Services</li><li>• Mental Health Subacute Residential Treatment</li><li>• Mental Health Inpatient Professional Services</li><li>• SUD Acute Inpatient Services</li><li>• SUD Acute Inpatient Detoxification</li><li>• SUD Subacute Residential Treatment</li><li>• SUD Inpatient Professional Services</li></ul> <p>No MH/SUD inpatient benefits are subject to fail-first and/or step therapy requirements.</p>	<p>whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e., peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S or MH/SUD inpatient days upon pre-service review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna (clinical appropriateness) the value of the service exceeds the administrative costs, and verification that a service will be rendered for a covered benefit.</p> <p>All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification based upon high cost, high risk and complexity for members receiving the service.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Internal claims data</li><li>• UM program operating costs</li><li>• UM authorization data</li></ul>	<p>provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e., peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S or MH/SUD inpatient days upon pre-service review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna (clinical appropriateness) the value of the service exceeds the administrative costs, and verification that a service will be rendered for a covered benefit.</p> <p>All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification based upon high cost, high risk and complexity for members receiving the service.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Internal claims data</li><li>• UM program operating costs</li></ul>	<p>psychiatrist and expertise in, and dedicated support for, behavioral health matters is consulted to ensure appropriate evaluation of MH/SUD services that may be considered for application of prior authorization and concurrent review.</p> <p>Cigna's MTAC – which includes representation across a number of disciplines, including MH/SUD expertise – approves any implementation of, or changes to, coverage policies used to make medical necessity determinations to ensure the appropriateness of the same. The inclusion of appropriate representation of MH/SUD expertise in the coverage policy development process ensures that coverage policies for MH/SUD benefits appropriately incorporate generally-accepted standards of practice, including consideration of type or duration of treatment or level of care for patients with specific MH/SUD conditions.</p> <p>Comparable representation of expertise in MH/SUD services is therefore ensured to the extent any MH/SUD benefits may be considered for inclusion on the precertification list, thus ensuring comparable reviews of MH/SUD benefits. Moreover, the list of services subject to prior authorization and concurrent review is reviewed no less frequently than annually to determine if any services, whether MH/SUD or M/S, should be removed or added to the list, so the frequency of review of the continued appropriateness</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>Expert Medical Review</li><li>Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b> The evidentiary standard relied on to determine whether to apply prior authorization to inpatient M/S 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 M/S 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:</p> <ul style="list-style-type: none"><li>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.</li><li>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</li></ul>	<ul style="list-style-type: none"><li>UM authorization data</li><li>Expert Medical Review</li><li>Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b> The evidentiary standard relied on to determine whether to apply prior authorization to inpatient MH/SUD 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 MH/SUD 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:</p> <ul style="list-style-type: none"><li>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.</li><li>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</li></ul>	<p>of application of prior authorization is comparable across MH/SUD and M/S benefits.</p> <p>Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the prior authorization list. Because the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization).</p> <p>An “in operation” review of Cigna’s application of the Prior Authorization NQL, specifically approvals and denial information, in the In-Patient classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business data. A review was completed with Georgia data for the In-patient classification and revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQL compliance, and an insurer may comply with the NQL requirement notwithstanding a disparate outcome for an NQL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQL requirement. Consequently,</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>informed by costs/expenses such as personnel salaries and time.</p> <p>Clinical Appropriateness is defined as those services that as determined in the exercise of the professional judgement of Cigna’s internal medical experts, are in accordance with generally accepted standards of care and nationally recognized guidelines. Nationally recognized guidelines are included in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 as outlined in the development of clinical criteria of Medical Necessity.</p>	<p>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.</p> <p>Clinical Appropriateness is defined as those services that as determined in the exercise of the professional judgement of Cigna’s internal medical experts, are in accordance with generally accepted standards of care and nationally recognized guidelines. Nationally recognized guidelines are included in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 as outlined in the development of clinical criteria of Medical Necessity.</p>	<p>Cigna concludes that the NQL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>Cigna also reviewed the ROIs for both MH/SUD and M/S non-emergent inpatient admissions. For the purposes of the ROI calculation, the estimated costs to perform a coverage review, which is informed by costs/expenses for personnel salaries and time to review. Cigna reviewed the ROI for both M/S and MH/SUD non-emergent inpatient admissions. M/S services for non-emergent inpatient admissions calculated at 9:1 for 2019, 8:0 for 2020 and 10:1 for partial year 2021 and ROIs for MH/SUD services for non-emergent inpatient admissions calculated at 2.93:1 for 2019, 2.05:1 for 2020 and 2.03:1 for partial year 2021 respectively. These calculations are consistent with the factor/evidentiary standard outlined in Steps 2 and 3, namely that the application of prior authorization to inpatient M/S benefits produces a positive savings for both MH/SUD and M/S benefits, as measured in the aggregate across the Cigna-administered book-of-business. To be clear, if the number preceding the colon is greater than 1 (e.g., 2.93), then the application of prior authorization produces a positive ROI and thus meets the evidentiary standard for application of the same to MH/SUD or M/S inpatient benefits.</p> <p>The process by which services are considered for application of Prior Authorization is comparable in</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			writing and in operation across MH/SUD and M/S benefits, as evidenced by Cigna’s assessment of several components of the prior authorization determination process in the overall context of its utilization management programs.
<b>Outpatient Office Visits</b>	<b>Not Applicable.</b>	<b>Not Applicable.</b>	Cigna sub-classifies the outpatient benefit classification into Outpatient-Office Visit and Outpatient-All Other for MH/SUD and M/S benefits. The Prior Authorization NQTL does not apply to MH/SUD or M/S services assigned to the Outpatient-Office Visits sub-classification.
<b>All Other Outpatient Services</b>  The Prior Authorization NQTL is applied to certain Outpatient-All Other MH/SUD and M/S services sub-classification including:  <b>M/S Outpatient-All Other Services</b> 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)	<b>All Other Outpatient Services Subject to Prior Authorization</b>  The Prior Authorization NQTL is applied to certain Outpatient M/S services in the All Other sub-classification (typically those subject to higher cost and/or utilization).  <b>Process</b> For an All Other Outpatient service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an outpatient service electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the outpatient service requested, he/she	<b>All Other Outpatient Services Subject to Prior Authorization</b>  The Prior Authorization NQTL is applied to certain Outpatient MH/SUD services in the All Other sub-classification (typically those subject to higher cost and/ or utilization).  <b>Process</b> For an All Other Outpatient service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an outpatient service electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the outpatient service requested, he/she	Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria.  <b>As Written</b> A review of Cigna’s written policies and processes reveals the comparable process by which MH/SUD and M/S services are selected for application of prior authorization within the applicable benefit classification the evidences comparability and equivalent stringency in-writing and in-operation.  First, a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
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)	<p>authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the outpatient service at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the outpatient service at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Pre-Certification List</b> Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.</p> <p>When determining which M/S All Other Outpatient benefits are subject to pre-service medical necessity review (prior authorization/ precertification), Cigna conducts at least annually, a Precertification Code Review Procedure by the Total Health and Network Operations and Medical Economics Coverage Policy, Precertification Team (“Precertification Team”).</p>	<p>authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the outpatient service at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the outpatient service at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Pre-Certification List.</b> Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.</p> <p>When determining which MH/SUD All Other Outpatient benefits are subject to pre-service medical necessity review (prior authorization/precertification), Cigna conducts at least annually, a Precertification Code Review Procedure by the Total Health and Network</p>	<p>services shall be subject to prior authorization or concurrent review. To the extent any MH/SUD services within the inpatient or outpatient classifications are considered for inclusion on the “precertification list” a Cigna-employed Medical Director with former practice experience as a psychiatrist and expertise in, and dedicated support for, behavioral health matters is consulted to ensure appropriate evaluation of MH/SUD services that may be considered for application of prior authorization and concurrent review.</p> <p>Cigna's MTAC – which includes representation across a number of disciplines, including MH/SUD expertise – approves any implementation of, or changes to, coverage policies used to make medical necessity determinations to ensure the appropriateness of the same. The inclusion of appropriate representation of MH/SUD expertise in the coverage policy development process ensures that coverage policies for MH/SUD benefits appropriately incorporate generally-accepted standards of practice, including consideration of type or duration of treatment or level of care for patients with specific MH/SUD conditions.</p> <p>Comparable representation of expertise in MH/SUD services is therefore ensured to the extent any MH/SUD benefits may be considered for inclusion on the precertification list, thus ensuring comparable reviews of MH/SUD benefits. Moreover, the list of</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>MH/SUD Outpatient-All Other Services</b> Partial Hospitalization Applied Behavior Analysis (ABA) Transcranial Magnetic Stimulation	<p>Precertification Team workgroup leaders include Coding Team Supervisors, the Total Health and Network Operations (“THN”) Medical Director and ad hoc members including Cigna Medical Directors and subject matter expertise with the ability to exercise professional judgement. The Precertification Team makes a final recommendation to the THN medical and clinical leadership, a final determination is made and the Precertification List is updated, operationalized and provider notifications are communicated.</p> <p><b>Factors</b> 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 <i>first</i>, then a Return on Investment (“ROI”) threshold must be established for the service to be subject to prior authorization/concurrent review.</p> <p>The factors used to determine that the Prior Authorization NQTL will apply to either M/S benefits in the Outpatient All Other benefit classifications is</p>	<p>Operations and Medical Economics Coverage Policy, Precertification Team (“Precertification Team”). Precertification Team workgroup leaders include Coding Team Supervisors, the Total Health and Network Operations (“THN”) Medical Director and ad hoc members including Cigna Medical Directors and subject matter expertise with the ability to exercise professional judgement. The Precertification Team makes a final recommendation to the THN medical and clinical leadership, a final determination is made and the Precertification List is updated, operationalized and provider notifications are communicated.</p> <p><b>Factors</b> 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 <i>first</i>, then a Return on Investment (“ROI”) threshold must be established for the service to be subject to prior authorization/concurrent review.</p> <p>The factors used to determine that the Prior</p>	<p>services subject to prior authorization and concurrent review is reviewed no less frequently than annually to determine if any services, whether MH/SUD or M/S, should be removed or added to the list, so the frequency of review of the continued appropriateness of application of prior authorization is comparable across MH/SUD and M/S benefits.</p> <p>Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the prior authorization list. The factor and its accompanying evidentiary standard used to determine whether prior authorization will apply to an outpatient service pursuant to the processes described herein, namely the ROI metric, is likewise uniform for MH/SUD and M/S benefits.</p> <p><b>In Operation</b> An “in operation” review of Cigna’s application of the Prior Authorization NQTL, specifically approvals and denial information, in the Outpatient All Other classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. A review was completed with Georgia data for the Out-patient All Other classification and revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• 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.</li><li>• Expert Medical Review</li><li>• Input from national vendors</li><li>• Medical Economics biannual provider and facility analyses report for codes not included on precertification list</li><li>• Nationally recognized evidence-based guidelines and CMS and HCPS updates</li><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li><li>○ American Formulary Association (AFA) publication of codes</li><li>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</li></ul></li></ul>	<p>Authorization NQTL will apply to either MH/SUD benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• 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.</li><li>• Expert Medical Review</li><li>• Input from national vendors</li><li>• Medical Economics biannual provider and facility analyses report for codes not included on precertification list</li><li>• Nationally recognized evidence-based guidelines and CMS and HCPS updates</li><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li><li>○ American Formulary Association (AFA) publication of codes</li></ul></li></ul>	<p>Cigna reviewed the ROIs for both MH/SUD and M/S outpatient services subject to prior authorization/concurrent review and confirmed that the MH/SUD outpatient services subject to prior authorization/concurrent review revealed sufficiently positive ROIs to warrant continued application of prior authorization/concurrent review without further consideration.</p> <p>Cigna regularly reviews utilization management data to evaluate and ensure operational compliance of the NQTL as referenced in the Medical Necessity Section of this document. Data is reviewed by benefit classification and sub-classification to calculate denial rates to ensure comparability. Cigna’s application of the medical necessity NQTL, specifically approvals and denials rates for Concurrent Review across benefit classifications for a sampling of Cigna plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits.</p> <p>In the outpatient benefit classification, including the All Other sub-classification, denial rates for MH/SUD had a less than 2 percentage point deviation in the Outpatient All Other sub-classification for the Cigna book of business data..</p>

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Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p><b>Evidentiary Standard</b> The evidentiary standards for factors that must be established to trigger a ROI evaluation for the application of Prior Authorization in the Outpatient All Other sub-classification.</p> <p>All Other classification are as follows:</p> <p>(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 Evidence<sup>1</sup>;</p> <p>(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 warning or recall (e.g. FDA recall for a device or pharmaceutical product);</p>	<p>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</p> <p><b>Evidentiary Standard</b> The evidentiary standards for factors that must be established to trigger a ROI evaluation for the application of Prior Authorization in the Outpatient All Other sub-classification.</p> <p>All Other classification are as follows:</p> <p>(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 Evidence<sup>2</sup>;</p> <p>(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</p>	

<sup>1</sup> **Clinical evidence** includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.

<sup>2</sup> **Clinical evidence** includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>(iii) 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.</p> <p>(iv) 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</p>	<p>warning or recall (e.g. FDA recall for a device or pharmaceutical product);</p> <p>(iii) 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.</p> <p>(iv) 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</p>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>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).</p> <p>(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:</p> <p>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)</p> <p>b. “Waste” means overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to</p>	<p>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).</p> <p>(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:</p> <p>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)</p>	





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>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.</p> <p>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.</p> <p>The evidentiary standard used for the ROI factor in the application of Prior Authorization of M/S services the Outpatient-All Other benefit classification is a ratio of 3.0. Codes not meeting the 3.0 ROI threshold are assessed for potential removal from the prior authorization/concurrent review program, with an emphasis placed on identifying ways to improve the cost-effectiveness of the reviews themselves by reducing administrative cost/expense (e.g., time to review). Cigna reviews the ROI of codes requiring precertification based on data contained in Cigna’s Precertification Dashboard. Codes with ROI greater than 3 are considered as operationally effective and are not typically considered for removal, while codes with ROI less than 3 are considered for removal. Codes are removed with low ROI/savings and codes are included that have a higher ROI/savings based upon utilization review and cost trends.</p>	<p>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.</p> <p>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.</p> <p>The evidentiary standard used for the ROI factor in the application of Prior Authorization of MH/SUD services the Outpatient-All Other benefit classification is a ratio of 3.0. Codes not meeting the 3.0 ROI threshold are assessed for potential removal from the prior authorization/concurrent review program, with an emphasis placed on identifying ways to improve the cost-effectiveness of the reviews themselves by reducing administrative cost/expense (e.g., time to review). Cigna reviews the ROI of codes requiring precertification based on data contained in Cigna’s Precertification Dashboard. Codes with ROI greater than 3 are considered as operationally effective and are not typically considered for removal, while codes with ROI less than 3 are considered for</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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.</li></ul> <p>Cigna imposes step therapy and/or fail first requirements on certain M/S services including for example, MRI, gastric bypass, lumbar spine fusion where higher-cost therapies may be denied unless it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy” protocols).</p>	<p>removal. Codes are removed with low ROI/savings and codes are included that have a higher ROI/savings based upon utilization review and cost trends.</p> <p>The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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.</li></ul> <p>Cigna does not impose a Fail First/Step Therapy NQL on MH/SUD services where higher-cost therapies may be denied unless it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy” protocols).</p>	
Concurrent Care Review			



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>Process – Include frequency and penalties for all services. Describe any step-therapy or “fail first” requirements and requirements for submission of treatment request forms or treatment plans.</b>			
<b>Inpatient</b>  Concurrent Review is applied to all inpatient benefits, based upon high cost, high risk and complexity for members receiving the service with the exception of any services reimbursed to the provider on a case rate/Diagnostic Resource Group (DRG) basis, including non-emergent M/S and MH/SUD services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other facility and certain outpatient benefits, without service/procedure level distinctions for the inpatient benefit classification. Inpatient services subject to Concurrent Review include:  <b>M/S Inpatient Services :</b> <ul style="list-style-type: none"><li>Acute Inpatient Services,</li><li>Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc.</li><li>Inpatient Professional Services</li></ul>	Concurrent Review is applied to all non-emergent M/S services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other residential facility based upon high cost, high risk and complexity for members receiving the service.  <b>Process</b> Inpatient Concurrent Care Review occurs when a facility/provider requests to extend an inpatient stay beyond the previously authorized length of stay or more frequently based upon review of the level of care and clinical criteria. For M/S benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information	Concurrent Review is applied to all non-emergent MH/SUD services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other residential facility based upon high cost, high risk and complexity for members receiving the service.  <b>Process</b> Inpatient Concurrent Care Review occurs when a facility/provider requests to extend an inpatient stay beyond the previously authorized length of stay or more frequently based upon review of the level of care and clinical criteria. For MH/SUD benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may	Cigna applies the concurrent care review NQTL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day. Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for Concurrent Review.  <b>DRG Variation</b> Inpatient services reimbursed on the basis of a DRG/case rate and otherwise authorized pursuant to a prior authorization review are not subject to concurrent review because, for the duration of the period for which the DRG/case rate applies, the amount of benefits the plan is obligated to pay for a facility stay does not depend on the duration of time that the individual received care in the facility. DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. The lack of correlation between the length of stay and the plan’s obligation to pay benefits for the same means that assessing the ongoing medical necessity of a

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>MH/SUD Inpatient Services:</b> <ul style="list-style-type: none"><li>• Mental Health Acute Inpatient Services</li><li>• Mental Health Subacute Residential Treatment</li><li>• Mental Health Inpatient Professional Services</li><li>• SUD Acute Inpatient Services</li><li>• SUD Acute Inpatient Detoxification</li><li>• SUD Subacute Residential Treatment</li><li>• SUD Inpatient Professional Services</li></ul>	<p>provided by the treating provider). Cigna typically authorizes 1-4 M/S inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p>UM coverage determinations of M/S services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Cigna uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care, home care, and behavioral health care for coverage guidance in utilization review of services that are not addressed in a Cigna medical, or co-branded coverage policy.</p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Concurrent Review to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit. Services covered under a medical or behavioral benefit administered by Cigna that are on-going with multiple services over multiple dates of service beyond the initial period for which coverage was approved may be subject to Concurrent Review to confirm level of care and clinical appropriateness.</p>	<p>authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-6 MH/SUD inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p>UM coverage determinations of MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Cigna uses MCG for non-SUD primary diagnosis of behavioral health level of care and Cigna uses ASAM Criteria for coverage guidance in utilization review level of care of SUD services.</p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Concurrent Review to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit. Services covered under a medical or behavioral benefit administered by Cigna that are on-going with multiple services over multiple dates of service beyond the initial period for which coverage was</p>	<p>continued facility stay for coverage/benefit purposes is unnecessary for such period of time.</p> <p>The case rate/DRG payment functions as payment in full for any and all services rendered to the individual for the pre-authorized course of treatment for the length of time covered by the case rate/DRG payment and over which the individual remains in the facility. The plan’s liability for payment of benefits for services, and the individuals’ cost-sharing obligation, does not increase or decrease depending on how long the individual remains in the facility receiving the pre-authorized treatment in question, unless the individual’s stay extends beyond the time period that the DRG/case rate payment covers.</p> <p>DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. Concurrent Review by Cigna is clinically appropriate and permissible for psychiatric hospitalizations as general medical hospitalizations that are not reimbursed based on DRGs are also subject to concurrent review. Differences in utilization management of inpatient behavioral health is not a more stringent application because DRG-based fees have not been established for psychiatric hospitalizations.</p> <p>An “in operation” review of Cigna’s application of the Concurrent Review NQT, specifically approvals and</p>

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## Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>A Service may be subject to Concurrent Review, when such Service requires (1) the ongoing assessment to determine or continue to establish the medical necessity of continued services; and (2) appropriateness of current level of care for the severity; or (3) one or more of the following:</p> <ul style="list-style-type: none"><li>• complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines</li><li>• Expected timeframe for clinical response/outcomes based on literature</li><li>• Efficacy of the treatment modality</li><li>• Progress toward goals of therapy</li><li>• Discharge / transition planning</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li><li>○ American Formulary Association (AFA) publication of codes</li><li>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</li></ul></li><li>• Internal claims data</li></ul>	<p>approved may be subject to Concurrent Review to confirm level of care and clinical appropriateness.</p> <p>A Service may be subject to Concurrent Review, when such Service requires (1) the ongoing assessment to determine or continue to establish the medical necessity of continued services; and (2) appropriateness of current level of care for the severity; or (3) one or more of the following:</p> <ul style="list-style-type: none"><li>• complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines</li><li>• Expected timeframe for clinical response/outcomes based on literature</li><li>• Efficacy of the treatment modality</li><li>• Progress toward goals of therapy</li><li>• Discharge / transition planning</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li><li>○ American Formulary Association (AFA) publication of codes</li><li>○ Centers for Medicare and Medicaid</li></ul></li></ul>	<p>denial information, in the Inpatient classification revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. On average, denial rates for concurrent medical necessity review of Inpatient MH/SUD benefits were lower than M/S services. A review of concurrent denials was completed with Georgia data for the In-patient classification and denial rates for concurrent medical necessity review of Inpatient MH/SUD benefits were lower than M/S services.</p> <p>A review of appeals data reveals comparable upheld and overturn rates and, on average, lower overturn rates for MH/SUD benefits in the outpatient and inpatient classifications for the Cigna book of business. Specifically, an analysis of the total appeal overturn rate as-between inpatient MH/SUD and M/S services includes a 9 percent lower denial rate (about 30% to about 39%) for MH/SUD services concurrent review appeals for Out Patient, showed comparable appeal overturn rates (about 23% as-compared to about 27%) for MH/SUD and M/S services appeals to a concurrent review determination. The sample size for Georgia specific data did not allow for a statistically significant sample for appeals.</p> <p>Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTl)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>• UM program operating costs</li><li>• UM authorization data</li><li>• Expert Medical Review of Clinical Criteria</li><li>• Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b> The evidentiary standard relied on to determine whether to apply Concurrent Review to inpatient MH/SUD and M/S benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business. The value associated with inpatient benefit reviews, as calculated by reference to the expected financial savings relative to the costs to review benefit claims, is assessed at the classification level and not at a service/procedure level.</p> <p>Cigna has determined the value of subjecting all inpatient M/S services to Concurrent Review must exceed the administrative costs by at least 1:1. The Concurrent Review NQTL applies to all M/S services. The administration is identical.</p> <p>Cigna imposes step therapy and/or fail first requirements on certain M/S services including for example, MRI, gastric bypass, lumbar spine fusion where higher-cost therapies may be denied unless it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy”</p>	<p>Services (CMS) publication of codes</p> <ul style="list-style-type: none"><li>• Internal claims data</li><li>• UM program operating costs</li><li>• UM authorization data</li><li>• Expert Medical Review of Clinical Criteria</li><li>• Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b> The evidentiary standard relied on to determine whether to apply Concurrent Review to inpatient MH/SUD and M/S benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business. The value associated with inpatient benefit reviews, as calculated by reference to the expected financial savings relative to the costs to review benefit claims, is assessed at the classification level and not at a service/procedure level.</p> <p>Cigna has determined the value of subjecting all inpatient M/S and MH/SUD services to Concurrent Review must exceed the administrative costs by at least 1:1. The Concurrent Review NQTL applies to all MH/SUD and M/S services. The administration is identical.</p> <p>Cigna does not impose a Fail First/Step Therapy NQTL on MH/SUD services where higher-cost therapies may be denied unless it can be shown that a</p>	concurrent care medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	protocols).	lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy” protocols).	
<b>Outpatient Office Visits</b>	<b>Not Applicable</b>	<b>Not Applicable</b>	The Concurrent Review NQTL does not apply to MH/SUD or M/S services assigned to the Outpatient-Office Visits sub-classification.
<b>All Other Outpatient Services</b>  The Concurrent Review NQTL is applied to certain Outpatient-All Other MH/SUD and M/S services sub-classification including:  <b>M/S Outpatient-All Other Services</b> 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	<b>All Other Outpatient Services Subject to Concurrent Review</b> Certain non-routine outpatient services are subject to Concurrent Review for the ongoing assessment to determine medical necessity of the care provided.  <b>Process</b> Concurrent care reviews for M/S services are typically initiated by a provider telephonically a day or two before the last covered/authorized day.  <b>Factors</b> When determining which M/S benefits are subject to concurrent care medical necessity review, Cigna conducts a cost-benefit analysis based upon the following factors: <ul style="list-style-type: none"><li>• Cost of treatment/procedure</li><li>• Whether treatment type is a driver of high cost growth</li></ul>	<b>All Other Outpatient Services Subject to Concurrent Review</b> Certain non-routine outpatient services are subject to Concurrent Review for the ongoing assessment to determine medical necessity of the care provided.  <b>Process</b> Concurrent care reviews for MH/SUD services are typically initiated by a provider telephonically a day or two before the last covered/authorized day.  <b>Factors</b> When determining which MH/SUD benefits are subject to concurrent care medical necessity review, Cigna conducts a cost-benefit analysis based upon the following factors: <ul style="list-style-type: none"><li>• Cost of treatment/procedure</li><li>• Whether treatment type is a driver of high cost growth</li></ul>	Cigna applies the Concurrent Review NQTL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day.  Coverage determinations of MS services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, Cigna's methodology for determining which MH/SUD services within a classification of benefits are subject to concurrent care review is comparable to, and applied no more stringently than, its methodology for determining which M/S services within the same classification of benefits are subject

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
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)	<ul style="list-style-type: none"><li>• Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region</li><li>• Treatment types subject to a higher potential for fraud, waste and/or abuse</li><li>• Projected return on investment and/or savings if treatment type is subjected to concurrent care review</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li><li>○ American Formulary Association (AFA) publication of codes</li><li>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</li></ul></li><li>• Internal claims data</li><li>• UM program operating costs</li><li>• UM authorization data</li><li>• Expert Medical Review</li><li>• Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b></p>	<ul style="list-style-type: none"><li>• Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region</li><li>• Treatment types subject to a higher potential for fraud, waste and/or abuse</li><li>• Projected return on investment and/or savings if treatment type is subjected to concurrent care review</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li><li>○ American Formulary Association (AFA) publication of codes</li><li>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</li></ul></li><li>• Internal claims data</li><li>• UM program operating costs</li><li>• UM authorization data</li><li>• Expert Medical Review</li><li>• Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b></p>	<p>to concurrent care review.</p> <p>An “in operation” review of Cigna’s application of the Concurrent Review NQTL, specifically approvals and denial information, in the “Outpatient Other Items and Services” classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business. A review of concurrent denials was completed with Georgia data for the Out-patient All Other classification and revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits.</p> <p>While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>A review of concurrent review appeals data reveals comparable upheld and overturn rates and, on average, lower overturn rates for MH/SUD benefits in the outpatient and inpatient classifications for the Cigna book of business. Specifically, an analysis of the total appeal overturn rate as-between inpatient</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>MH/SUD Outpatient-All Other Services</b> Partial Hospitalization Applied Behavior Analysis (ABA) Transcranial Magnetic Stimulation	<p>When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p> <ul style="list-style-type: none"><li>Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>Inadequate 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;</li><li>when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li></ul></li><li>Whether the service is/may be excluded from coverage: Cigna assesses whether the</li></ul>	<p>When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p> <ul style="list-style-type: none"><li>Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>Inadequate 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;</li><li>when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li></ul></li><li>Whether the service is/may be excluded from coverage: Cigna assesses whether the</li></ul>	<p>MH/SUD and M/S services includes a 9 percent lower denial rate (about 30% to about 39%) for MH/SUD services concurrent review appeals for Out Patient, and nearly identical appeal overturn rates (about 23% as-compared to about 27%) for MH/SUD and M/S services appeals to a concurrent review determination. The sample size for Georgia specific data did not allow for a statistically significant sample for appeals.</p> <p>Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</p> <ul style="list-style-type: none"><li>• Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>• Whether the service demonstrates significant variations from evidence-based care: A variation in evidence-based care must reflect a statistically significant standard deviation from the standard frequency or duration in treatment using the</li></ul>	<p>plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</p> <ul style="list-style-type: none"><li>• Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>• Whether the service demonstrates significant variations from evidence-based care: A variation in evidence-based care must reflect a statistically significant standard deviation from the standard frequency or duration in treatment using the</li></ul>	





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>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</li><li>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.</li></ul></li><li>• Performing coverage reviews for a service is projected to meet or exceed a certain return on</li></ul>	<p>service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>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</li><li>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.</li></ul></li><li>• Performing coverage reviews for a service is projected to meet or exceed a certain return on</li></ul>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>investment ratio. The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>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.</li><li>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.</li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.</p>	<p>investment ratio. The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>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.</li><li>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.</li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQTL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the factors relied on by Cigna to design its NQTLs in a numerical threshold or formula. By contrast, the quantitative factors that Cigna considers when deciding whether to apply prior authorization to MH/SUD and M/S benefits are defined by reference to specific thresholds at which the factor is met.	Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQTL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the	
Retrospective Review			
Process, including timeline and penalties			
<b>Inpatient Outpatient (including applicable sub-classifications)</b>  Cigna defines Retrospective Review of M/S services as its review of a claim after the service has already been provided, but before the claim for that service has been paid. Specifically, these are reviews of coverage authorizations that were not approved prior to the service being rendered. Cigna does not incorporate	All non-emergent M/S and MH/SUD inpatient and outpatient services are theoretically subject to a medical necessity review. Cigna also employs the same definition of medical necessity to M/S and MH/SUD benefits.  Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the	All non-emergent MH/SUD inpatient and outpatient services are theoretically subject to a medical necessity review. Cigna also employs the same definition of medical necessity to M/S and /SUD benefits.  Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the	<b>As written:</b> Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for developing coverage criteria.  Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to retrospective review as written and in operation, as well as its

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
language related to Retrospective Review in its certificate or benefits booklet.	<p>above, Cigna's standard definition of "medical necessity" is as follows:</p> <p><b>"Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of</li></ul>	<p>above, Cigna's standard definition of "medical necessity" is as follows:</p> <p><b>"Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of</li></ul>	<p>retrospective medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.</p> <p><b>In operation:</b> Cigna has conducted a review of its application of the Retrospective Review NQTL, specifically approvals and denial information, which revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business. A review of Retrospective denials was completed with Georgia data across all classifications and revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>The comparative analysis performed for application of Retrospective Review to inpatient and outpatient benefits evidences compliance with the MHPAEA</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>alternative services, supplies, medications or settings when determining least intensive setting.”</p> <p>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. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.</p> <p><b>Factors</b></p> <p>When developing coverage criteria to evaluate the medical necessity of services, Cigna's Coverage Policy Unit (CPU), 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 Medical Technology Assessment Committee’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific</p>	<p>alternative services, supplies, medications or settings when determining least intensive setting.”</p> <p>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. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.</p> <p><b>Factors</b></p> <p>When developing coverage criteria to evaluate the medical necessity of services, Cigna's Coverage Policy Unit (CPU), 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 Medical Technology Assessment Committee’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific</p>	<p>NQTL requirement, in writing and in operation. Cigna's analysis of the process and policies governing the application of Retrospective Review across MH/SUD and M/S benefits, as well as the process by which MH/SUD and M/S services are selected for application of Retrospective Review, evidences comparability and equivalent stringency, in writing and in operation. The written process, the trigger for application of Retrospective Review, and the medical necessity standard used to review services subject to Retrospective Review, comparable across MH/SUD and M/S benefits, but the assessment of denial rates across a sample of Cigna-administered benefit plans do not reveal any potential “warning signs” warranting further assessment and/or changes to how the Retrospective Review NQTL is designed or applied to MH/SUD benefits.</p> <p>The factor and its accompanying evidentiary standard used to determine whether Retrospective Review will apply to an inpatient or outpatient service pursuant to the above-described process, namely the ROI metric, is likewise uniform for MH/SUD and M/S benefits. Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the list of services subject to Retrospective Review.</p> <p>Cigna's methodology for determining which M/S services and which MH/SUD services within a</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford:</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p>	<p>Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford:</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p>	<p>classification of benefits are subject Retrospective Review as written and in operation, as well as its medical necessity review processes, are no more stringent for MH/SUD services than for M/S services within the same classification of benefits.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p><b>Evidentiary Standards</b></p> <p>When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p> <ul style="list-style-type: none"><li>• Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>○ Inadequate 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;</li><li>○ when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>○ the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>○ the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li></ul></li></ul>	<p><b>Evidentiary Standards</b></p> <p>When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p> <ul style="list-style-type: none"><li>• Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>○ Inadequate 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;</li><li>○ when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>○ the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>○ the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li></ul></li></ul>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>Whether the service is/may be excluded from coverage: Cigna assesses whether the plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</li><li>Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>Whether the service demonstrates significant variations from evidence-based care: A variation in evidence-based care must reflect a statistically</li></ul>	<ul style="list-style-type: none"><li>Whether the service is/may be excluded from coverage: Cigna assesses whether the plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</li><li>Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>Whether the service demonstrates significant variations from evidence-based care: A variation in evidence-based care must reflect a statistically</li></ul>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>significant standard deviation from the standard frequency or duration in treatment using the service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>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</li><li>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.</li></ul></li></ul>	<p>significant standard deviation from the standard frequency or duration in treatment using the service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>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</li><li>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.</li></ul></li></ul>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>Performing coverage reviews for a service is projected to meet or exceed a certain return on investment ratio. The ROI ratio is calculated using the following formula:<ul style="list-style-type: none"><li>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.</li><li>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.</li></ul></li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in</p>	<ul style="list-style-type: none"><li>Performing coverage reviews for a service is projected to meet or exceed a certain return on investment ratio. The ROI ratio is calculated using the following formula:<ul style="list-style-type: none"><li>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.</li><li>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.</li></ul></li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in</p>	





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>the English language, peer reviewed, published, evidence-based scientific studies or literature.</p> <p>Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the factors relied on by Cigna to design its NQLs in a numerical threshold or formula. By contrast, the quantitative factors that Cigna considers when deciding whether to apply prior authorization to MH/SUD and M/S benefits are defined by reference to specific thresholds at which the factor is met.</p>	<p>the English language, peer reviewed, published, evidence-based scientific studies or literature.</p> <p>Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the factors relied on by Cigna to design its NQLs in a numerical threshold or formula. By contrast, the quantitative factors that Cigna considers when deciding whether to apply prior authorization to MH/SUD and M/S benefits are defined by reference to specific thresholds at which the factor is met.</p>	
<b>Emergency Services</b>			
<b>Process for emergency services</b>	<p>Emergency M/S services are not subject to prior authorization or Concurrent Review.</p> <p>Emergency services that are furnished by a provider qualified to provide emergency services to evaluate and stabilize an emergency medical condition, including ambulance services, are assigned to the emergency care classification of benefits. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of</p>	<p>Emergency MH/SUD services are not subject to prior authorization or Concurrent Review.</p> <p>Emergency services that are furnished by a provider qualified to provide emergency services to evaluate and stabilize an emergency medical condition, including ambulance services, are assigned to the emergency care classification of benefits. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of</p>	<p>Cigna's integrated medical and behavioral health plans have only one, single benefit for emergency room and urgent care. Accordingly, there are no differences between how coverage for M/S and MH/SUD emergency room and urgent care services.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	health and medicine, could reasonably expect the absence of immediate medical attention to result in: <ul style="list-style-type: none"><li>Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child;</li><li>Serious impairment to bodily function; or</li></ul> Serious dysfunction of any bodily organ or part.	health and medicine, could reasonably expect the absence of immediate medical attention to result in: <ul style="list-style-type: none"><li>Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child;</li><li>Serious impairment to bodily function; or</li></ul> Serious dysfunction of any bodily organ or part.	
<b>Pharmacy Services</b>			
<b>Include all services for which prior authorization is required, any step-therapy or “fail first” requirements, and any other NQTLs.</b>			
<b>Tier 1</b>	<p>Cigna requires prior authorization, step therapy, or quantity limits for certain prescription drugs to ensure the prescribed drugs are medically necessary to treat the enrollee’s condition. Cigna uses the same medical necessity standard when reviewing coverage for both M/S and MH/SUD drugs.</p> <p>Cigna's prior authorization, step therapy, or quantity limit requirements were developed without regard to whether the prescription drugs are prescribed to treat a medical condition or a MH/SUD condition.</p> <p>Some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded</p>	<b>Same as Medical/Surgical</b>	<p>Cigna has confirmed that its utilization management programs are applied comparably, and no more stringently, to MH/SUD drugs as compared to M/S drugs. Its written policies governing formulary placement and application of utilization management do not distinguish between the processes, factors or standards that inform design and application of the formulary placement and utilization management NQTLs. Indeed, Cigna uses one, combined policy to govern its formulary management and utilization management requirements across M/S and MH/SUD benefits, and, while uniformity in processes is not required by the NQTL requirements (only comparability), uniformity in processes for designing and applying an NQTL can evidence comparability in the NQTL as-written.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it doesn't warrant coverage on the formulary. If the P&amp;T Committee identifies a drug as “Exclude” or “Optional,” for example, then the Cigna VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from claims/reimbursement information and available rebate revenue) to Cigna as compared to therapeutic alternatives.</p> <p>Notably, Cigna does not apply prior authorization or step therapy requirements to any drugs used to treat an opioid use disorder or alcohol use disorder. Cigna does apply prior authorization or quantity limits to several MH/SUD drugs. Mental health drugs are generally considered to be controlled substances under federal law and, with the exception of drugs generally used to treat opioid use disorder and alcohol use disorder, Cigna applies prior authorization to controlled substances such as opioids used for pain management. This approach is consistent with Cigna’s application of prior authorization to controlled substances on the basis of identified safety risks, and regardless of whether the controlled substance is used to treat an M/S condition, such as</p>		<p>In terms of operational parity compliance, Cigna confirmed that all drugs, whether MH/SUD or M/S drugs, that the P&amp;T Committee designates must be covered are, in fact, covered on the formulary, and all drugs’ coverage conform to other P&amp;T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes. Moreover, Cigna's coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status, and drugs subject to a utilization management requirement, including prior authorization, step therapy, and/or quantity limits, conform to the aforementioned standards established for inclusion in a utilization management program. That is, Cigna does not apply a utilization management requirement to an MH/SUD drug that does not exhibit the factors/standards described in the preceding columns that, as-written, justify application of a utilization management requirement to a drug, and in terms of stringency of application of the NQTL no M/S drugs are omitted from a utilization management requirement if they exhibit the same factors/standards.</p> <p>While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	pain management, or an MH/SUD condition such as ADHD or bipolar disorder. Cigna applies prior authorization to M/S drugs for other reasons, such as specialty drug/high cost status (i.e. specialty drugs are subject to prior authorization), but these are rationales in addition to, and not exclusive of, the safety risk factor based on a drug's status as a controlled substance. Cigna also applies step therapy to a number of brand drugs in certain MH/SUD and M/S therapeutic classes in order to incentivize the use of lower net cost (inclusive of ingredient cost and available manufacturer revenue) generic and/or preferred brand alternatives as identified through an analysis of claims/reimbursement information for the brand drugs.		<p>the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the prescription drug classification of benefits.</p>
<b>Tier 2</b>	Same as Tier 1	Same as Tier 1	Same as Tier 1
<b>Tier 3</b>	Same as Tier 1	Same as Tier 1	Same as Tier 1
<b>Tier 4</b>	Same as Tier 1	Same as Tier 1	Same as Tier 1
<b>Prescription Drug Formulary Design</b>			
<b>How are formulary decisions made for the diagnosis and medically necessary treatment of medical, mental health, and substance use disorder conditions?</b>	<p>Cigna offers a multi-tiered formulary that includes covered MH/SUD and M/S drugs; a tiered formulary design is considered an NQTL and, as such, the methodology by which drugs are placed on specific formulary tiers is subject to the NQTL parity requirement.</p> <p>Cigna offers a variety of prescription drug formularies comprised of generic, preferred and non-preferred brand name drugs, and specialty drugs. The coverage</p>	<b>Same as Medical/Surgical</b>	<p>Cigna does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design for its Standard, Value, Advantage, Performance, and Legacy formularies. Formulary tiers are designed based on reasonable factors, consistent with the requirements of 45 CFR §146.136.</p> <p>Cigna has confirmed that its formulary management and utilization management processes are applied</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>of drugs covered on Cigna’s formularies are, subject to a client policyholder’s election, determined by two internal/affiliated committees that perform different, but interrelated, functions: the Pharmacy &amp; Therapeutics Committee ("P&amp;T Committee"); and, the Cigna Value Assessment Committee (a/k/a Business Decision Team).</p> <p>The coverage of drugs covered on Cigna’s formularies are, subject to a client policyholder’s election, as applicable, determined by two internal/affiliated committees that perform different, but interrelated, functions: the Pharmacy &amp; Therapeutics Committee (“P&amp;T Committee”); and, the Cigna Health Plan Value Assessment Committee (“CHP VAC”).</p> <p>The P&amp;T Committee is composed of voting external clinicians across a number of specialties that perform, among other responsibilities, clinical reviews of drugs to determine whether a drug must be covered on the formulary as a clinical matter. In rendering clinical findings on drugs, the P&amp;T Committee assesses the FDA labeling and, as appropriate and available, clinical practice standards/trends and documentation like clinical literature and guidelines.</p> <p>The CHP VAC is composed of representatives representing several functional areas of the combined company, including, for example, clinicians and representatives from our sales and economics areas,</p>		<p>comparably, and no more stringently, to MH/SUD drugs as compared to M/S drugs. Specifically, all drugs, whether MH/SUD or M/S drugs, that the P&amp;T Committee designates must be covered are, in fact, covered on the formulary, and all drugs conform to other P&amp;T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes.</p> <p>Moreover, Cigna's coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status, and Cigna's review evidences that the processes and standards used to determine whether to subject a drug to utilization review is not only comparable, but identical, across M/S and MH/SUD drugs. The same P&amp;T and CHP VAC committee structure reviews M/S and MH/SUD drugs for formulary placement and whether to subject a drug to a prior authorization requirement, and pursuant to common policies and procedures. The process for reviewing drugs for coverage does not differ by whether the drug is used to treat a M/S condition or a MH/SUD condition.</p> <p>In terms of operational parity compliance, Cigna has also assessed as follows across its formularies: a comparable percentage of MH/SUD drugs are</p>





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>that have experience with formulary management or PBM/health plan operations, and is responsible for deciding - within the clinical parameters established by the P&amp;T Committee - which drugs will be covered on the formularies offered by Cigna. If the P&amp;T Committee finds that a drug must be covered on the formulary as a clinical matter, then the Value Assessment Committee must place the drug on the formulary. If the P&amp;T Committee determines that a drug may or may not be covered on the formulary as a clinical matter, then the CHP VAC may consider other factors, including economic factors, when deciding whether to place the drug on the formulary.</p> <p><b>Factors</b></p> <p>In its decision criteria, the CHP VAC primarily considers the following factors:</p> <ol style="list-style-type: none"><li>1. Pharmacy and Therapeutics (“P&amp;T”) Committee clinical safety and efficacy evaluation and designation.</li><li>2. Economic implications to enrollees and plans.</li><li>3. Status of drug as a generic, brand, or specialty drug</li><li>4. Competitor/market practices</li><li>5. Legal and regulatory requirements.</li></ol> <p>When deciding whether to place a drug on a three-tiered formulary, and, if so, on which formulary tier, the formulary committee considers the following factors: the brand or generic status of a drug; whether,</p>		<p>covered on v. off-formulary as compared to M/S drugs; a comparable, and in some cases lower, percentage of MH/SUD drugs are subject to prior authorization or step therapy requirements as compared to M/S drugs; and a comparable, and, in fact, lower, percentage of MH/SUD drugs are covered on the non-preferred brand tier (Tier 3) of the formularies offered by Cigna as compared to the MH/SUD drugs covered on Tiers 1 and 2. Cigna confirmed that all drugs, whether MH/SUD or M/S drugs, that the P&amp;T Committee designates must be covered are, in fact, covered on the formulary, and all drugs’ coverage conform to other P&amp;T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes. Moreover, for its large group formularies Cigna's coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status.</p> <p>Cigna has also assessed as follows across its group formularies. First, a comparable percentage of MH/SUD drug NDCs are covered on v. off-formulary as compared to M/S drug NDCs under such formularies (about 4% of MH/SUD and M/S drug NDCs each are covered off-formulary, with small variations to the tenths of a percent across the noted</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>as applicable, a brand drug has available generic alternatives; whether the drug is the lowest net cost drug as compared to therapeutic alternatives; and whether a rebate arrangement exists for the drug to offset its cost.</p> <p>The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the lowest net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information.</p> <p><b>Evidentiary Standards</b> In its decision criteria, the CHP VAC considers the following factors as defined by the noted evidentiary standards:</p> <ul style="list-style-type: none"><li>• Pharmacy and Therapeutics (“P&amp;T”) Committee clinical evaluation and designation. The clinical P&amp;T Committee’s designations are based on reviews of a drug’s safety and efficacy and place in therapy, using available clinical evidence such as FDA label information and available clinical</li></ul>		<p>formularies). Second, a comparable, and, in fact, lower, percentage of MH/SUD drug NDCs are covered on the higher cost, non-preferred brand tier (Tier 3) of the group formularies offered by Cigna as compared to the MH/SUD drug NDCs covered on Tiers 1 and 2.</p> <p>While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>Cigna employs measures to ensure comparability in both design and application of the multi-tiered formulary NQTL to MH/SUD and M/S prescription drug benefits. The written policies governing how MH/SUD or M/S drugs are placed on the formulary and tiered are uniform (i.e., on/off-formulary and tiering factors/standards) to ensure that the in-writing process and factors/standards relied on are comparable irrespective of the underlying use of the drug. Moreover, Cigna assesses outcomes data, including incidence rates for the application of utilization management NQTLs (i.e., the proportion</p>

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Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>literature and guidelines (e.g. federal regulatory publications or professional society publications). The P&amp;T Committee assigns one of several clinical designations to a drug based on the drug’s safety/efficacy and place in therapy: Access, Include, Optional, or Exclude. These designations dictate whether, from a clinical perspective a drug must be covered on the formulary, or, alternatively, may, but is not required to be, covered on the formulary, and whether a drug may be covered more favorably than therapeutically alternative drugs. A drug designated “Include” or “Access” must be covered to the extent medically necessary, and alternative drugs may not be preferred over it through application of tier placement or step therapy. A drug designated “Optional” may or may not be covered on the formulary, and may be subject to a step therapy protocol that requires the use of alternative drugs.</p> <p>These formulary placement designations are more specifically defined as follows, and are subject to any overriding plan exclusions such as exclusions of over-the-counter drugs or prescription drugs with over-the-counter alternatives:</p> <p><b>Include:</b> A drug may be given an include designation if it meets at least one of the clinical bases enumerated</p>		<p>of MH/SUD and M/S drugs that are subject to utilization management), to ensure that there are no significant discrepancies in the outcomes of the NQTLs’ application across MH/SUD and M/S benefits that warrant further scrutiny of the formulary decision-making process. Finally, the P&amp;T Committee annually reviews the formularies to ensure that the CHP VAC adheres to its clinical designations, irrespective of whether they are MH/SUD or M/S drugs, when making formulary placement/tiering decisions for Cigna's formularies.</p> <p>Moreover, as further evidence of comparability and equivalent stringency in-operation, Cigna has also assessed as follows across its formularies: a comparable percentage of MH/SUD drugs are covered on v. off-formulary as compared to M/S drugs; a lower absolute number of MH/SUD drugs are covered off-formulary as compared to M/S drugs; a comparable, and indeed a lower, percentage of MH/SUD brand drugs are covered on the non-preferred brand tier (Tier 3) relative to the total number of MH/SUD drugs covered on Tiers 1 and 2 of the formulary, as compared to the proportion of M/S drugs covered on Tier 3 relative to the total M/S drugs covered on Tiers 1 and 2 of the formulary. As all generic drugs covered on the formulary are placed on Tier 1 and no brand drugs are placed on Tier 1, whether MH/SUD or M/S benefits, the placement of drugs on Tier 1 of the formulary is deemed to meet the NQTL stringency and comparability requirements</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>below and is anticipated, or validated via claims data, to treat relatively large patient population (i.e., greater than 1 in 50,000).</p> <p>The clinical bases include:</p> <ul style="list-style-type: none"><li>a. It has a unique indication for use addressing a clinically significant unmet treatment need;</li><li>b. Its efficacy is superior to that of existing therapy alternatives;</li><li>c. Its safety profile is superior to that of existing therapy alternatives, it has a unique place in therapy; and/or</li><li>d. It treats medical condition(s) that necessitate individualized therapy and for which there are multiple treatment options.</li></ul> <p>Include drugs must be placed on a tier of the applicable formulary by the Value Assessment Committee but may not be disadvantaged relative to other drugs in a drug grouping, as defined by the P&amp;T Committee, with a less favorable clinical designation. A drug grouping is a list of drugs that generally possess the same mechanism of action and a similar place in therapy.</p> <p><b>Access:</b> A drug may be given an access designation if it meets at least one of the clinical bases enumerated below AND the drug is either anticipated, or validated via claims data at the time the P&amp;T Committee</p>		<p>for formulary placement. Put differently, there are no differences in placement of covered generic drugs for MH/SUD or M/S drugs, as the evidentiary standard – which was consistently applied to the placement of MH/SUD and M/S drugs on the formulary – for Tier 1 placement is the generic status of a drug. Additionally, by including a psychiatrist on the clinical P&amp;T committee, Cigna ensures that comparable clinical expertise in treating MH/SUD conditions and M/S conditions is represented in the formulary decision-making process.</p> <p>While physicians, regardless of specialty, are qualified under their scope of licensure to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, Cigna acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&amp;T Committee. In the context of NQTL compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&amp;T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits.</p> <p>Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and</p>

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Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>renders a designation on the drug, to treat a relatively small sub-population. The clinical bases include:</p> <ul style="list-style-type: none"><li>a. It has a unique indication for use addressing a clinically significant unmet treatment need;</li><li>b. Its efficacy is superior to that of existing therapy alternatives;</li><li>c. Its safety profile is superior to that of existing therapy alternatives;</li><li>d. It has a unique place in therapy; and/or</li><li>e. It treats medical condition(s) that necessitate individualized therapy and for which there are multiple treatment options.</li></ul> <p>Access drugs are forwarded to the Value Assessment Committee for further analysis of whether the drug should be covered on the applicable formulary and, if covered on the formulary, on which tier. The Value Assessment Committee may either place the drug on the applicable formulary or designate the drug as non-formulary. If the Value Assessment Committee does not place the drug on the formulary, the P&amp;T Committee shall establish formulary exception clinical criteria.</p> <p><b>Optional:</b> A drug may be given an optional designation if a significant proportion of its use is similar in terms of safety and efficacy to other currently available drug alternatives. In certain instances, a drug designated as optional may have a unique use in a small subset of patients in relation to the overall use of the drug. The P&amp;T Committee shall</p>		<p>standards that inform Cigna's formulary management decisions. Moreover, Cigna does not distinguish, in writing, between M/S and MH/SUD benefits in its prescription drug formulary design for its large group plan formularies, and it takes steps to monitor the consistency of decision-making across MH/SUD and M/S drugs by performing policy reviews and assessing operational outcomes periodically. As described in detail under the narrative response to Steps 2 and 3, Cigna considers the same factors and accompanying evidentiary standards for MH/SUD and M/S drugs when designing its large group formularies pursuant to a uniform formulary decision-making process. The written process for reviewing drugs for coverage does not differ by whether the drug is used to treat an M/S condition or a MH/SUD condition, and in terms of the timing of decisions, the P&amp;T Committee and Value Assessment Committee typically review all new-to-market drugs, whether MH/SUD or M/S drugs, within six months of market availability, and typically reviews potential opportunities to make formulary changes of any kind outside the context of new-to-market drug entries up to twice per year.</p> <p>In summary, the comparative analyses documented here, which construe the application of the multi-tiered formulary design NQTL designed based on the factors articulated above, demonstrate the compliance in-writing and in-operation of the NQTL. While operational outcomes are not determinative of NQTL</p>

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Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>establish formulary exceptions to account for cases where the optional drug may have a unique use in a relatively small subset of patients. Optional drugs are forwarded to the Value Assessment Committee for further analysis of whether the drug should be covered on the applicable formulary and, if covered on the formulary, on which tier. The Value Assessment Committee may either place the drug on the formulary or designate the drug as non-formulary. If the drug is not placed on the formulary, the P&amp;T Committee shall establish formulary exception clinical criteria.</p> <p><b>Exclude:</b> Drugs may be given an exclude designation for one or more of the following clinical reasons: efficacy inferior to that of existing therapy alternatives, a safety profile inferior to that of existing therapy alternatives, and/or insufficient data to evaluate the drug. Drugs recalled from the market for safety reasons are automatically designated as “Exclude” drugs, pending further P&amp;T Committee review.</p> <ul style="list-style-type: none"><li>Economic implications to enrollees and Cigna. When assessing potential formulary placement decisions, the CHP VAC reviews based on projected drug expenditure information derived from available manufacturer revenue and claims costs whether a drug is a lower net cost option relative to any therapeutic alternatives.</li><li>Status of drug as a generic, brand, or specialty</li></ul>		<p>compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. In this case, there were comparable, and in some cases more advantageous, outcomes for the placement and tiering of MH/SUD drugs as compared to M/S drugs based on the absolute number of, and incidence of, non-formulary v. formulary and, for on-formulary drugs, Tier 2 v. Tier 3 drugs under large group formularies. These comparable outcomes, along with the confirmation that the evidentiary standards and factors were actually applied consistently to MH/SUD drugs as compared to M/S drugs in terms of the adherence to P&amp;T Committee clinical designations, evidence in-operation compliance in terms of comparability and equivalent stringency. Consequently, Cigna concludes that the NQTL of formulary management is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>drug. A drug is identified as generic or brand based on an algorithm that considers drug indicators made available by an external vendor called First DataBank. A drug is identified as a specialty drug based on the presence of one more of the following characteristics: the requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; the need for intensive patient training and compliance assistance to facilitate therapeutic goals; limited or exclusive specialty pharmacy distribution (if a drug is only available through limited specialty pharmacy distribution it is considered specialty, even if it doesn't have other specialty drug characteristics); or specialized product handling and/or administration requirements.</p> <ul style="list-style-type: none"><li>• Competitor/market practices. This factor refers to an assessment of how competitors are covering drugs on their formularies based on publicly available information, which, while never determinative, may be considered when making certain formulary decisions.</li><li>• Legal and regulatory requirements. This factor refers to any legal or regulatory requirements that mandate certain drug coverage, such as tier placement</li></ul>		



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>requirements.</p> <p>Cigna offers several formularies for its large group insured business. For most formularies, some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it doesn't warrant coverage on the formulary. If the P&amp;T Committee identifies a drug as "Exclude" or "Optional," for example, then the Cigna VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from claims/reimbursement information and available rebate revenue) to Cigna as compared to therapeutic alternatives.</p> <p>For large group insured plans, Tier 1 of the formulary includes covered generic drugs. Tier 2 of the formulary includes covered preferred brand drugs. Tier 3 of the formulary includes covered non-preferred brand drugs. The brand or generic status of</p>		



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	a drug is determined by reference to an algorithm that analyzes available drug indicators, currently including First DataBank’s drug indicator file, and not by reference to the drug’s status as an M/S or MH/SUD benefit. Once brand drug status is determined by application of the algorithm, a covered brand drug is typically placed on Tier 2 for one of several reasons, including, for example, if the drug lacks available generic alternatives or if Cigna maintains a rebate arrangement for the brand drug, even if the brand drug has generic alternatives. Conversely, a covered brand drug is typically placed on Tier 3 if it either has available generic alternatives or Cigna lacks a rebate arrangement for the brand drug. Tier 4, if elected by the client plan sponsor, includes specialty drugs identified based on application of the above-stated definition.		
<b>Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.</b>	Cigna applies, in addition to the formulary management and utilization management requirements in its prior responses regarding NQTL application to prescription drug benefits, several kinds of NQTLS. These include, as previously described, formulary placement/tiering, and application of step therapy, prior authorization, and quantity limits for medical necessity. Certain NQTLS, such as exclusions for drugs obtained outside of the United States, apply uniformly across M/S and MH/SUD drugs. Of note, and consistent with Connecticut insurance law, Cigna does not apply	<b>Same as Medical/Surgical</b>	<p>In addition to Cigna's explanations for how its formulary management decisions, and decisions to apply utilization management to certain drugs, complies with the cited parity standard, Cigna has also reviewed its utilization management process for compliance with the parity NQTL requirement.</p> <p>With respect to parity compliance as-written, Cigna employed the same medical necessity standard and operational policies and procedures for reviewing utilization management approval requests. Similarly to its process for formulary management, Cigna reviews coverage requests for MH/SUD and M/S</p>



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	mandatory mail order requirements to any drugs, including M/S and MH/SUD drugs.		drugs subject to a utilization management requirement using a uniform, consolidated process that leverages identical policies and procedures. A team called the Pharmacy Service Center reviews initial utilization review requests based on coverage criteria developed by a uniform approval process, and a team called the National Appeals Organization reviews any appeals of denied drug claims, regardless of whether a drug is an MH/SUD or M/S benefit. Both teams employ identical procedures, including turnaround time requirements for standard and expedited requests, the method by which prescribers can submit utilization management approval requests, the issuance of coverage approval or denial determinations to enrollees and prescribers, and quality/oversight protocols. Cigna reviews non-formulary and step therapy coverage exception requests for any drug, whether a M/S or MH/SUD benefit, that is non-formulary or subject to a step therapy requirement. The coverage exception process ensures that enrollees for which the covered, preferred alternative drugs are clinically inappropriate can obtain coverage for drugs otherwise subject to non-formulary status or a step therapy requirement. If the enrollee’s prescriber demonstrates that the non-formulary or, as applicable, drug subject to step therapy is medically necessary, generally by evidencing that the preferred drug(s) are inappropriate or were ineffective for treating the enrollee’s condition, then Cigna approves coverage of the requested drug as medically necessary regardless of





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Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			<p>the drug’s status as an MH/SUD or M/S benefit.</p> <p>In terms of operational parity compliance, a review of utilization management data across a sampling of Cigna-administered plans revealed comparable, and, in fact, lower, medical necessity denial rates for MH/SUD drugs subject to prior authorization, step therapy, a quantity limit, or non-formulary status, as compared to M/S drugs subject to the same utilization management requirements.</p> <p>While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the prescription drug classification.</p>
What disciplines, such as primary care physicians (internists and	The clinical P&T committee assesses the utilization and appropriateness of therapeutic agents and	The clinical P&T committee assesses the utilization and appropriateness of therapeutic agents and	By including a psychiatrist on the clinical P&T committee, Cigna ensures that comparable clinical



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health, and substance use disorder conditions?</b>	provides the clinical parameters within which the CHP VAC’s decisions regarding formulary placement and application of utilization management must occur. The P&T committee is comprised of 16 independent, external providers, including 14 physicians and two pharmacists representing the following clinical practice areas: internal medicine, pulmonology, geriatrics, pediatrics, OB/GYN, endocrinology, gastroenterology, oncology, dermatology, rheumatology, cardiology, pharmacy (geriatrics), pharmacy (general), psychiatry, and neurology.	provides the clinical parameters within which the CHP VAC’s decisions regarding formulary placement and application of utilization management must occur. The P&T committee is comprised of 16 independent, external providers, including 14 physicians and two pharmacists representing the following clinical practice areas: internal medicine, pulmonology, geriatrics, pediatrics, OB/GYN, endocrinology, gastroenterology, oncology, dermatology, rheumatology, cardiology, pharmacy (geriatrics), pharmacy (general), psychiatry, and neurology.	<p>expertise in treating MH/SUD conditions and M/S conditions is represented in the formulary decision making process. While physicians, regardless of specialty, may be able to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, Cigna acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&amp;T Committee.</p> <p>In the context of NQL compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&amp;T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits. Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and standards that inform Cigna’s formulary management decisions.</p>
<b>Case Management</b>			
<b>What case management services are available?</b>  Case Management does not impact the scope of care, treatment or benefits delivered to MH/SUD services and	For Cigna enrollees with complex medical and/or behavioral health conditions, Cigna provides voluntary case management services which includes providing educational information, assessment/evaluation, planning, facilitation, care coordination, discharge planning and other services to meet an individual’s and family’s comprehensive	Cigna maintains active support and coaching programs for autism, eating disorders, intensive behavioral case management, opioid and pain management, substance use, and coaching support for parents and families with these disorders. Each program retains its own referral and eligibility criteria	Participation in case management services is not required, and an enrollee’s participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. Consequently, case management does not function as an NQL under the cited parity requirement.

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Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
does not function as an NQTL under the parity requirements.	health care needs through communication and sharing available resources to promote optimal patient care.	including self-referral which remains complimentary and voluntary.	
<b>What case management services are required?</b>	Health plan enrollees are not required to participate in case management services.	Health plan enrollees are not required to participate in case management services.	Participation in case management services is not required, and an enrollee’s participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. . Consequently, case management does not function as an NQTL under the cited parity requirement.
<b>What are the eligibility criteria for case management services?</b>	Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex medical conditions.	Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex MH/SUD health conditions.	Participation in case management services is not required, and an enrollee’s participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. Consequently, case management does not function as an NQTL under the cited parity requirement. Notwithstanding the inapplicability of the NQTL requirement to Cigna's voluntary case management program, Cigna offers case management services to enrollees with either complex MH/SUD or M/S conditions.
<b>Assessment of New Technologies</b>			
<b>Definition of experimental/investigational</b>	<b>Services Subject to the Assessment of New Technologies (Experimental, Investigational and Unproven, EIU)</b>  The evaluation of Experimental, Investigational and Unproven (“EIU”) services are applicable to all M/S services, regardless of benefit classification.	<b>Services Subject to the Assessment of New Technologies (Experimental, Investigational and Unproven, EIU)</b>  The evaluation of Experimental, Investigational and Unproven (“EIU”) services are applicable to all MH/SUD services, regardless of benefit classification.	The definition of experimental/investigational /unproven services is the same for MS and MH/SUD. A single review committee, Cigna’s MTAC evaluates all new technologies for M/S and MH/SUD benefits. Cigna's methodology and processes for determining whether M/S interventions and MH/SUD interventions within a classification of benefits are experimental, investigational and/or unproven are

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Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>EIU services are medical, surgical, diagnostic, or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, to be:</p> <ul style="list-style-type: none"><li>not demonstrated through or an inadequate volume of, existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li><li>not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;</li><li>the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.</li></ul> <p><b>Process</b> Cigna's Medical Technology Assessment Committee (MTAC) applies a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical technologies. The MTAC</p>	<p>EIU services are psychiatric or substance abuse health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, to be:</p> <ul style="list-style-type: none"><li>not demonstrated through or an inadequate volume of, existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li><li>not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;</li><li>the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.</li></ul> <p><b>Process</b> Cigna's Medical Technology Assessment Committee (MTAC) applies a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical technologies. The MTAC</p>	<p>comparable and no more stringent for MH/SUD services within a classification of benefits than for M/s services within the same classification of benefits as written and in operation.</p> <p>Cigna collects, tracks and trends relevant metrics on a semi-annual basis for services within each classification of M/S and MH/SUD benefits. Metrics may include initial EIU coverage denials, coverage denials upheld and overturned upon internal appeal and coverage denials upheld and overturned upon external appeal/review.</p> <p>An "in operation" review of claims data from a sampling of Cigna-administered plans revealed no excessive denial rates for MH/SUD claims denied as experimental, investigational and unproven as compared to M/S claims denied as experimental, investigational and unproven. An "in operation" review of Cigna's application of the Experimental, Investigational, and Unproven NQL, specifically approvals and denial information, in the "All Other Outpatient Services" classification revealed no statistically significant discrepancies in EIU denial rates as-between MH/SUD and M/S benefits.</p> <p>While operational outcomes are not determinative of NQL compliance, and an insurer may comply with the NQL requirement notwithstanding a disparate outcome for an NQL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes</p>

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Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC also consults with internal Cigna subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to, orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists, and psychiatrists.</p> <p>The committee reviews (i) FDA approval/clearance status, (ii) English language peer reviewed publications; and (iii) relevant documents prepared by specialty societies and evidence-based review centers and uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage policies. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven.</p> <p><b>Factors</b> Cigna considers the following factors in determining</p>	<p>committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC also consults with internal Cigna subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to, orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists, and psychiatrists.</p> <p>The committee reviews (i) FDA approval/clearance status, (ii) English language peer reviewed publications; and (iii) relevant documents prepared by specialty societies and evidence-based review centers and uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage policies. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven.</p> <p><b>Factors</b> Cigna considers the following factors in determining</p>	<p>can help evidence compliance with the in-operation component of the NQL requirement. Consequently, Cigna concludes that the NQL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>The application of the same NQL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.</p> <p>The use of MTAC for development of evidence based Coverage Policies for M/S and MH/SUD demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services.</p>

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Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>whether a services is experimental, investigational or unproven:</p> <ul style="list-style-type: none"><li>• inadequate 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;</li><li>• when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the in a clinical trial</li><li>• the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the clinical trials section below.</li></ul> <p><b>Sources</b> In approving new technology, MTAC uses principles of evidence-based medicine in its evaluation of the following sources:</p> <ul style="list-style-type: none"><li>• clinical literature</li><li>• FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven.</li><li>• FDA approval or clearance</li><li>• English language peer reviewed publications</li></ul>	<p>whether a services is experimental, investigational or unproven:</p> <ul style="list-style-type: none"><li>• inadequate 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;</li><li>• when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the in a clinical trial</li><li>• the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the clinical trials section below.</li></ul> <p><b>Sources</b> In approving new technology, MTAC uses principles of evidence-based medicine in its evaluation of the following sources:</p> <ul style="list-style-type: none"><li>• clinical literature</li><li>• FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven.</li><li>• FDA approval or clearance</li><li>• English language peer reviewed publications</li></ul>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>including documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality.</p> <p><b>Evidentiary Standard.</b> Levels of evidence are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes.</p> <p>Cigna considers other sources of internal and external information as part of its decision making process including input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed as part of the annual update process.</p>	<p>including documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality.</p> <p><b>Evidentiary Standard.</b> Levels of evidence are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes.</p> <p>Cigna considers other sources of internal and external information as part of its decision making process including input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed as part of the annual update process.</p>	
<b>Exclusions for Failure to Complete a Course of Treatment</b>			



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>Does the plan exclude benefits for failure to complete a course of treatment?</b>	Cigna does not exclude benefits for failure to complete treatment.	Cigna does not exclude benefits for failure to complete treatment.	Cigna does not exclude benefits for failure to complete treatment for M/S or MH/SUD Benefits. Cigna's process is consistent between M/S and MH/SUD, so Cigna does not apply such an NQTL to MH/SUD benefits that warrants analysis under the NQTL requirement.
<b>Restrictions that Limit Duration or Scope of Benefits for Services</b>			
<b>Does the plan restrict the geographic location in which services can be received? (e.g., service area, within a specific State, within the U.S.)</b>	Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna's geographic limitations on coverage for services apply uniformly across MH/SUD and M/S benefits.
<b>Does the plan restrict the type(s) of facilities in which enrollees can receive services?</b>	Not Applicable	Not Applicable	Cigna standardly covers medically necessary services rendered by licensed and/or certified healthcare providers for the treatment of M/S conditions and MH/SUD conditions. Services determined by Cigna not to be medically necessary would be excluded under the terms of the plan.
<b>Provider Specialties</b>			
<b>Does the plan restrict the types of provider specialties that can provide certain M/S or MH/SUD benefits?</b>	Providers are required to work within the scope of their licenses. No additional restrictions apply.	Providers are required to work within the scope of their licenses. No additional restrictions apply.	Cigna requires providers to work within the scope of their licenses for both M/S and MH/SUD benefits. The process is consistent between M/S and MH/SUD benefits. Cigna does not, in writing or in operation, further restrict provision of MH/SUD benefits to certain types of specialties so long as the rendering provider is acting within the scope of the provider's license, and, in terms of stringency, Cigna confirms that it does not waive for any M/S providers the

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			requirement that the M/S provider act within the scope of the provider’s license in order for services to be covered.
<b>Usual, Customary &amp; Reasonable Charges</b>			
<b>Explain the plan’s method for determining usual, customary and reasonable charges</b>	<p>The following information can vary by client election and/or state compliance rules, and Cigna's administration of any given client’s plan is subject to the client’s benefit plan elections. To the extent that a client makes a non-standard benefit, the following information may not apply.</p> <p>Cigna's standard out-of-network reimbursement methodology incorporated by clients into their benefit plans is predicated on achieving two fundamental objectives: reducing costs for enrollees/plan sponsors while, wherever possible, protecting the enrollees in Cigna-administered plans from excessive balance bills from providers. These objectives are achieved through a combination of techniques described more fully below.</p> <p>The Company may use a program provided by a partner entity that utilizes one of three methods to establish appropriate reimbursement levels for covered charges with non-contracted providers. These include the following:</p> <ol style="list-style-type: none"><li>1. The partner companies have standing agreements with providers that establish discounted rates which Cigna can access</li></ol>	<p>The following information can vary by client election and/or state compliance rules, and Cigna's administration of any given client’s plan is subject to the client’s benefit plan elections. To the extent that a client makes a non-standard benefit, the following information may not apply.</p> <p>Cigna's standard out-of-network reimbursement methodology incorporated by clients into their benefit plans is predicated on achieving two fundamental objectives: reducing costs for enrollees/plan sponsors while, wherever possible, protecting the enrollees in Cigna-administered plans from excessive balance bills from providers. These objectives are achieved through a combination of techniques described more fully below.</p> <p>The Company may use a program provided by a partner entity that utilizes one of three methods to establish appropriate reimbursement levels for covered charges with non-contracted providers. These include the following:</p> <ol style="list-style-type: none"><li>1.The partner companies have standing agreements with providers that establish discounted rates which Cigna can access through</li></ol>	<p>Cigna has assessed across Cigna-administered plans the NQL compliance of its standard reimbursement methodology and has confirmed that its standard reimbursement methodology, both in-writing and in-operation, applies comparably to MH/SUD benefits and no more stringently than M/S benefits.</p> <p>More specifically, Cigna ensures consistency with the NQL requirement in, subject to client election, its design of its reimbursement methodology with respect to any indirect discount arrangements with providers for reimbursement of MH/SUD or M/S services in several ways. For one, for both MH/SUD and M/S benefits Cigna retains third party vendors with which it contracts for indirect discount arrangements, whether maintained pursuant to a standing agreement between the third party vendor and provider or negotiated on a case-by-case basis with the provider, to make available, as applicable, rates that are within Cigna's established target pricing for a service. The MRC and the established MRC target pricing within which an indirect discount arrangement may be used to calculate reimbursement rates for covered services are derived identically for an MH/SUD or M/S benefit. Specifically, under the MRC1 methodology the</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>through its agreement with the partner company. This is an agreement where the provider remains non-contracted with Cigna, but agrees not to balance bill the member.</p> <p>2. The partner company reviews claims received by Cigna from non-contracted providers and negotiates with the provider on the plan’s behalf for a claim-specific discount. This is a direct discount agreement where the provider remains non-contracted but agrees not to balance bill the member.</p> <p>3. The partner company facilitates an electronic offer to the provider on the plan’s behalf whereby a provider is reimbursed at a market rate, as determined by the partner company, and deemed to have agreed to the reimbursement absent an objection by the provider.*</p> <p>If the claim cannot be adjudicated utilizing one of the above methodologies, then reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). A description of the MRC is included in the plan documents.</p> <p>The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount:</p> <ul style="list-style-type: none"><li>• MRC1</li></ul>	<p>its agreement with the partner company. This is an agreement where the provider remains non-contracted with Cigna, but agrees not to balance bill the member.</p> <p>2.The partner company reviews claims received by Cigna from non-contracted providers and negotiates with the provider on the plan’s behalf for a claim-specific discount. This is a direct discount agreement where the provider remains non-contracted but agrees not to balance bill the member.</p> <p>3.The partner company facilitates an electronic offer to the provider on the plan’s behalf whereby a provider is reimbursed at a market rate, as determined by the partner company, and deemed to have agreed to the reimbursement absent an objection by the provider.*</p> <p>If the claim cannot be adjudicated utilizing one of the above methodologies, then reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). A description of the MRC is included in the plan documents.</p> <p>The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount:</p> <ul style="list-style-type: none"><li>• MRC1</li></ul>	<p>MRC is derived from the same process, factors and evidentiary standards across MH/SUD and M/S benefits, and the target pricing for a service is equivalent to the MRC, which means that if any indirect discount arrangement that the third party vendors achieve with a provider is lower than the MRC for the service then the amount resulting from the indirect discount arrangement is the amount that Cigna calculates as reimbursement to the provider. Conversely, if the indirect discount arrangement equals an amount exceeding the MRC for the service, then the reimbursement amount due to the provider equals the MRC. That is, the reimbursement amount never exceeds, but may be lesser than, the client-elected percentile of the applicable MRC for any MH/SUD or M/S service under the MRC1 methodology, and the MRC itself is derived from the same process, factors, and standards across MH/SUD and M/S benefits.</p> <p>Likewise, under the MRC2 methodology – which is based on a Medicare pricing methodology across MH/SUD and M/S services – any negotiations resulting in indirect discount arrangements maintained by a third party vendor and a provider, whether rendering MH/SUD or M/S services, the same MRC2 target price for MH/SUD or M/S services is utilized. Similarly to the calculation of reimbursement under the MRC1 methodology, where the indirect discount arrangement amount meets or is lower than the target price – which target</p>

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## Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna.</li><li>Clients select an MRC1 percentile: 70<sup>th</sup> or 80<sup>th</sup>. Standard offerings are 70<sup>th</sup> percentile for HMO and POS product claims and 80<sup>th</sup> percentile for PPO and EPO products claims.</li></ul> <ul style="list-style-type: none"><li>MRC2<ul style="list-style-type: none"><li>Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area.</li><li>Clients select an MRC2 percentage: 110 (standard), 150, 200, or 300.</li></ul></li></ul> <p>If the provider balance bills the member and the claim was paid utilizing either (1) the partner company's electronic offer and negotiation is not successful, or (2) the Maximum Reimbursable Charge (MRC), then:</p> <ul style="list-style-type: none"><li>If the administration of the plan permits additional payment to protect the customer from balance billing, then Cigna's Offer &amp; Settlement policy may apply. An additional amount, up to the amount being balance billed, may be</li></ul>	<ul style="list-style-type: none"><li>Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna.</li><li>Clients select an MRC1 percentile: 70<sup>th</sup> or 80<sup>th</sup>. Standard offerings are 70<sup>th</sup> percentile for HMO and POS product claims and 80<sup>th</sup> percentile for PPO and EPO products claims.</li></ul> <ul style="list-style-type: none"><li>MRC2<ul style="list-style-type: none"><li>Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area.</li><li>Clients select an MRC2 percentage: 110 (standard), 150, 200, or 300.</li></ul></li></ul> <p>If the provider balance bills the member and the claim was paid utilizing either (1) the partner company's electronic offer and negotiation is not successful, or (2) the Maximum Reimbursable Charge (MRC), then:</p> <ul style="list-style-type: none"><li>If the administration of the plan permits additional payment to protect the customer from balance billing, then Cigna's Offer &amp; Settlement policy may apply. An additional amount, up to the amount being balance billed, may be</li></ul>	<p>price is, again, the same percentage of the applicable Medicare rate whether it is an MH/SUD or M/S service – the amount resulting from the indirect discount arrangement is the allowable reimbursement amount, and where the indirect discount arrangement amount exceeds the target price the MRC is the allowable reimbursement amount.</p> <p>In terms of the stringency of the application of the NQT, when calculating reimbursement for either MH/SUD or M/S benefits Cigna does not accommodate exceptions to the MRCs derived from the aforementioned sources/evidentiary standards (e.g., declining to use for a particular MH/SUD or M/S benefit claim the MRC derived from the database broadly used to derive an MRC) or the target price (e.g., agreeing through an indirect discount arrangement to pay a provider in excess of the target price for the service, which, for MRC1, would be the MRC) for M/S services or comparable MH/SUD services. That is, Cigna neither applies more stringently to MH/SUD services the limitation on the target price within which the third party vendor may negotiate with the provider for a discounted rate off of billed charges in return for an agreement not to balance-bill the patient for any difference between the billed charges and discounted rate, nor does Cigna use the methodology, including the process, factors, and evidentiary standards, for calculating reimbursement rates for covered</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>allowed. The customer copay/coinsurance and deductible may increase, based on the revised allowed amount, subject to state law.</p> <ul style="list-style-type: none"><li>If the administration of the plan does not permit additional payment to protect the customer from balance billing, then the claim will be paid up to that amount and no additional amount will be allowed. The customer may be liable for any amount over the allowed amount, in addition to their copay/coinsurance and deductible.</li></ul> <p>Non-Par services that are subject to the No Surprises Act (NSA) are reimbursed at an amount negotiated with the Non-Par provider. If an amount cannot be agreed upon, these services would generally be reimbursed based on the Qualifying Payment Amount (QPA) as defined in the NSA.</p> <p>*Important Note: Cigna's Offer &amp; Settlement policy does not apply to claims subject to the No Surprises Act.</p> <p>Cigna's reimbursement methodology incorporated by clients into their benefit plans is predicated on achieving two fundamental objectives: reducing costs for enrollees/plan sponsors while, wherever possible, protecting the enrollees in Cigna-administered plans from excessive balance bills from providers. In pursuing this objective, Cigna's reimbursement methodology ultimately rests on</p>	<p>allowed. The customer copay/coinsurance and deductible may increase, based on the revised allowed amount, subject to state law.</p> <ul style="list-style-type: none"><li>If the administration of the plan does not permit additional payment to protect the customer from balance billing, then the claim will be paid up to that amount and no additional amount will be allowed. The customer may be liable for any amount over the allowed amount, in addition to their copay/coinsurance and deductible.</li></ul> <p>Non-Par services that are subject to the No Surprises Act (NSA) are reimbursed at an amount negotiated with the Non-Par provider. If an amount cannot be agreed upon, these services would generally be reimbursed based on the Qualifying Payment Amount (QPA) as defined in the NSA.</p> <p>*Important Note: Cigna's Offer &amp; Settlement policy does not apply to claims subject to the No Surprises Act.</p> <p>Cigna's reimbursement methodology incorporated by clients into their benefit plans is predicated on achieving two fundamental objectives: reducing costs for enrollees/plan sponsors while, wherever possible, protecting the enrollees in Cigna-administered plans from excessive balance bills from providers. In pursuing this objective, Cigna's reimbursement methodology ultimately rests on</p>	<p>MH/SUD benefits in a manner that disadvantages MH/SUD benefits relative to M/S benefits.</p> <p>To further support its conclusion of comparability/stringency, Cigna as also assessed operational outcomes to validate that there are no potential disparities warranting closer scrutiny. Specifically, Cigna validated that across its commercial book-of-business it covers the full billed charges submitted by the MH/SUD providers at a comparable and, generally, higher rate than it pays the full billed charges for M/S providers as measured across inpatient and outpatient services paid for its entire book of business. Moreover, in the aggregate Cigna generally pays to MH/SUD providers a more favorable reimbursement amount than M/S providers as measured as a discount off the providers' billed charges. Finally, for comparable services like office visits for E&amp;M the average reimbursement for MH/SUD services across Cigna's commercial book-of-business is comparable to the average reimbursement for M/S services.</p> <p>The foregoing analysis evidences comparability and no less than equivalent stringency in the application of the reimbursement process, factors, and standards across MH/SUD and M/S benefits, in-writing and in-operation, which established compliance with the NQTL requirement.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>ensuring that the Maximum Reimbursable Charge (or “MRC”) for a service, commonly referred to in the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular MRC methodology adopted by the client. As noted in Cigna's prior response, Cigna makes available to client plans two MRC methodologies, MRC1 and MRC2, which serve as the foundation for Cigna's reimbursement program.</p> <p><u>Maximum Reimbursable Charge 1 (MRC1)</u></p> <p>In calculating the MRC for a service under the MRC1 methodology, Cigna applies a plan-sponsor-elected percentile to a charge (which is often referred to as a “U&amp;C” charge) as compiled in a national charges database. The charges in the database are derived based on factors including the service in question, charges submitted by providers located in the geographic area, specifically zip code groupings, if a charge for the zip code is available in which the claimant provider resides. That is, the evidentiary standard for the MRC for the service is the charge set forth in a national charges database for the service in the geographic area of the claimant provider that aligns with the percentile elected by the client. Plan sponsors may select one of several possible MRC1 percentiles to apply to the applicable charge; these percentiles, which vary by plan, include as follows: 50th percentile, 60th percentile, 70th percentile, 80th percentile, etc.</p>	<p>ensuring that the Maximum Reimbursable Charge (or “MRC”) for a service, commonly referred to in the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular MRC methodology adopted by the client. As noted in Cigna's prior response, Cigna makes available to client plans two MRC methodologies, MRC1 and MRC2, which serve as the foundation for Cigna's reimbursement program.</p> <p><u>Maximum Reimbursable Charge 1 (MRC1)</u></p> <p>In calculating the MRC for a service under the MRC1 methodology, Cigna applies a plan-sponsor-elected percentile to a charge (which is often referred to as a “U&amp;C” charge) as compiled in a national charges database. The charges in the database are derived based on factors including the service in question, charges submitted by providers located in the geographic area, specifically zip code groupings, if a charge for the zip code is available in which the claimant provider resides. That is, the evidentiary standard for the MRC for the service is the charge set forth in a national charges database for the service in the geographic area of the claimant provider that aligns with the percentile elected by the client. Plan sponsors may select one of several possible MRC1 percentiles to apply to the applicable charge; these percentiles, which vary by plan, include as follows: 50th percentile, 60th percentile,</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>More specifically, to calculate the MRC for professional (i.e., non-facility) claims Cigna utilizes the FAIR Health database, which is a database maintained by a third party vendor. FAIR Health collects actual charge data through a data contribution program available to its payer clients. FAIR Health clients (including Cigna) submit an extensive layout, including the non-discounted fee-for-service billed charges that are submitted to them by providers. Once FAIR Health receives the submission, the data are run through a validation process to validate zip code, procedure code, date of service, and other data.</p> <p><b>GeoZips:</b> FAIR Health GeoZips (geographical areas) are based on the first three digits of US ZIP codes. GeoZips may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. GeoZip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, local billing patterns and the quantity of available data are also taken into consideration. State boundaries are not crossed. FAIR Health currently has 494 GeoZips throughout the nation.</p> <p><b>Actual Charge Data:</b> Charges collected for a given period of time are sorted into appropriate GeoZips based on the provider zip codes.</p>	<p>70th percentile, 80th percentile, etc.</p> <p>More specifically, to calculate the MRC for professional (i.e., non-facility) claims Cigna utilizes the FAIR Health database, which is a database maintained by a third party vendor. FAIR Health collects actual charge data through a data contribution program available to its payer clients. FAIR Health clients (including Cigna) submit an extensive layout, including the non-discounted fee-for-service billed charges that are submitted to them by providers. Once FAIR Health receives the submission, the data are run through a validation process to validate zip code, procedure code, date of service, and other data.</p> <p><b>GeoZips:</b> FAIR Health GeoZips (geographical areas) are based on the first three digits of US ZIP codes. GeoZips may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. GeoZip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, local billing patterns and the quantity of available data are also taken into consideration. State boundaries are not crossed. FAIR Health currently has 494 GeoZips throughout the nation.</p> <p><b>Actual Charge Data:</b> Charges collected for a given period of time are sorted into appropriate GeoZips based on the</p>	



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Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>Once the charges are sorted by GeoZip, they are then sorted by CPT, ASA, ADA, or HCPCS procedure code. For each code, the charges are sorted in ascending order (lowest to highest). After the charges are sorted a total count of the charges is obtained. Each charge is assigned a number based on rank within the total count. To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.</p> <p>For example, if there are 200 charges for Procedure Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on line 160 is the 80<sup>th</sup> percentile. <math>200 \times .80 = 160</math></p> <p>Any other percentile can be found the same way: <math>200 \times .70 = 140</math> (The charge on line 140 is the 70<sup>th</sup> percentile) <math>200 \times .90 = 180</math> (The charge on line 180 is the 90<sup>th</sup> percentile)</p> <p>If there are at least 9 charges for a Procedure Code/GeoZip combination, then that is considered to be statistically valid.</p> <p><b>Actual Charge Data (National/USA values):</b> Charges collected for a given period of time are sorted by CPT, ASA, ADA, or HCPCS procedure</p>	<p>provider zip codes.</p> <p>Once the charges are sorted by GeoZip, they are then sorted by CPT, ASA, ADA, or HCPCS procedure code. For each code, the charges are sorted in ascending order (lowest to highest). After the charges are sorted a total count of the charges is obtained. Each charge is assigned a number based on rank within the total count. To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.</p> <p>For example, if there are 200 charges for Procedure Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on line 160 is the 80<sup>th</sup> percentile. <math>200 \times .80 = 160</math></p> <p>Any other percentile can be found the same way: <math>200 \times .70 = 140</math> (The charge on line 140 is the 70<sup>th</sup> percentile) <math>200 \times .90 = 180</math> (The charge on line 180 is the 90<sup>th</sup> percentile)</p> <p>If there are at least 9 charges for a Procedure Code/GeoZip combination, then that is considered to be statistically valid.</p> <p><b>Actual Charge Data (National/USA values):</b> Charges collected for a given period of time are</p>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>code. For each code, the charges are sorted in ascending order (lowest to highest). After the charges are sorted, a total count of the charges is obtained. Each charge is assigned a number based on rank within the total count.</p> <p>To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.</p> <p>For example, if there are 200 charges for Procedure Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on the line assigned to #160 is the 80<sup>th</sup> percentile. <math>200 \times .80 = 160</math>.</p> <p>Any other percentile can be found the same way: <math>200 \times .70 = 140</math> (The charge on line 140 is the 70<sup>th</sup> percentile) <math>200 \times .90 = 180</math> (The charge on line 180 is the 90<sup>th</sup> percentile)</p> <p>If there are at least 9 charges for a Procedure Code, then that is considered to be statistically valid.</p> <p><b>Derived Charge Data</b> If there are fewer than 9 charges for a Procedure Code, then data that is derived from charges for other services may be used. See next page for detailed description of FAIR Health’s derived charge</p>	<p>sorted by CPT, ASA, ADA, or HCPCS procedure code. For each code, the charges are sorted in ascending order (lowest to highest). After the charges are sorted, a total count of the charges is obtained. Each charge is assigned a number based on rank within the total count.</p> <p>To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.</p> <p>For example, if there are 200 charges for Procedure Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on the line assigned to #160 is the 80<sup>th</sup> percentile. <math>200 \times .80 = 160</math>.</p> <p>Any other percentile can be found the same way: <math>200 \times .70 = 140</math> (The charge on line 140 is the 70<sup>th</sup> percentile) <math>200 \times .90 = 180</math> (The charge on line 180 is the 90<sup>th</sup> percentile)</p> <p>If there are at least 9 charges for a Procedure Code, then that is considered to be statistically valid.</p> <p><b>Derived Charge Data</b> If there are fewer than 9 charges for a Procedure Code, then data that is derived from charges for other services may be used. See next page for</p>	



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>methodology.</p> <p><b>FAIR Health Relative Value Methodology (Derived Data)</b> FAIR Health employs a relative value methodology to calculate benchmarks in its FH Benchmarks modules when the actual data for a procedure code/geozip combination are insufficient to produce a benchmark. This methodology uses the relationships between procedure codes to determine the benchmark rates. Relative value methodologies are standard industry methods that use data for more frequently performed services in a specific geographic area and specific time period to derive values for less frequently performed services for the same geographic area and time period.</p> <p><b>Derivation Process</b> Derived Charge Data is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed, to get the relative value for the procedure code. The relative value is then multiplied by the Geozip area Conversion Factor to get the derived charge.</p> <p><b>Code Range</b> FAIR Health groups related procedure codes into a series of ranges. Using a range of codes, FAIR Health can model less frequently performed services using the billing patterns of frequently performed</p>	<p>detailed description of FAIR Health’s derived charge methodology.</p> <p><b>FAIR Health Relative Value Methodology (Derived Data)</b> FAIR Health employs a relative value methodology to calculate benchmarks in its FH Benchmarks modules when the actual data for a procedure code/geozip combination are insufficient to produce a benchmark. This methodology uses the relationships between procedure codes to determine the benchmark rates. Relative value methodologies are standard industry methods that use data for more frequently performed services in a specific geographic area and specific time period to derive values for less frequently performed services for the same geographic area and time period.</p> <p><b>Derivation Process</b> Derived Charge Data is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed, to get the relative value for the procedure code. The relative value is then multiplied by the Geozip area Conversion Factor to get the derived charge.</p> <p><b>Code Range</b> FAIR Health groups related procedure codes into a series of ranges. Using a range of codes, FAIR Health can model less frequently performed services</p>	



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>similar services in the same geographic area and time period. All charge data for the codes within a range are used to derive the percentile values for each of the codes under this methodology.</p> <p><b>Relative Value</b> Each code has a relative value, a number designed to represent the resources used to provide the service represented by the code. FAIR Health uses a third-party relative value scale that is commonly used in the industry.</p> <p><b>Geozip</b> FAIR Health defines geographic areas for its data generally on the basis of the first three digits of a ZIP code. Referred to as a geozip, an area may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. Geozip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, similarities in billing patterns and the quantity of available data are also taken into consideration. In most cases, geozips do not cross state boundaries. FAIR Health currently divides the United States into 493 geozips.</p> <p><b>Conversion Factor</b> The conversion factor is determined by dividing each of the billed charges for every code in a range by its associated relative value.</p> <p><b>Note:</b> A code must have a relative value in order for</p>	<p>using the billing patterns of frequently performed similar services in the same geographic area and time period. All charge data for the codes within a range are used to derive the percentile values for each of the codes under this methodology.</p> <p><b>Relative Value</b> Each code has a relative value, a number designed to represent the resources used to provide the service represented by the code. FAIR Health uses a third-party relative value scale that is commonly used in the industry.</p> <p><b>Geozip</b> FAIR Health defines geographic areas for its data generally on the basis of the first three digits of a ZIP code. Referred to as a geozip, an area may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. Geozip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, similarities in billing patterns and the quantity of available data are also taken into consideration. In most cases, geozips do not cross state boundaries. FAIR Health currently divides the United States into 493 geozips.</p> <p><b>Conversion Factor</b> The conversion factor is determined by dividing each of the billed charges for every code in a range by its associated relative value.</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>FAIR Health to develop a derived rate. Examples of codes with no relative value are unlisted CPT codes and unlisted HCPCS codes.</p> <p>For any client plan that has adopted the MRC1 methodology, FAIR Health’s charges database is used to calculate the MRC for either outpatient MH/SUD or M/S services rendered by health care professionals (i.e., non-facility). If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered outpatient professional claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient professional claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Outpatient facility claims are calculated by reference to a database maintained by Viant, which is a business unit within MultiPlan and derives MRC amounts for outpatient facility services in a similar way to how FAIR Health derives MRC amounts for outpatient professional services. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any</p>	<p><b>Note:</b> A code must have a relative value in order for FAIR Health to develop a derived rate. Examples of codes with no relative value are unlisted CPT codes and unlisted HCPCS codes.</p> <p>For any client plan that has adopted the MRC1 methodology, FAIR Health’s charges database is used to calculate the MRC for either outpatient MH/SUD or M/S services rendered by health care professionals (i.e., non-facility). If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered outpatient professional claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient professional claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Outpatient facility claims are calculated by reference to a database maintained by Viant, which is a business unit within MultiPlan and derives MRC amounts for outpatient facility services in a similar way to how FAIR Health derives MRC amounts for outpatient professional services. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will</p>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>otherwise covered outpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient facility claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Inpatient facility claims, including acute hospital services or subacute services are not subject to an MRC under the MRC1 methodology. Instead, the reimbursement rates for inpatient facility claims are calculated based on any indirect discount arrangement that Cigna accesses through a vendor or, if one is unavailable or exceeds the facility’s billed charges, the facility’s billed charges. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered inpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered inpatient facility claim will be paid at the provider’s billed charges.</p> <p><u>Maximum Reimbursable Charge 2 (MRC2)</u></p> <p>Under MRC2, the plan applies to a covered inpatient or outpatient service a percentage of a charge based</p>	<p>dictate the allowable reimbursement rate for any otherwise covered outpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient facility claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Inpatient facility claims, including acute hospital services or subacute services are not subject to an MRC under the MRC1 methodology. Instead, the reimbursement rates for inpatient facility claims are calculated based on any indirect discount arrangement that Cigna accesses through a vendor or, if one is unavailable or exceeds the facility’s billed charges, the facility’s billed charges. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered inpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered inpatient facility claim will be paid at the provider’s billed charges.</p> <p><u>Maximum Reimbursable Charge 2 (MRC2)</u></p> <p>Under MRC2, the plan applies to a covered inpatient</p>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>on a methodology similar to that used by CMS to pay Medicare claims, in which a charge is derived similarly to CMS’ fee schedule methodology in that factors like service type, place of service, and geographic location impact the charge used to calculate the MRC, which are defined generally by reference to CMS’ fee schedule methodology. Most of CMS’ methodologies adjust payments based on regional costs and whether the claimant is a practitioner or a facility. Specifically, physician fees are adjusted based on the geographic practice cost index (GPCI) in about 100 localities, and institutional payments are adjusted for wage variations in about 200 core-based statistical areas (CBSA). Additionally, durable medical equipment (DME) and lab fees are adjusted by state, and ambulance fees are adjusted by GPCI and by the degree of urbanization.</p> <p>The evidentiary standards for the aforementioned factors informing the MRC are reflected in the Medicare fee schedule or, where no Medicare fee exists for a service (e.g. a service not covered by Medicare), a charge generally developed by reference to the Medicare methodology. Specifically, Cigna obtains Medicare fees for inpatient facility services from the CMS Inpatient Prospective Payment System (IPPS) schedule, outpatient facility services from the CMS Outpatient Prospective Payment System (OPPS) schedule, and outpatient professional services from the CMS</p>	<p>or outpatient service a percentage of a charge based on a methodology similar to that used by CMS to pay Medicare claims, in which a charge is derived similarly to CMS’ fee schedule methodology in that factors like service type, place of service, and geographic location impact the charge used to calculate the MRC, which are defined generally by reference to CMS’ fee schedule methodology. Most of CMS’ methodologies adjust payments based on regional costs and whether the claimant is a practitioner or a facility. Specifically, physician fees are adjusted based on the geographic practice cost index (GPCI) in about 100 localities, and institutional payments are adjusted for wage variations in about 200 core-based statistical areas (CBSA). Additionally, durable medical equipment (DME) and lab fees are adjusted by state, and ambulance fees are adjusted by GPCI and by the degree of urbanization.</p> <p>The evidentiary standards for the aforementioned factors informing the MRC are reflected in the Medicare fee schedule or, where no Medicare fee exists for a service (e.g. a service not covered by Medicare), a charge generally developed by reference to the Medicare methodology. Specifically, Cigna obtains Medicare fees for inpatient facility services from the CMS Inpatient Prospective Payment System (IPPS) schedule, outpatient facility services from the CMS Outpatient Prospective Payment System (OPPS) schedule, and</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	Physician Fee Schedule. And for services without an available Medicare fee, Cigna generally utilizes a methodology similar to Medicare, whereby, along with the Geographic Practice Cost Indices and conversion factors, Cigna utilizes a derived Relative Value Unit (RVU) using the RVU for a similar service or calculating what the RVU should be based on an assessment of the factors informing the RVU figure. Under MRC2, plan sponsor clients can select the percentage of the MRC paid to health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. These percentages are applied uniformly to the MRC for MH/SUD and M/S inpatient and outpatient services.	outpatient professional services from the CMS Physician Fee Schedule. And for services without an available Medicare fee, Cigna generally utilizes a methodology similar to Medicare, whereby, along with the Geographic Practice Cost Indices and conversion factors, Cigna utilizes a derived Relative Value Unit (RVU) using the RVU for a similar service or calculating what the RVU should be based on an assessment of the factors informing the RVU figure. Under MRC2, plan sponsor clients can select the percentage of the MRC paid to health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. These percentages are applied uniformly to the MRC for MH/SUD and M/S inpatient and outpatient services.	
<b>Restrictions on Provider Billing Codes</b>			
<b>Explain any restrictions the plan places on provider billing codes</b>	<p>Cigna does not place restrictions on provider billing codes or place restrictions on M/S providers that would limit the scope of their practice.</p> <p>Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes or applicable Centers for Medicare &amp; Medicaid Services (CMS) medical reporting code requirements. Appropriate billing instructions are set forth in the provider's contract.</p>	<p>Cigna does not place restrictions on provider billing codes or place restrictions on MH/SUD providers that would limit the scope of their practice.</p> <p>Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes or applicable Centers for Medicare &amp; Medicaid Services (CMS) medical reporting code requirements. Appropriate billing instructions are set forth in the provider's contract.</p>	<p>Cigna requires claims to be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes for both M/S and MH/SUD providers. Cigna does not place any additional restrictions on provider billing codes for M/S or MH/SUD.</p> <p>Consistency in provider billing process evidences compliance with the NQL requirement that the medical management process be applied</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			comparably, and no more stringently, to MH/SUD services than to M/S services.
<b>Restrictions on Provider Specialty</b>			
<b>Explain any restrictions the plan places on services provided by specialty providers.</b>	Cigna does not place any restrictions on provider		
<b>Post Claim Payment Retrospective Review (Fraud, Waste and Abuse)</b>			
Cigna maintains corporate-wide policies applicable to multiple business segments including Cigna Healthcare (M/S) and Behavioral Health (MH/SUD), and policies applicable to specific business segments only. Cigna defines Post-Payment Retrospective Review as its medical necessity review of a claim after a service has already been provided and after the claim for that service has already been paid.	<p>Cigna does not routinely impose post payment medical necessity review on a retrospective basis. All M/S and MH/SUD services and providers are subject to fraud, waste and abuse compliance.</p> <p>Cigna Healthcare and Evernorth Behavioral Health maintain one Anti-Fraud Plan and one Special Investigations Unit (“SIU”), which is part of the Corporate Audit Department. SIU is responsible for anti-fraud detection and investigation, prepayment saving and post payment recovery services.</p> <p>The only instance in which a post-claim payment retrospective review might occur would be the result of application of the protocols implemented by Cigna’s SIU program, which serves, as relevant here, to identify and prevent the payment of fraudulent claims. Only those benefits that are flagged through an SIU program, which are generally agnostic to whether the benefit is MH/SUD or M/S, would be subject to retrospective review to determine whether fraud was involved. Importantly, Cigna does not</p>	Same as Medical/Surgical	<p><b>As written:</b> While Cigna maintains that the SIU’s programs do not constitute NQTLs because they do not in any way limit benefits, the overall process for identifying potentially fraudulent claims is identical for both MH/SUD and M/S services. As made clear in Cigna policies, different approaches may be taken for certain types of benefits that reflect the variance in the manner in which fraud, waste, and abuse might occur in any given setting. For example, overbilling related to IOP might be investigated in a manner that differs from the way in which non-routine laboratory work is investigated.</p> <p><b>In Operation:</b> Cigna applies general policies without regard to whether a given service is a MH/SUD or M/S service. Cigna has developed specific written policies governing the investigation of substance use disorder benefits and laboratory services where potentially fraudulent activity is commonly reported. In operation, the SIU has investigated a significantly</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>believe that its SIU program constitutes an NQL because the program does not in any way limit the duration or scope of benefits that are available under the plan.</p> <p>To the extent fraud, waste, or abuse is identified and any overpayments are recovered, this is entirely outside the terms and conditions of the plan or coverage. By definition, this cannot be an NQL, which is broadly defined as a limitation on benefits under the plan. Nevertheless, Cigna has prepared this NQL comparative analysis to describe its Post-Payment Retrospective Review program, and therefore its SIU program.</p> <p>Cigna does not incorporate language related to fraud detection in its certificate or benefits booklet. There are no terms related to post-claim payment retrospective review contained in the GSA. Information related to Health Care Fraud is posted online including how to report health care fraud on the Cigna website: <a href="https://www.cigna.com/legal/members/report-fraud">https://www.cigna.com/legal/members/report-fraud</a>.</p> <p><b>Factors</b> The SIU provides anti-fraud detection and investigation, pre-payment savings, and post-payment recovery services. As part of Cigna’s corporate audit department, the SIU actively detects, investigates, and deters fraud. The SIU performs the following activities:</p>		<p>larger number of potentially fraudulent M/S claims as compared to MH/SUD claims.</p> <p>As noted herein, Cigna applies the same general principals to identifying and investigating potentially fraudulent claims behavior by providers and facilities without regard to whether the provider or facility is MH/SUD or M/S. The operation of Cigna’s SIU, which results in retrospective review of claims, is identical for both MH/SUD and M/S services and therefore meets the comparability requirement. In operation, the SIU program is applied no more stringently to MH/SUD benefits as it is to M/S benefits, as evidenced by the significantly higher number of claims investigated for M/S services as compared to MH/SUD services.</p> <p>Cigna maintains that detection of fraud, waste, or abuse and claims overpayment recovery is outside the scope of MHPAEA and its NQL requirements because these things are outside the scope of covered benefits under the plan, and NQLs by definition only limit valid benefits under the plan. However, to the extent fraud, waste, and abuse detection and claims overpayment recovery could be considered an NQL, Cigna concludes that the SIU process nevertheless meets the requirements of the NQL rule in MHPAEA.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>• conducting investigations and analyzing cases to determine the scope of potential fraud</li><li>• flagging health care providers/facilities/members in claim systems to ensure payments suspected of fraud are addressed prior to releasing funds</li><li>• obtaining evidence for referrals to law enforcement, regulatory agencies, and associations</li><li>• pursuing civil recoveries</li><li>• delivering anti-fraud training and communicating current fraud schemes to Cigna employees</li><li>• using advanced technology and data-mining techniques to identify suspect behavior or patterns of possible fraudulent providers/facilities</li><li>• serving as a founding member of the National Health Care Anti-Fraud Association (NHCAA), an organization made up of health care experts from the public and private sectors</li><li>• partnering with the Health Insurance Counter Fraud Group, which includes participants from 32 health insurance companies to prevent and detect health care fraud</li><li>• working with clients and members who inform us of discrepancies that may reveal potential fraud</li></ul> <p>The SIU works in partnership with dedicated resources within our claim, legal, and clinical management teams to establish guidelines and controls to assist in the fight against fraud and abuse. While the SIU leads Cigna’s anti-fraud activities, its</p>		





Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>efforts are complemented by almost two million individual standards-based (e.g., National Correct Coding Initiative, CMS) claim edits incorporated as a part of the claim payment process and by multiple targeted prepayment programs to address areas of potential risk (DRGs, implantable devices, complex claims, and specialties).</p> <p><b>Evidentiary Standards</b> SIU relies on the following definitions:</p> <ul style="list-style-type: none"><li>• Fraud: Knowingly and wilfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretences, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.</li><li>• Waste: Practices that, directly or indirectly, result in unnecessary costs to the underlying health plan, such as overusing services. Waste is generally considered a misuse of resources.</li><li>• Abuse: Actions that may, directly or indirectly, result in unnecessary costs such as paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.</li></ul> <p>Cigna does not establish thresholds for any one of these factors but instead utilizes analytics to identify areas of risk and those areas are analyzed for potential</p>		



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	investigation. Analytics assess risk to the portfolio and risk to individual clients. SIU also maintains a fraud hotline and all referrals to the hotline or similar intake capability are assessed.		



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

<b>Cigna Health and Life Insurance Company (CHLIC)</b>	<b>Last Revised:</b> January 10, 2023
<b>Health Plan Products:</b> Open Access Plus, Preferred Provider Organization, Network Point of Service, Network Point of Service Open Access, Point of Service	<b>Prescription Drug Coverage:</b> Yes
<b>Utilization Management Model:</b> Inpatient & Outpatient	<b>Funding Types:</b> Insured & Self-Funded

<b>Non-Quantitative Treatment Limitation (NQL)</b>	<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>	<b>Comparative Analysis Conclusions</b>
<b>Medical Necessity</b>			
All M/S and MH/SUD services, whether in-network or out-of-network must be medically necessary. Services determined by Cigna not to be medically necessary would be excluded under the terms of the plan unless otherwise dictated by regulatory requirement or specific plan design.	<p>Cigna Health Management, Inc., an affiliate of CHLIC performs utilization reviews for most medical/surgical (M/S) benefits. A separate entity, eviCore, reviews certain M/S services for Cigna, American Specialty Health, reviews physical therapy and occupational therapy on behalf of CHLIC and both national and regional vendors to perform UM. All entities adhere to Cigna’s policies and procedures when performing utilization reviews, and all of the data provided is inclusive of utilization reviews of certain M/S services.</p> <p>Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna’s standard definition of “medical necessity” is as follows:</p>	<p>Evernorth Behavioral Health (“Evernorth,” “EBH” or “Behavioral Health” formerly Cigna Behavioral Health) an affiliate of CHLIC, performs utilization reviews for MH/SUD benefits. No separate entities review MH/SUD services for CHLIC.</p> <p>Cigna employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, Cigna’s standard definition of “medical necessity” is as follows:</p> <p><b>“Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that</p>	<p>A review of Cigna’s written policies and processes reveals the comparable application of Medical Necessity to M/S and MH/SUD services within the applicable benefit classification. Cigna’s Medical Necessity coverage policy development and application process is consistent between M/S and MH/SUD. Cigna applies comparable evidence-based guidelines to define established standards of effective care in both M/S and MH/SUD benefits. Compliance is further demonstrated through Cigna’s uniform definition of Medical Necessity for M/S and MH/SUD benefits. Consistency in policy development, process and application evidences compliance with the NQL requirement that the medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services.</p> <p><b>Peer to Peer Review Variation</b></p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
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Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p><b>“Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services,</li></ul>	<p>are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. 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.</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. 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.</li></ul>	<p>With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, Cigna ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee’s clinical situation warrants an approval for medically necessary care yet the provider’s request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials.</p> <p>Cigna’s medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and Cigna’s Clinical Coverage policies and plan documents approved for use in care management determinations. Cigna’s Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and Cigna’s Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care</p>

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	<p>supplies, medications or settings when determining least intensive setting.</p> <p>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.</p> <p>In determining whether health care services, supplies, or medications are Medically Necessary, the Cigna Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies 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.”</p> <p><b>Development of Clinical Criteria</b> Cigna utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of M/S services, procedures, devices, equipment, imaging, diagnostic interventions and its own internally developed Coverage Policies and the MCG™ Care Guidelines.</p> <p>The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines</p>	<p>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.</p> <p>In determining whether health care services, supplies, or medications are Medically Necessary, the Cigna Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies 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.”</p> <p><b>Development of Clinical Criteria</b> Cigna utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of MH services, procedures, devices, equipment, imaging, diagnostic interventions and the ASAM criteria for conducting medical necessity reviews of SUD services.</p> <p>The Medical Technology Assessment Committee (MTAC) 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,</p>	<p>where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer.</p> <p>The Peer-to-Peer review is available for any coverage request for which Cigna anticipates issuing a denial Cigna incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a Cigna clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the Cigna Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the Cigna Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the Cigna clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request.</p> <p>If Cigna’s pro-active, <i>volunteer</i> Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>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 M/S services determined to be experimental and investigational.</p> <p>Clinical coverage policies 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.</p> <p>While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies.</p> <p>Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to</p>	<p>devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address MH/SUD services determined to be experimental and investigational.</p> <p>Clinical coverage policies 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.</p> <p>While Cigna's Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving technologies.</p> <p>Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.</p>	<p>discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. Cigna's pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to Cigna.</p> <p>Cigna has not identified any additional discrepancies in operational policies between MH/SUD and M/S benefits where the discrepancies present a comparability or stringency problem within the context of the NQL requirement. Instances where discrepancies between the process of administering MH/SUD and M/S benefits do not present an NQL issue include, for example, situations where a discrepancy in process is <i>more</i> advantageous to the administration of MH/SUD benefits than M/S benefits such as the pro-active behavioral health peer-to-peer review process outlined herein. The Peer-to-Peer analysis is addressed in the "in operation" section of this submission set forth below.</p> <p>Cigna regularly reviews utilization management data to evaluate and ensure operational compliance of the medical management suite of NQLs, including Medical Necessity and Appeals, Prior Authorization</p>

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	<p>revise its coverage policies governing reviews of MH/SUD benefits.</p> <p><b>Factors</b> Cigna maintains medical necessity criteria (also referred to as clinical criteria) for all medical health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG or are developed by Cigna from the comparison of national, scientific and evidenced based criteria sets. Cigna's Medical Technology Assessment Committee ("MTAC") reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. Cigna reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process.</p> <p>Cigna requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all M/S benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the</p>	<p><b>Factors</b> Cigna maintains medical necessity criteria (also referred to as clinical criteria) for all behavioral health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG, the American Society of Addiction Medicine ("ASAM") or are developed by Cigna from the comparison of national, scientific and evidenced based criteria sets. Cigna's Medical Technology Assessment Committee ("MTAC") reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. Cigna reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process.</p> <p>Cigna requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all MH/SUD benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the</p>	<p>and Concurrent Review. Data is reviewed by benefit classification and sub-classification to calculate denial rates to ensure comparability. Cigna's application of the medical necessity</p> <p>NQTL, specifically approvals and denials rates, for Prior Authorization, Retrospective Review, and Concurrent Review across benefit classifications for a sampling of Cigna plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits for the Cigna book of business including all commercial data Medical Necessity denial rates.</p> <p>Cigna utilizes appeals data to review the number of utilization review decisions across the book-of-business. Appeals data is delineated by pre and post services and includes prior authorization and concurrent review, overturned for the same time period relating to the utilization management data metrics included in Cigna's book of business data. Data reflected overall comparable overturn rates across benefit classifications. The sample size for Georgia specific data did not allow for a statistically significant sample for appeals.</p> <p>While the rate of appeals, where the original denial for lack of medical necessity was upheld, is higher for MH/SUD than for M/S claims for the Cigna book of business. This appeal rate, coupled with the utilization management data reflecting higher Medical Necessity</p>

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	<p>standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.</p> <p><b>Sources and Evidentiary Standards</b> The use of the various guidelines for clinical criteria/medical necessity (both external and internal) <u>do not overlap</u> and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific Cigna medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee ("MTAC"), 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.</p> <p>MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists.</p>	<p>reviewed, evidence-based scientific literature or guidelines.</p> <p><b>Sources and Evidentiary Standards</b> The use of the various guidelines for clinical criteria/medical necessity (both external and internal) <u>do not overlap</u> and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific Cigna medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee ("MTAC"), 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.</p> <p>MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists.</p>	<p>denial rates for M/S claims than for MH/SUD claims is representative of Cigna's proactive approach to peer-to-peer review. Approximately 37% of all pre-service MH/SUD peer-to-peer reviews inclusive of read only reviews, which includes a Medical Director review of the medical file without discussion when a peer-to-peer is scheduled but the requesting provider does not attend, in Cigna's book-of-business data resulted in approvals that may have otherwise have resulted in a medical necessity denial.</p> <p>Additionally, Cigna conducts routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) testing is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Corrective action is initiated if a score falls below 85% and if the results are below 90% the Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits.</p> <p>The number of utilization review decisions across the Cigna book of business data, reflects comparable average denial rates based upon Medical Necessity across all benefit classifications for utilization management programs including prior authorization, concurrent review and retrospective review with</p>

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	<p>The Cigna-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the “Behavioral Health” clinicians listed in the “Coverage Policy SME” tab – consulted when drafting or reviewing coverage policies).</p> <p>The MTAC’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna’s Medical Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48):</p>	<p>The Cigna-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the “Behavioral Health” clinicians listed in the “Coverage Policy SME” tab – consulted when drafting or reviewing coverage policies).</p> <p>The MTAC’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in Cigna’s Medical Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48) :</p>	<p>medical necessity denials for M/S services on average higher than medical necessity denials of MH/SUD services. A review was completed with Georgia data across all benefit classifications and medical necessity denials for M/S services were on average higher than medical necessity denials of MH/SUD services. While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement.</p> <p>Cigna concludes the Medical Necessity NQTL is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. In performing the ‘as written’ comparative analysis Cigna reviewed applicable policies, processes and procedures to ensure comparability of the application of Medical Necessity to M/S and MH/SUD services which revealed the application of Medical Necessity to be applied to MH/SUD services no more stringently than M/S Services. In performing the operational analysis of the application of UM, Cigna reviewed denial rates for both M/S and MH/SUD within each classification of benefits and for benefits subject to prior authorization, concurrent review, and retrospective review.</p>

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	<p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p> <p>The MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD</p>	<p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p> <p>The MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD</p>	





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Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes.</p> <p><b>Medical Necessity Appeals</b> Cigna uses the same factors, sources and evidentiary standards applicable to the medical necessity NQTL for the Medical Necessity Appeals.</p> <p><b>Internal Appeals.</b> Cigna follows the same internal appeal process for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits for both M/S and MH/SUD. For medical necessity reviews a second health care professional, who was not involved in any previous decision and is not a subordinate of the individual in the previous decision, performs an appeal, whether expedited or standard.</p> <p>Expedited appeals are completed within 72 hours. Standard level 1 and level 2 pre-service medical necessity appeals are completed within 15 calendar days and standard post-service level 1 and level 2 medical necessity appeals are completed within 30 calendar days, post-service administrative appeals are completed within 30 calendar days. The assigned appeal processor notes the adverse determination as a denial in our system and communicates the determination by phone to the requesting party if the appeal was handled as expedited. At each step in the process, Cigna provides written notification of the</p>	<p>health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes.</p> <p><b>Medical Necessity Appeals</b> Cigna uses the same factors, sources and evidentiary standards applicable to the medical necessity NQTL for the Medical Necessity Appeals.</p> <p><b>Internal Appeals.</b> Cigna follows the same internal appeal process for resolving disputes regarding pre/post-service benefit coverage and medical necessity denials of requested benefits for both M/S and MH/SUD. For medical necessity reviews a second health care professional, who was not involved in any previous decision and is not a subordinate of the individual in the previous decision, performs an appeal, whether expedited or standard.</p> <p>Expedited appeals are completed within 72 hours. Standard level 1 and level 2 pre-service medical necessity appeals are completed within 15 calendar days and standard post-service level 1 and level 2 medical necessity appeals are completed within 30 calendar days, post-service administrative appeals are completed within 30 calendar days. The assigned appeal processor notes the adverse determination as a denial in our system and communicates the determination by phone to the requesting party if the appeal was handled as expedited. At each step in the process, Cigna provides written notification of the</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>outcome and resolution, including the clinical rationale for the determination to the member and the treating provider or facility.</p> <p><b>External Appeals.</b> Cigna informs customers of their right to request an external appeal to an IRO, at no cost to the Customer, in the final internal appeal denial letter for both M/S and MH/SUD external appeals. The communication provides the Customer with all information regarding the right of appeal, applicable time limitations and specific instructions on the initiation of an appeal by the Customer or the Customer’s designate. The National Appeals Organization will facilitate the appeal through the provision of program information and IRO program description.</p> <p>All records and materials relevant to the adverse determination and included in the previous appeal files are presented for review to an Independent Review Organization (IRO). New information and documentation submitted with the external review request is forwarded to the IRO to consider. The decision of the IRO is final and is binding on us and the plan. Relevant portions of the Customer’s contract (e.g., Certificate of Coverage, Summary Plan Description) are included in the materials for external review. The IRO will render a decision without deference to the previous decisions. Standard external appeals are completed within 45 days and expedited external appeals are completed within 72 hours.</p>	<p>outcome and resolution, including the clinical rationale for the determination to the member and the treating provider or facility.</p> <p><b>External Appeals.</b> Cigna informs customers of their right to request an external appeal to an IRO, at no cost to the Customer, in the final internal appeal denial letter for both M/S and MH/SUD external appeals. The communication provides the Customer with all information regarding the right of appeal, applicable time limitations and specific instructions on the initiation of an appeal by the Customer or the Customer’s designate. The National Appeals Organization will facilitate the appeal through the provision of program information and IRO program description.</p> <p>All records and materials relevant to the adverse determination and included in the previous appeal files are presented for review to an Independent Review Organization (IRO). New information and documentation submitted with the external review request is forwarded to the IRO to consider. The decision of the IRO is final and is binding on us and the plan. Relevant portions of the Customer’s contract (e.g., Certificate of Coverage, Summary Plan Description) are included in the materials for external review. The IRO will render a decision without deference to the previous decisions. Standard external appeals are completed within 45 days and expedited external appeals are completed within 72 hours.</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>Prior Authorization/Pre-Certification Review</b>			
<b>Process – Include all services for which prior authorization/pre-certification review is required. Describe any step-therapy or “fail first” requirements and requirements for submission of treatment request forms or treatment plans.</b>			
<b>Inpatient, In-Network Inpatient, Out-of-Network</b>  Prior Authorization is applied to all non-emergent inpatient benefits, including residential services. The MH/SUD and M/S services assigned to the inpatient classification include non-emergent MH/SUD and M/S services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other facility and non-emergent MH/SUD services. This specifically includes, for MH/SUD and M/S benefits.  <b>M/S Inpatient Services :</b> <ul style="list-style-type: none"><li>Acute Inpatient Services,</li><li>Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc.</li><li>Inpatient Professional Services</li></ul>	<b>Inpatient, In-Network and Out-of-Network Services Subject to Prior Authorization</b>  All non-emergent M/S inpatient services are subject to pre-service medical necessity review (i.e., prior authorization, precertification review (PCR)) including Inpatient, In-Network and Inpatient, Out-of-Network benefits. Cigna has no additional Prior Authorization requirements applied to Out-of-Network M/S benefits than it does to that applied to Inpatient, In-Network M/S benefits.  <b>Process</b> For a service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. If the request cannot be authorized using an approved algorithm, the case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she	<b>Inpatient, In-Network and Out-of-Network Services Requiring Prior Authorization</b>  All non-emergent MH/SUD inpatient services are subject to pre-service medical necessity review (i.e., prior authorization, precertification review (PCR)) including Inpatient, In-Network and Inpatient, Out-of-Network benefits. Cigna has no additional Prior Authorization requirements applied to Out-of-Network MH/SUD benefits than it does to that applied to Inpatient, In-Network MH/SUD benefits.  <b>Process</b> For a service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. . If the request cannot be authorized using an approved algorithm, t the case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she	Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria.  A review of Cigna’s written policies and processes reveals the comparable process by which MH/SUD and M/S services are selected for application of prior authorization within the applicable benefit classification the evidences comparability and equivalent stringency in-writing and in-operation.  First, a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD services shall be subject to prior authorization or concurrent review. To the extent any MH/SUD services within the inpatient or outpatient classifications are considered for inclusion on the “precertification list” a Cigna-employed Medical Director with former practice experience as a

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<p><b>MH/SUD Inpatient Services:</b></p> <ul style="list-style-type: none"><li>• Mental Health Acute Inpatient Services</li><li>• Mental Health Subacute Residential Treatment</li><li>• Mental Health Inpatient Professional Services</li><li>• SUD Acute Inpatient Services</li><li>• SUD Acute Inpatient Detoxification</li><li>• SUD Subacute Residential Treatment</li><li>• SUD Inpatient Professional Services</li></ul> <p>No MH/SUD inpatient benefits are subject to fail-first and/or step therapy requirements.</p>	<p>authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e., peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S or MH/SUD inpatient days upon pre-service review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna (clinical appropriateness) the value of the service exceeds the administrative costs, and verification that a service will be rendered for a covered benefit.</p> <p>All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification</p>	<p>authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e., peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S or MH/SUD inpatient days upon pre-service review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna (clinical appropriateness) the value of the service exceeds the administrative costs, and verification that a service will be rendered for a covered benefit.</p> <p>All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification</p>	<p>psychiatrist and expertise in, and dedicated support for, behavioral health matters is consulted to ensure appropriate evaluation of MH/SUD services that may be considered for application of prior authorization and concurrent review.</p> <p>Cigna's MTAC – which includes representation across a number of disciplines, including MH/SUD expertise – approves any implementation of, or changes to, coverage policies used to make medical necessity determinations to ensure the appropriateness of the same. The inclusion of appropriate representation of MH/SUD expertise in the coverage policy development process ensures that coverage policies for MH/SUD benefits appropriately incorporate generally-accepted standards of practice, including consideration of type or duration of treatment or level of care for patients with specific MH/SUD conditions.</p> <p>Comparable representation of expertise in MH/SUD services is therefore ensured to the extent any MH/SUD benefits may be considered for inclusion on the precertification list, thus ensuring comparable reviews of MH/SUD benefits. Moreover, the list of services subject to prior authorization and concurrent review is reviewed no less frequently than annually to determine if any services, whether MH/SUD or M/S, should be removed or added to the list, so the frequency of review of the continued appropriateness</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>based upon high cost, high risk and complexity for members receiving the service.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Internal claims data</li><li>• UM program operating costs</li><li>• UM authorization data</li><li>• Expert Medical Review</li><li>• Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b></p> <p>The evidentiary standard relied on to determine whether to apply prior authorization to inpatient M/S 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 M/S 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:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• For services for which Cigna maintains</li></ul>	<p>based upon high cost, high risk and complexity for members receiving the service.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Internal claims data</li><li>• UM program operating costs</li><li>• UM authorization data</li><li>• Expert Medical Review</li><li>• Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b></p> <p>The evidentiary standard relied on to determine whether to apply prior authorization to inpatient MH/SUD 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 MH/SUD 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:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• For services for which Cigna maintains</li></ul>	<p>of application of prior authorization is comparable across MH/SUD and M/S benefits.</p> <p>Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the prior authorization list. Because the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization).</p> <p>An “in operation” review of Cigna’s application of the Prior Authorization NQL, specifically approvals and denial information, in the In-Patient, In-Network classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business data. A review was completed with Georgia data for the In-patient classification and revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQL compliance, and an insurer may comply with the NQL requirement notwithstanding a disparate outcome for an NQL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQL requirement. Consequently,</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>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.</p> <p>Clinical Appropriateness is defined as those services that as determined in the exercise of the professional judgement of Cigna's internal medical experts, are in accordance with generally accepted standards of care and nationally recognized guidelines. Nationally recognized guidelines are included in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 as outlined in the development of clinical criteria of Medical Necessity.</p>	<p>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.</p> <p>Clinical Appropriateness is defined as those services that as determined in the exercise of the professional judgement of Cigna's internal medical experts, are in accordance with generally accepted standards of care and nationally recognized guidelines. Nationally recognized guidelines are included in Cigna's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 as outlined in the development of clinical criteria of Medical Necessity.</p>	<p>Cigna concludes that the NQL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>Cigna also reviewed the ROIs for both MH/SUD and M/S non-emergent inpatient admissions. For the purposes of the ROI calculation, the estimated costs to perform a coverage review, which is informed by costs/expenses for personnel salaries and time to review. Cigna reviewed the ROI for both M/S and MH/SUD non-emergent inpatient admissions. M/S services for non-emergent inpatient admissions calculated at 9:1 for 2019, 8:0 for 2020 and 10:1 for partial year 2021 and ROIs for MH/SUD services for non-emergent inpatient admissions calculated at 2.93:1 for 2019, 2.05:1 for 2020 and 2.03:1 for partial year 2021 respectively. These calculations are consistent with the factor/evidentiary standard outlined in Steps 2 and 3, namely that the application of prior authorization to inpatient M/S benefits produces a positive savings for both MH/SUD and M/S benefits, as measured in the aggregate across the Cigna-administered book-of-business. To be clear, if the number preceding the colon is greater than 1 (e.g., 2.93), then the application of prior authorization produces a positive ROI and thus meets the evidentiary standard for application of the same to MH/SUD or M/S inpatient benefits.</p> <p>The process by which services are considered for application of Prior Authorization is comparable in</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			writing and in operation across MH/SUD and M/S benefits, as evidenced by Cigna’s assessment of several components of the prior authorization determination process in the overall context of its utilization management programs.
<b>Outpatient Office Visits, In-Network</b> <b>Outpatient Office Visits, Out-of-Network</b>	<b>Not Applicable.</b>	<b>Not Applicable.</b>	Cigna sub-classifies the outpatient benefit classification into Outpatient-Office Visit and Outpatient-All Other for MH/SUD and M/S benefits. The Prior Authorization NQTL does not apply to MH/SUD or M/S services assigned to the Outpatient-Office Visits sub-classification.
<b>All Other Outpatient Services, In-Network</b> <b>All Other Outpatient Services, Out-of-Network</b>  The Prior Authorization NQTL is applied to certain Outpatient-All Other MH/SUD and M/S services sub-classification including:  <b>M/S Outpatient-All Other Services</b> Advanced imaging services (e.g., CT scans, PET scans, MRIs, diagnostic cardiology) Certain outpatient surgical procedures Certain cardiology procedures Clinical trials	<b>All Other Outpatient, In-Network and Out-of-Network Services Subject to Prior Authorization</b>  The Prior Authorization NQTL is applied to certain Outpatient, In-Network and Out-of-Network M/S services in the All Other sub-classification (typically those subject to higher cost and/or utilization). Cigna has no additional Prior Authorization requirements applied to Out-of-Network M/S benefits than it does to that applied to Inpatient, In-Network M/S benefits.  <b>Process</b> For an All Other Outpatient, In Network or Out-of-Network service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an outpatient service electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who	<b>All Other Outpatient, In-Network and Out-of-Network Services Subject to Prior Authorization</b>  The Prior Authorization NQTL is applied to certain Outpatient In-Network and Out-of-Network MH/SUD services in the All Other sub-classification (typically those subject to higher cost and/ or utilization). Cigna has no additional Prior Authorization requirements applied to Out-of-Network MH/SUD benefits than it does to that applied to Inpatient, In-Network MH/SUD benefits.  <b>Process</b> For an All Other Outpatient, In Network or Out-of-Network service subject to prior authorization, the enrollee’s treating provider submits a request for benefit authorization of an outpatient service electronically or by phone, fax or mail. The case is	Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria.  <b>As Written</b> A review of Cigna’s written policies and processes reveals the comparable process by which MH/SUD and M/S services are selected for application of prior authorization within the applicable benefit classification the evidences comparability and equivalent stringency in-writing and in-operation.  First, a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
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	<p>collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the outpatient service requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the outpatient service at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the outpatient service at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Pre-Certification List</b> Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.</p> <p>When determining which M/S All Other Outpatient benefits are subject to pre-service medical necessity review (prior authorization/ precertification), Cigna</p>	<p>referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the outpatient service requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the outpatient service at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the outpatient service at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p><b>Pre-Certification List.</b> Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.</p>	<p>services shall be subject to prior authorization or concurrent review. To the extent any MH/SUD services within the inpatient or outpatient classifications are considered for inclusion on the “precertification list” a Cigna-employed Medical Director with former practice experience as a psychiatrist and expertise in, and dedicated support for, behavioral health matters is consulted to ensure appropriate evaluation of MH/SUD services that may be considered for application of prior authorization and concurrent review.</p> <p>Cigna's MTAC – which includes representation across a number of disciplines, including MH/SUD expertise – approves any implementation of, or changes to, coverage policies used to make medical necessity determinations to ensure the appropriateness of the same. The inclusion of appropriate representation of MH/SUD expertise in the coverage policy development process ensures that coverage policies for MH/SUD benefits appropriately incorporate generally-accepted standards of practice, including consideration of type or duration of treatment or level of care for patients with specific MH/SUD conditions.</p> <p>Comparable representation of expertise in MH/SUD services is therefore ensured to the extent any MH/SUD benefits may be considered for inclusion on the precertification list, thus ensuring comparable reviews of MH/SUD benefits. Moreover, the list of</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<p>procedure or service is billed as “unlisted,” meaning that no existing CPT code exists for the procedure or service)</p> <p><b>MH/SUD Outpatient-All Other Services</b> Partial Hospitalization Applied Behavior Analysis (ABA) Transcranial Magnetic Stimulation</p>	<p>conducts at least annually, a Precertification Code Review Procedure by the Total Health and Network Operations and Medical Economics Coverage Policy, Precertification Team (“Precertification Team”). Precertification Team workgroup leaders include Coding Team Supervisors, the Total Health and Network Operations (“THN”) Medical Director and ad hoc members including Cigna Medical Directors and subject matter expertise with the ability to exercise professional judgement. The Precertification Team makes a final recommendation to the THN medical and clinical leadership, a final determination is made and the Precertification List is updated, operationalized and provider notifications are communicated.</p> <p><b>Factors</b> 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 <i>first</i>, then a Return on Investment (“ROI”) threshold must be established for the service to be subject to prior authorization/concurrent review.</p>	<p>When determining which MH/SUD All Other Outpatient benefits are subject to pre-service medical necessity review (prior authorization/precertification), Cigna conducts at least annually, a Precertification Code Review Procedure by the Total Health and Network Operations and Medical Economics Coverage Policy, Precertification Team (“Precertification Team”). Precertification Team workgroup leaders include Coding Team Supervisors, the Total Health and Network Operations (“THN”) Medical Director and ad hoc members including Cigna Medical Directors and subject matter expertise with the ability to exercise professional judgement. The Precertification Team makes a final recommendation to the THN medical and clinical leadership, a final determination is made and the Precertification List is updated, operationalized and provider notifications are communicated.</p> <p><b>Factors</b> 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</p>	<p>services subject to prior authorization and concurrent review is reviewed no less frequently than annually to determine if any services, whether MH/SUD or M/S, should be removed or added to the list, so the frequency of review of the continued appropriateness of application of prior authorization is comparable across MH/SUD and M/S benefits.</p> <p>Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the prior authorization list. The factor and its accompanying evidentiary standard used to determine whether prior authorization will apply to an outpatient service pursuant to the processes described herein, namely the ROI metric, is likewise uniform for MH/SUD and M/S benefits.</p> <p><b>In Operation</b> An “in operation” review of Cigna’s application of the Prior Authorization NQTL, specifically approvals and denial information, in the Outpatient All Other, In-Network and Out-of-Network classifications for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. A review was completed with Georgia data for the Out-patient All Other classification and revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>The factors used to determine that the Prior Authorization NQL will apply to either M/S benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• 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.</li><li>• Expert Medical Review</li><li>• Input from national vendors</li><li>• Medical Economics biannual provider and facility analyses report for codes not included on precertification list</li><li>• Nationally recognized evidence-based guidelines and CMS and HCPS updates</li><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li></ul></li></ul>	<p>potential for fraud, waste and/or abuse must be met <i>first</i>, then a Return on Investment (“ROI”) threshold must be established for the service to be subject to prior authorization/concurrent review.</p> <p>The factors used to determine that the Prior Authorization NQL will apply to either MH/SUD benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0.</p> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• 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.</li><li>• Expert Medical Review</li><li>• Input from national vendors</li><li>• Medical Economics biannual provider and facility analyses report for codes not included on precertification list</li><li>• Nationally recognized evidence-based guidelines and CMS and HCPS updates</li><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA)</li></ul></li></ul>	<p>Cigna reviewed the ROIs for both MH/SUD and M/S outpatient services subject to prior authorization/concurrent review and confirmed that the MH/SUD outpatient services subject to prior authorization/concurrent review revealed sufficiently positive ROIs to warrant continued application of prior authorization/concurrent review without further consideration.</p> <p>Cigna regularly reviews utilization management data to evaluate and ensure operational compliance of the NQL as referenced in the Medical Necessity Section of this document. Data is reviewed by benefit classification and sub-classification to calculate denial rates to ensure comparability. Cigna’s application of the medical necessity NQL, specifically approvals and denials rates for Concurrent Review across benefit classifications for a sampling of Cigna plans revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits.</p> <p>In the outpatient benefit classification, including the All Other sub-classification, denial rates for MH/SUD were on average lower than M/S services for the In Network Outpatient All Other sub-classification and had a less than 2 percentage point deviation in the Out-of-Network Outpatient All Other sub-classification for the Cigna book of business data..</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>○ American Formulary Association (AFA) publication of codes</li><li>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</li></ul> <p><b>Evidentiary Standard</b> The evidentiary standards for factors that must be established to trigger a ROI evaluation for the application of Prior Authorization in the Outpatient All Other sub-classification.</p> <p>All Other classification are as follows:</p> <p>(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 Evidence<sup>1</sup>;</p> <p>(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</p>	<p>publication of the Current Procedural Terminology (CPT) book</p> <ul style="list-style-type: none"><li>○ American Hospital Association (AHA) publication of revenue codes</li><li>○ American Formulary Association (AFA) publication of codes</li><li>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</li></ul> <p><b>Evidentiary Standard</b> The evidentiary standards for factors that must be established to trigger a ROI evaluation for the application of Prior Authorization in the Outpatient All Other sub-classification.</p> <p>All Other classification are as follows:</p> <p>(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 Evidence<sup>2</sup>;</p> <p>(ii) whether the service may present a serious customer safety risk; The service is</p>	

<sup>1</sup> **Clinical evidence** includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.

<sup>2</sup> **Clinical evidence** includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>detoxification under anesthesia, or the use of a service that is the subject of a serious warning or recall (e.g. FDA recall for a device or pharmaceutical product);</p> <p>(iii) 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.</p> <p>(iv) 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</p>	<p>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 warning or recall (e.g. FDA recall for a device or pharmaceutical product);</p> <p>(iii) 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.</p> <p>(iv) 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</p>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>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).</p> <p>(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:</p> <p>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</p>	<p>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).</p> <p>(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:</p> <p>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</p>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>healthcare benefit plan/program. (18 U.S.C. § 1347)</p> <p>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.</p> <p>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.</p> <p>The evidentiary standard used for the ROI factor in the application of Prior Authorization of M/S services the Outpatient-All Other benefit classification is a ratio of 3.0. Codes not meeting the 3.0 ROI threshold are assessed for potential removal from the prior authorization/concurrent review program, with an emphasis placed on identifying ways to improve the cost-effectiveness of the reviews themselves by reducing administrative cost/expense (e.g., time to review). Cigna reviews the ROI of codes requiring precertification based on data contained in Cigna’s Precertification Dashboard. Codes with ROI greater than 3 are considered as operationally effective and</p>	<p>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)</p> <p>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.</p> <p>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.</p> <p>The evidentiary standard used for the ROI factor in the application of Prior Authorization of MH/SUD services the Outpatient-All Other benefit classification is a ratio of 3.0. Codes not meeting the 3.0 ROI threshold are assessed for potential removal from the prior authorization/concurrent review program, with an emphasis placed on identifying ways to improve the cost-effectiveness of the reviews themselves by reducing administrative cost/expense (e.g., time to review). Cigna reviews the ROI of codes</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>are not typically considered for removal, while codes with ROI less than 3 are considered for removal. Codes are removed with low ROI/savings and codes are included that have a higher ROI/savings based upon utilization review and cost trends.</p> <p>The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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.</li></ul> <p>Cigna imposes step therapy and/or fail first requirements on certain M/S services including for example, MRI, gastric bypass, lumbar spine fusion where higher-cost therapies may be denied unless it</p>	<p>requiring precertification based on data contained in Cigna's Precertification Dashboard. Codes with ROI greater than 3 are considered as operationally effective and are not typically considered for removal, while codes with ROI less than 3 are considered for removal. Codes are removed with low ROI/savings and codes are included that have a higher ROI/savings based upon utilization review and cost trends.</p> <p>The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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.</li></ul>	





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy” protocols).	Cigna does not impose a Fail First/Step Therapy NQTL on MH/SUD services where higher-cost therapies may be denied unless it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy” protocols).	
<b>Concurrent Care Review</b>			
<b>Process – Include frequency and penalties for all services. Describe any step-therapy or “fail first” requirements and requirements for submission of treatment request forms or treatment plans.</b>			
<b>Inpatient, In-Network Inpatient, Out-of-Network</b>  Concurrent Review is applied to all inpatient benefits, based upon high cost, high risk and complexity for members receiving the service with the exception of any services reimbursed to the provider on a case rate/Diagnostic Resource Group (DRG) basis, including non-emergent M/S and MH/SUD services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other facility and certain outpatient benefits, without service/procedure level distinctions for the inpatient benefit classification. Inpatient services subject to Concurrent Review include:  <b>M/S Inpatient Services :</b>	Concurrent Review is applied to all non-emergent M/S services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other residential facility based upon high cost, high risk and complexity for members receiving the service.  <b>Process</b> Inpatient Concurrent Care Review occurs when a facility/provider requests to extend an inpatient stay beyond the previously authorized length of stay or more frequently based upon review of the level of care and clinical criteria. For M/S benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for	Concurrent Review is applied to all non-emergent MH/SUD services rendered by a hospital or other facility to plan enrollees who are confined overnight to the hospital or other residential facility based upon high cost, high risk and complexity for members receiving the service.  <b>Process</b> Inpatient Concurrent Care Review occurs when a facility/provider requests to extend an inpatient stay beyond the previously authorized length of stay or more frequently based upon review of the level of care and clinical criteria. For MH/SUD benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for	Cigna applies the concurrent care review NQTL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day. Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for Concurrent Review.  <b>DRG Variation</b> Inpatient services reimbursed on the basis of a DRG/case rate and otherwise authorized pursuant to a prior authorization review are not subject to concurrent review because, for the duration of the period for which the DRG/case rate applies, the amount of benefits the plan is obligated to pay for a facility stay does not depend on the duration of time that the individual received care in the facility. DRG-

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<ul style="list-style-type: none"><li>Acute Inpatient Services,</li><li>Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc.</li><li>Inpatient Professional Services</li></ul> <b>MH/SUD Inpatient Services:</b> <ul style="list-style-type: none"><li>Mental Health Acute Inpatient Services</li><li>Mental Health Subacute Residential Treatment</li><li>Mental Health Inpatient Professional Services</li><li>SUD Acute Inpatient Services</li><li>SUD Acute Inpatient Detoxification</li><li>SUD Subacute Residential Treatment</li><li>SUD Inpatient Professional Services</li></ul>	<p>continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-4 M/S inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p>UM coverage determinations of M/S services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Cigna uses MCG Guidelines for ambulatory care, inpatient and surgical care, recovery facility care, home care, and behavioral health care for coverage guidance in utilization review of services that are not addressed in a Cigna medical, or co-branded coverage policy.</p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including M/S benefits, may require Concurrent Review to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit. Services covered under a medical</p>	<p>continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). Cigna typically authorizes 1-6 MH/SUD inpatient days upon concurrent care review. (See Peer to Peer Variation Analysis in Medical Necessity Section).</p> <p>UM coverage determinations of MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Cigna uses MCG for non-SUD primary diagnosis of behavioral health level of care and Cigna uses ASAM Criteria for coverage guidance in utilization review level of care of SUD services.</p> <p><b>Factors</b> Services covered under a Cigna-administered benefit plan, including MH/SUD benefits, may require Concurrent Review to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a</p>	<p>based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. The lack of correlation between the length of stay and the plan's obligation to pay benefits for the same means that assessing the ongoing medical necessity of a continued facility stay for coverage/benefit purposes is unnecessary for such period of time.</p> <p>The case rate/DRG payment functions as payment in full for any and all services rendered to the individual for the pre-authorized course of treatment for the length of time covered by the case rate/DRG payment and over which the individual remains in the facility. The plan's liability for payment of benefits for services, and the individuals' cost-sharing obligation, does not increase or decrease depending on how long the individual remains in the facility receiving the pre-authorized treatment in question, unless the individual's stay extends beyond the time period that the DRG/case rate payment covers.</p> <p>DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. Concurrent Review by Cigna is clinically appropriate and permissible for psychiatric hospitalizations as general medical hospitalizations that are not reimbursed based on DRGs are also subject to concurrent review. Differences in utilization management of inpatient behavioral health</p>

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## Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>or behavioral benefit administered by Cigna that are on-going with multiple services over multiple dates of service beyond the initial period for which coverage was approved may be subject to Concurrent Review to confirm level of care and clinical appropriateness.</p> <p>A Service may be subject to Concurrent Review, when such Service requires (1) the ongoing assessment to determine or continue to establish the medical necessity of continued services; and (2) appropriateness of current level of care for the severity; or (3) one or more of the following:</p> <ul style="list-style-type: none"><li>• complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines</li><li>• Expected timeframe for clinical response/outcomes based on literature</li><li>• Efficacy of the treatment modality</li><li>• Progress toward goals of therapy</li><li>• Discharge / transition planning</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>○ American Hospital Association (AHA) publication of revenue codes</li></ul></li></ul>	<p>service will be rendered for a covered benefit. Services covered under a medical or behavioral benefit administered by Cigna that are on-going with multiple services over multiple dates of service beyond the initial period for which coverage was approved may be subject to Concurrent Review to confirm level of care and clinical appropriateness.</p> <p>A Service may be subject to Concurrent Review, when such Service requires (1) the ongoing assessment to determine or continue to establish the medical necessity of continued services; and (2) appropriateness of current level of care for the severity; or (3) one or more of the following:</p> <ul style="list-style-type: none"><li>• complexity of the condition and if extension, expansion, or reduction of services is appropriate based on nationally recognized guidelines</li><li>• Expected timeframe for clinical response/outcomes based on literature</li><li>• Efficacy of the treatment modality</li><li>• Progress toward goals of therapy</li><li>• Discharge / transition planning</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>• Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>○ American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li></ul></li></ul>	<p>is not a more stringent application because DRG-based fees have not been established for psychiatric hospitalizations.</p> <p>An “in operation” review of Cigna’s application of the Concurrent Review NQTL, specifically approvals and denial information, in the “Inpatient, In-Network” classification revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. On average, denial rates for concurrent medical necessity review of In-Network Inpatient and Out-of-Network MH/SUD benefits were lower than M/S services. A review of concurrent denials was completed with Georgia data for the In-patient classification and denial rates for concurrent medical necessity review of Inpatient MH/SUD benefits were lower than M/S services.</p> <p>A review of appeals data reveals comparable upheld and overturn rates and, on average, lower overturn rates for MH/SUD benefits in the out of-network outpatient and inpatient classifications for the Cigna book of business. Specifically, an analysis of the total out-of-network appeal overturn rate as-between inpatient MH/SUD and M/S services includes a 9 percent lower denial rate (about 30% to about 39%) for MH/SUD services concurrent review appeals for Out of Network, Out Patient, showed comparable appeal overturn rates (about 23% as-compared to about 27%) for MH/SUD and M/S services appeals to</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>○ American Formulary Association (AFA) publication of codes</li><li>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</li><li>● Internal claims data</li><li>● UM program operating costs</li><li>● UM authorization data</li><li>● Expert Medical Review of Clinical Criteria</li><li>● Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b> The evidentiary standard relied on to determine whether to apply Concurrent Review to inpatient MH/SUD and M/S benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business. The value associated with inpatient benefit reviews, as calculated by reference to the expected financial savings relative to the costs to review benefit claims, is assessed at the classification level and not at a service/procedure level.</p> <p>Cigna has determined the value of subjecting all inpatient In-Network and Out-of-Network M/S services to Concurrent Review must exceed the administrative costs by at least 1:1. The Concurrent Review NQL applies to all M/S services. The administration is identical.</p>	<ul style="list-style-type: none"><li>○ American Hospital Association (AHA) publication of revenue codes</li><li>○ American Formulary Association (AFA) publication of codes</li><li>○ Centers for Medicare and Medicaid Services (CMS) publication of codes</li><li>● Internal claims data</li><li>● UM program operating costs</li><li>● UM authorization data</li><li>● Expert Medical Review of Clinical Criteria</li><li>● Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b> The evidentiary standard relied on to determine whether to apply Concurrent Review to inpatient MH/SUD and M/S benefits is whether application of Concurrent Review produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business. The value associated with inpatient benefit reviews, as calculated by reference to the expected financial savings relative to the costs to review benefit claims, is assessed at the classification level and not at a service/procedure level.</p> <p>Cigna has determined the value of subjecting all inpatient In-Network and Out-of-Network M/S and MH/SUD services to Concurrent Review must exceed the administrative costs by at least 1:1. The Concurrent Review NQL applies to all MH/SUD</p>	<p>a concurrent review determination. The sample size for Georgia specific data did not allow for a statistically significant sample for appeals.</p> <p>Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.</p>

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Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	Cigna imposes step therapy and/or fail first requirements on certain M/S services including for example, MRI, gastric bypass, lumbar spine fusion where higher-cost therapies may be denied unless it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy” protocols).	and M/S services. The administration is identical.  Cigna does not impose a Fail First/Step Therapy NQTL on MH/SUD services where higher-cost therapies may be denied unless it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “ step therapy” protocols).	
<b>Outpatient Office Visits, In-Network</b> <b>Outpatient Office Visits, Out-of-Network</b>	<b>Not Applicable</b>	<b>Not Applicable</b>	The Concurrent Review NQTL does not apply to MH/SUD or M/S services assigned to the Outpatient-Office Visits sub-classification.
<b>All Other Outpatient Services, In-Network</b> <b>All Other Outpatient Services, Out-of-Network</b>  The Concurrent Review NQTL is applied to certain Outpatient-All Other MH/SUD and M/S services sub-classification including:  <b>M/S Outpatient-All Other Services</b> 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	<b>All Other Outpatient, In-Network and Out-of-Network Services Subject to Concurrent Review</b> Certain non-routine outpatient services are subject to Concurrent Review for the ongoing assessment to determine medical necessity of the care provided.  <b>Process</b> Concurrent care reviews for M/S services are typically initiated by a provider telephonically a day or two before the last covered/authorized day.  <b>Factors</b> When determining which M/S benefits are subject to concurrent care medical necessity review, Cigna conducts a cost-benefit analysis based upon the following factors: <ul style="list-style-type: none"><li>• Cost of treatment/procedure</li><li>• Whether treatment type is a driver of high cost growth</li></ul>	<b>All Other Outpatient, In-Network and Out-of-Network Services Subject to Concurrent Review</b> Certain non-routine outpatient services are subject to Concurrent Review for the ongoing assessment to determine medical necessity of the care provided.  <b>Process</b> Concurrent care reviews for MH/SUD services are typically initiated by a provider telephonically a day or two before the last covered/authorized day.  <b>Factors</b> When determining which MH/SUD benefits are subject to concurrent care medical necessity review, Cigna conducts a cost-benefit analysis based upon the following factors: <ul style="list-style-type: none"><li>• Cost of treatment/procedure</li><li>• Whether treatment type is a driver of high cost growth</li></ul>	Cigna applies the Concurrent Review NQTL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day.  Coverage determinations of MS services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, Cigna's methodology for determining which MH/SUD services within a classification of benefits are subject to concurrent care review is comparable to, and applied no more stringently than, its methodology for determining which M/S services within the same classification of benefits are subject

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
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	<ul style="list-style-type: none"><li>Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region</li><li>Treatment types subject to a higher potential for fraud, waste and/or abuse</li><li>Projected return on investment and/or savings if treatment type is subjected to concurrent care review</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>American Hospital Association (AHA) publication of revenue codes</li><li>American Formulary Association (AFA) publication of codes</li><li>Centers for Medicare and Medicaid Services (CMS) publication of codes</li></ul></li><li>Internal claims data</li><li>UM program operating costs</li><li>UM authorization data</li><li>Expert Medical Review</li><li>Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b></p>	<ul style="list-style-type: none"><li>Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region</li><li>Treatment types subject to a higher potential for fraud, waste and/or abuse</li><li>Projected return on investment and/or savings if treatment type is subjected to concurrent care review</li></ul> <p><b>Sources</b></p> <ul style="list-style-type: none"><li>Industry accepted procedures codes developed by:<ul style="list-style-type: none"><li>American Medical Association (AMA) publication of the Current Procedural Terminology (CPT) book</li><li>American Hospital Association (AHA) publication of revenue codes</li><li>American Formulary Association (AFA) publication of codes</li><li>Centers for Medicare and Medicaid Services (CMS) publication of codes</li></ul></li><li>Internal claims data</li><li>UM program operating costs</li><li>UM authorization data</li><li>Expert Medical Review</li><li>Nationally recognized evidence-based guidelines</li></ul> <p><b>Evidentiary Standards</b></p>	<p>to concurrent care review.</p> <p>An “in operation” review of Cigna’s application of the Concurrent Review NQL, specifically approvals and denial information, in the “Outpatient, In-Network, Other Items and Services” classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business. A review of concurrent denials was completed with Georgia data for the Out-patient All Other classification and revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits.</p> <p>While operational outcomes are not determinative of NQL compliance, and an insurer may comply with the NQL requirement notwithstanding a disparate outcome for an NQL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQL requirement. Consequently, Cigna concludes that the NQL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>A review of concurrent review appeals data reveals comparable upheld and overturn rates and, on average, lower overturn rates for MH/SUD benefits in the out of-network outpatient and inpatient classifications for the Cigna book of business. Specifically, an analysis of the total out-of-network</p>

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Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<p>“unlisted,” meaning that no existing CPT code exists for the procedure or service)</p> <p><b>MH/SUD Outpatient-All Other Services</b> Partial Hospitalization Applied Behavior Analysis (ABA) Transcranial Magnetic Stimulation</p>	<p>When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p> <ul style="list-style-type: none"><li>• Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>○ Inadequate 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;</li><li>○ when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>○ the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>○ the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li></ul></li><li>• Whether the service is/may be excluded from coverage: Cigna assesses whether the</li></ul>	<p>When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p> <ul style="list-style-type: none"><li>• Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>○ Inadequate 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;</li><li>○ when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>○ the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>○ the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li></ul></li><li>• Whether the service is/may be excluded from coverage: Cigna assesses whether the</li></ul>	<p>appeal overturn rate as-between inpatient MH/SUD and M/S services includes a 9 percent lower denial rate (about 30% to about 39%) for MH/SUD services concurrent review appeals for Out of Network, Out Patient, and nearly identical appeal overturn rates (about 23% as-compared to about 27%) for MH/SUD and M/S services appeals to a concurrent review determination. The sample size for Georgia specific data did not allow for a statistically significant sample for appeals.</p> <p>Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.</p>

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	<p>plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</p> <ul style="list-style-type: none"><li>• Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>• Whether the service demonstrates significant variations from evidence-based care: A variation in evidence-based care must reflect a statistically significant standard deviation from the standard frequency or duration in treatment using the</li></ul>	<p>plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</p> <ul style="list-style-type: none"><li>• Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>• Whether the service demonstrates significant variations from evidence-based care: A variation in evidence-based care must reflect a statistically significant standard deviation from the standard frequency or duration in treatment using the</li></ul>	



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Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>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.</li><li>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:<ul style="list-style-type: none"><li>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</li><li>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.</li></ul></li><li>Performing coverage reviews for a service is projected to meet or exceed a certain return on</li></ul>	<p>service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>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.</li><li>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:<ul style="list-style-type: none"><li>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</li><li>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.</li></ul></li><li>Performing coverage reviews for a service is projected to meet or exceed a certain return on</li></ul>	



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Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>investment ratio. The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>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.</li><li>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.</li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.</p>	<p>investment ratio. The ROI ratio is calculated using the following formula:</p> <ul style="list-style-type: none"><li>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.</li><li>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.</li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in the English language, peer reviewed, published, evidence-based scientific studies or literature.</p>	





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	Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQTL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the factors relied on by Cigna to design its NQTLS in a numerical threshold or formula. By contrast, the quantitative factors that Cigna considers when deciding whether to apply prior authorization to MH/SUD and M/S benefits are defined by reference to specific thresholds at which the factor is met.	Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQTL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the	
Retrospective Review			
Process, including timeline and penalties			
<b>Inpatient, In-Network Outpatient, In-Network (including applicable sub-classifications) Inpatient, Out-of-Network Outpatient, Out-of-Network (including applicable sub-classifications).</b>  Cigna defines Retrospective Review of M/S services as its review of a claim after the service has already been provided, but before the claim for that service has been	All non-emergent M/S and MH/SUD inpatient and outpatient services are theoretically subject to a medical necessity review. Cigna also employs the same definition of medical necessity to M/S and MH/SUD benefits.  Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the	All non-emergent MH/SUD inpatient and outpatient services are theoretically subject to a medical necessity review. Cigna also employs the same definition of medical necessity to M/S and /SUD benefits.  Cigna employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. Cigna Medical Directors apply the definition of “medical necessity” set forth in the governing plan instrument or the definition required by state law. Notwithstanding the	<b>As written:</b> Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for developing coverage criteria.  Cigna's methodology for determining which M/S services and which MH/SUD services within a classification of benefits are subject to retrospective review as written and in operation, as well as its

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Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
paid. Specifically, these are reviews of coverage authorizations that were not approved prior to the service being rendered. Cigna does not incorporate language related to Retrospective Review in its certificate or benefits booklet.	<p>above, Cigna's standard definition of "medical necessity" is as follows:</p> <p><b>"Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of</li></ul>	<p>above, Cigna's standard definition of "medical necessity" is as follows:</p> <p><b>"Medically Necessary/Medical Necessity</b> Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:</p> <ul style="list-style-type: none"><li>• required to diagnose or treat an illness, Injury, disease or its symptoms;</li><li>• in accordance with generally accepted standards of medical practice;</li><li>• clinically appropriate in terms of type, frequency, extent, site and duration;</li><li>• not primarily for the convenience of the patient, Physician or other health care provider;</li><li>• 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; and</li><li>• rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of</li></ul>	<p>retrospective medical necessity review processes applied to M/S services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.</p> <p><b>In operation:</b> Cigna has conducted a review of its application of the Retrospective Review NQTL, specifically approvals and denial information, which revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits for the Cigna book of business.A review of Retrospective denials was completed with Georgia data across all classifications and revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>The comparative analysis performed for application of Retrospective Review to inpatient and outpatient benefits evidences compliance with the MHPAEA</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>alternative services, supplies, medications or settings when determining least intensive setting.”</p> <p>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. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.</p> <p><b>Factors</b></p> <p>When developing coverage criteria to evaluate the medical necessity of services, Cigna's Coverage Policy Unit (CPU), 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 Medical Technology Assessment Committee’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific</p>	<p>alternative services, supplies, medications or settings when determining least intensive setting.”</p> <p>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. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual’s benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization.</p> <p><b>Factors</b></p> <p>When developing coverage criteria to evaluate the medical necessity of services, Cigna's Coverage Policy Unit (CPU), 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 Medical Technology Assessment Committee’s evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in Cigna’s “Levels of Scientific</p>	<p>NQTL requirement, in writing and in operation. Cigna's analysis of the process and policies governing the application of Retrospective Review across MH/SUD and M/S benefits, as well as the process by which MH/SUD and M/S services are selected for application of Retrospective Review, evidences comparability and equivalent stringency, in writing and in operation. The written process, the trigger for application of Retrospective Review, and the medical necessity standard used to review services subject to Retrospective Review, comparable across MH/SUD and M/S benefits, but the assessment of denial rates across a sample of Cigna-administered benefit plans do not reveal any potential “warning signs” warranting further assessment and/or changes to how the Retrospective Review NQTL is designed or applied to MH/SUD benefits.</p> <p>The factor and its accompanying evidentiary standard used to determine whether Retrospective Review will apply to an inpatient or outpatient service pursuant to the above-described process, namely the ROI metric, is likewise uniform for MH/SUD and M/S benefits. Cigna does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the list of services subject to Retrospective Review.</p> <p>Cigna's methodology for determining which M/S services and which MH/SUD services within a</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

<b>Non-Quantitative Treatment Limitation (NQT)</b>	<b>Medical/Surgical Benefits (M/S)</b>	<b>Mental Health/Substance Use Disorder Benefits (MH/SUD)</b>	<b>Comparative Analysis Conclusions</b>
	<p>Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford:</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p>	<p>Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford:</p> <p>Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.</p> <p>Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.</p> <p>Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.</p> <p>Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.</p> <p>Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.</p>	<p>classification of benefits are subject Retrospective Review as written and in operation, as well as its medical necessity review processes, are no more stringent for MH/SUD services than for M/S services within the same classification of benefits.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p><b>Evidentiary Standards</b></p> <p>When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p> <ul style="list-style-type: none"><li>• Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>○ Inadequate 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;</li><li>○ when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>○ the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>○ the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li></ul></li></ul>	<p><b>Evidentiary Standards</b></p> <p>When evaluating the non-quantitative factors for applying retrospective review to a service, Cigna utilizes the following evidentiary standards:</p> <ul style="list-style-type: none"><li>• Whether the service is determined to be experimental/investigational/unproven: A service is considered to be EIU if an assessment of available clinical evidence establishes any of the following:<ul style="list-style-type: none"><li>○ Inadequate 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;</li><li>○ when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>○ the subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; or</li><li>○ the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials.</li></ul></li></ul>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>Whether the service is/may be excluded from coverage: Cigna assesses whether the plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</li><li>Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>Whether the service demonstrates significant variations from evidence-based care: A variation in evidence-based care must reflect a statistically</li></ul>	<ul style="list-style-type: none"><li>Whether the service is/may be excluded from coverage: Cigna assesses whether the plan/policy excludes from coverage a particular service, or for a particular use. Specifically, a service may be rendered for one or more uses covered by a benefit plan and one or more uses that are excluded by the benefit plan, or the intended use of the service cannot be identified based on the information provided in a submitted benefit claim. For example, benefit plan may exclude a service if it is rendered for cosmetic purposes, but the benefit plan may cover a service if it is rendered to treat a covered condition. The clinically appropriate uses for a service are determined through an assessment of available Clinical Evidence for the service.</li><li>Whether the service presents a serious risk to enrollee safety: Whether a service presents a serious risk to enrollee safety is determined through an assessment of available Clinical Evidence for the service. 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 warning or recall.</li><li>Whether the service demonstrates significant variations from evidence-based care: A variation in evidence-based care must reflect a statistically</li></ul>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>significant standard deviation from the standard frequency or duration in treatment using the service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>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</li><li>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.</li></ul></li></ul>	<p>significant standard deviation from the standard frequency or duration in treatment using the service, while accounting for operational and knowledge variations that may exist across providers and geographic areas. What is considered statistically-significant will vary by the type of service, as the frequency or duration in treatment standard may vary by service type.</p> <ul style="list-style-type: none"><li>• 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.</li><li>• 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:<ul style="list-style-type: none"><li>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</li><li>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.</li></ul></li></ul>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>Performing coverage reviews for a service is projected to meet or exceed a certain return on investment ratio. The ROI ratio is calculated using the following formula:<ul style="list-style-type: none"><li>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.</li><li>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.</li></ul></li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in</p>	<ul style="list-style-type: none"><li>Performing coverage reviews for a service is projected to meet or exceed a certain return on investment ratio. The ROI ratio is calculated using the following formula:<ul style="list-style-type: none"><li>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.</li><li>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.</li></ul></li></ul> <p>"Clinical evidence" as referenced above includes publications from professional societies that include nationally recognized specialists in the appropriate field (e.g., American College of Obstetricians and Gynecologists); guidance published by appropriate Government Regulatory Agencies (e.g., CMS, FDA, NIH); and other original research studies, publish in</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTl)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>the English language, peer reviewed, published, evidence-based scientific studies or literature.</p> <p>Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQTL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the factors relied on by Cigna to design its NQTLS in a numerical threshold or formula. By contrast, the quantitative factors that Cigna considers when deciding whether to apply prior authorization to MH/SUD and M/S benefits are defined by reference to specific thresholds at which the factor is met.</p>	<p>the English language, peer reviewed, published, evidence-based scientific studies or literature.</p> <p>Notably, the above-stated standards used to apply the factors as previously described may not in each case be associated with a specific quantitative threshold at which the NQTL is triggered, as not every factor lends itself to simply quantitative assessment. Rather, the quantitative factors mentioned above in each case requires subject matter experts like clinicians to qualitatively assess publications that do not define the factors relied on by Cigna to design its NQTLS in a numerical threshold or formula. By contrast, the quantitative factors that Cigna considers when deciding whether to apply prior authorization to MH/SUD and M/S benefits are defined by reference to specific thresholds at which the factor is met.</p>	
<b>Emergency Services</b>			
<b>Process for emergency services</b>	<p>Emergency M/S services are not subject to prior authorization or Concurrent Review.</p> <p>Emergency services that are furnished by a provider qualified to provide emergency services to evaluate and stabilize an emergency medical condition, including ambulance services, are assigned to the emergency care classification of benefits. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of</p>	<p>Emergency MH/SUD services are not subject to prior authorization or Concurrent Review.</p> <p>Emergency services that are furnished by a provider qualified to provide emergency services to evaluate and stabilize an emergency medical condition, including ambulance services, are assigned to the emergency care classification of benefits. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of</p>	<p>Cigna's integrated medical and behavioral health plans have only one, single benefit for emergency room and urgent care. Accordingly, there are no differences between how coverage for M/S and MH/SUD emergency room and urgent care services.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	health and medicine, could reasonably expect the absence of immediate medical attention to result in: <ul style="list-style-type: none"><li>Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child;</li><li>Serious impairment to bodily function; or</li></ul> Serious dysfunction of any bodily organ or part.	health and medicine, could reasonably expect the absence of immediate medical attention to result in: <ul style="list-style-type: none"><li>Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child;</li><li>Serious impairment to bodily function; or</li></ul> Serious dysfunction of any bodily organ or part.	
<b>Pharmacy Services</b>			
<b>Include all services for which prior authorization is required, any step-therapy or “fail first” requirements, and any other NQTLs.</b>			
<b>Tier 1</b>	<p>Cigna requires prior authorization, step therapy, or quantity limits for certain prescription drugs to ensure the prescribed drugs are medically necessary to treat the enrollee’s condition. Cigna uses the same medical necessity standard when reviewing coverage for both M/S and MH/SUD drugs.</p> <p>Cigna's prior authorization, step therapy, or quantity limit requirements were developed without regard to whether the prescription drugs are prescribed to treat a medical condition or a MH/SUD condition.</p> <p>Some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded</p>	<b>Same as Medical/Surgical</b>	<p>Cigna has confirmed that its utilization management programs are applied comparably, and no more stringently, to MH/SUD drugs as compared to M/S drugs. Its written policies governing formulary placement and application of utilization management do not distinguish between the processes, factors or standards that inform design and application of the formulary placement and utilization management NQTLs. Indeed, Cigna uses one, combined policy to govern its formulary management and utilization management requirements across M/S and MH/SUD benefits, and, while uniformity in processes is not required by the NQTL requirements (only comparability), uniformity in processes for designing and applying an NQTL can evidence comparability in the NQTL as-written.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it doesn't warrant coverage on the formulary. If the P&amp;T Committee identifies a drug as “Exclude” or “Optional,” for example, then the Cigna VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from claims/reimbursement information and available rebate revenue) to Cigna as compared to therapeutic alternatives.</p> <p>Notably, Cigna does not apply prior authorization or step therapy requirements to any drugs used to treat an opioid use disorder or alcohol use disorder. Cigna does apply prior authorization or quantity limits to several MH/SUD drugs. Mental health drugs are generally considered to be controlled substances under federal law and, with the exception of drugs generally used to treat opioid use disorder and alcohol use disorder, Cigna applies prior authorization to controlled substances such as opioids used for pain management. This approach is consistent with Cigna’s application of prior authorization to controlled substances on the basis of identified safety risks, and regardless of whether the controlled substance is used to treat an M/S condition, such as</p>		<p>In terms of operational parity compliance, Cigna confirmed that all drugs, whether MH/SUD or M/S drugs, that the P&amp;T Committee designates must be covered are, in fact, covered on the formulary, and all drugs’ coverage conform to other P&amp;T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes. Moreover, Cigna's coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status, and drugs subject to a utilization management requirement, including prior authorization, step therapy, and/or quantity limits, conform to the aforementioned standards established for inclusion in a utilization management program. That is, Cigna does not apply a utilization management requirement to an MH/SUD drug that does not exhibit the factors/standards described in the preceding columns that, as-written, justify application of a utilization management requirement to a drug, and in terms of stringency of application of the NQL no M/S drugs are omitted from a utilization management requirement if they exhibit the same factors/standards.</p> <p>While operational outcomes are not determinative of NQL compliance, and an insurer may comply with</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	pain management, or an MH/SUD condition such as ADHD or bipolar disorder. Cigna applies prior authorization to M/S drugs for other reasons, such as specialty drug/high cost status (i.e. specialty drugs are subject to prior authorization), but these are rationales in addition to, and not exclusive of, the safety risk factor based on a drug's status as a controlled substance. Cigna also applies step therapy to a number of brand drugs in certain MH/SUD and M/S therapeutic classes in order to incentivize the use of lower net cost (inclusive of ingredient cost and available manufacturer revenue) generic and/or preferred brand alternatives as identified through an analysis of claims/reimbursement information for the brand drugs.		<p>the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLS of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the prescription drug classification of benefits.</p>
<b>Tier 2</b>	Same as Tier 1	Same as Tier 1	Same as Tier 1
<b>Tier 3</b>	Same as Tier 1	Same as Tier 1	Same as Tier 1
<b>Tier 4</b>	Same as Tier 1	Same as Tier 1	Same as Tier 1
<b>Prescription Drug Formulary Design</b>			
<b>How are formulary decisions made for the diagnosis and medically necessary treatment of medical, mental health, and substance use disorder conditions?</b>	<p>Cigna offers a multi-tiered formulary that includes covered MH/SUD and M/S drugs; a tiered formulary design is considered an NQTL and, as such, the methodology by which drugs are placed on specific formulary tiers is subject to the NQTL parity requirement.</p> <p>Cigna offers a variety of prescription drug formularies comprised of generic, preferred and non-preferred brand name drugs, and specialty drugs. The coverage</p>	<b>Same as Medical/Surgical</b>	<p>Cigna does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design for its Standard, Value, Advantage, Performance, and Legacy formularies. Formulary tiers are designed based on reasonable factors, consistent with the requirements of 45 CFR §146.136.</p> <p>Cigna has confirmed that its formulary management and utilization management processes are applied</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>of drugs covered on Cigna’s formularies are, subject to a client policyholder’s election, determined by two internal/affiliated committees that perform different, but interrelated, functions: the Pharmacy &amp; Therapeutics Committee ("P&amp;T Committee"); and, the Cigna Value Assessment Committee (a/k/a Business Decision Team).</p> <p>The coverage of drugs covered on Cigna’s formularies are, subject to a client policyholder’s election, as applicable, determined by two internal/affiliated committees that perform different, but interrelated, functions: the Pharmacy &amp; Therapeutics Committee (“P&amp;T Committee”); and, the Cigna Health Plan Value Assessment Committee (“CHP VAC”).</p> <p>The P&amp;T Committee is composed of voting external clinicians across a number of specialties that perform, among other responsibilities, clinical reviews of drugs to determine whether a drug must be covered on the formulary as a clinical matter. In rendering clinical findings on drugs, the P&amp;T Committee assesses the FDA labeling and, as appropriate and available, clinical practice standards/trends and documentation like clinical literature and guidelines.</p> <p>The CHP VAC is composed of representatives representing several functional areas of the combined company, including, for example, clinicians and representatives from our sales and economics areas,</p>		<p>comparably, and no more stringently, to MH/SUD drugs as compared to M/S drugs. Specifically, all drugs, whether MH/SUD or M/S drugs, that the P&amp;T Committee designates must be covered are, in fact, covered on the formulary, and all drugs conform to other P&amp;T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes.</p> <p>Moreover, Cigna's coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status, and Cigna's review evidences that the processes and standards used to determine whether to subject a drug to utilization review is not only comparable, but identical, across M/S and MH/SUD drugs. The same P&amp;T and CHP VAC committee structure reviews M/S and MH/SUD drugs for formulary placement and whether to subject a drug to a prior authorization requirement, and pursuant to common policies and procedures. The process for reviewing drugs for coverage does not differ by whether the drug is used to treat a M/S condition or a MH/SUD condition.</p> <p>In terms of operational parity compliance, Cigna has also assessed as follows across its formularies: a comparable percentage of MH/SUD drugs are</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>that have experience with formulary management or PBM/health plan operations, and is responsible for deciding - within the clinical parameters established by the P&amp;T Committee - which drugs will be covered on the formularies offered by Cigna. If the P&amp;T Committee finds that a drug must be covered on the formulary as a clinical matter, then the Value Assessment Committee must place the drug on the formulary. If the P&amp;T Committee determines that a drug may or may not be covered on the formulary as a clinical matter, then the CHP VAC may consider other factors, including economic factors, when deciding whether to place the drug on the formulary.</p> <p><b>Factors</b></p> <p>In its decision criteria, the CHP VAC primarily considers the following factors:</p> <ol style="list-style-type: none"><li>1. Pharmacy and Therapeutics (“P&amp;T”) Committee clinical safety and efficacy evaluation and designation.</li><li>2. Economic implications to enrollees and plans.</li><li>3. Status of drug as a generic, brand, or specialty drug</li><li>4. Competitor/market practices</li><li>5. Legal and regulatory requirements.</li></ol> <p>When deciding whether to place a drug on a three-tiered formulary, and, if so, on which formulary tier, the formulary committee considers the following factors: the brand or generic status of a drug; whether,</p>		<p>covered on v. off-formulary as compared to M/S drugs; a comparable, and in some cases lower, percentage of MH/SUD drugs are subject to prior authorization or step therapy requirements as compared to M/S drugs; and a comparable, and, in fact, lower, percentage of MH/SUD drugs are covered on the non-preferred brand tier (Tier 3) of the formularies offered by Cigna as compared to the MH/SUD drugs covered on Tiers 1 and 2. Cigna confirmed that all drugs, whether MH/SUD or M/S drugs, that the P&amp;T Committee designates must be covered are, in fact, covered on the formulary, and all drugs’ coverage conform to other P&amp;T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes. Moreover, for its large group formularies Cigna’s coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status.</p> <p>Cigna has also assessed as follows across its group formularies. First, a comparable percentage of MH/SUD drug NDCs are covered on v. off-formulary as compared to M/S drug NDCs under such formularies (about 4% of MH/SUD and M/S drug NDCs each are covered off-formulary, with small variations to the tenths of a percent across the noted</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>as applicable, a brand drug has available generic alternatives; whether the drug is the lowest net cost drug as compared to therapeutic alternatives; and whether a rebate arrangement exists for the drug to offset its cost.</p> <p>The source for the brand or generic status factor is a publication of drug indicators available from an external vendor (First DataBank). The sources for whether a drug has available generic alternatives are available drug indicators from First DataBank and other external information about other drugs available in the same therapeutic class. The sources for whether the drug is the lowest net cost drug as compared to therapeutic alternatives is internal drug claims utilization information. The source for whether a rebate arrangement exists for the drug to offset its cost is rebate contract or billing information.</p> <p><b>Evidentiary Standards</b> In its decision criteria, the CHP VAC considers the following factors as defined by the noted evidentiary standards:</p> <ul style="list-style-type: none"><li>• Pharmacy and Therapeutics (“P&amp;T”) Committee clinical evaluation and designation. The clinical P&amp;T Committee’s designations are based on reviews of a drug’s safety and efficacy and place in therapy, using available clinical evidence such as FDA label information and available clinical</li></ul>		<p>formularies). Second, a comparable, and, in fact, lower, percentage of MH/SUD drug NDCs are covered on the higher cost, non-preferred brand tier (Tier 3) of the group formularies offered by Cigna as compared to the MH/SUD drug NDCs covered on Tiers 1 and 2.</p> <p>While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>Cigna employs measures to ensure comparability in both design and application of the multi-tiered formulary NQTL to MH/SUD and M/S prescription drug benefits. The written policies governing how MH/SUD or M/S drugs are placed on the formulary and tiered are uniform (i.e., on/off-formulary and tiering factors/standards) to ensure that the in-writing process and factors/standards relied on are comparable irrespective of the underlying use of the drug. Moreover, Cigna assesses outcomes data, including incidence rates for the application of utilization management NQTLs (i.e., the proportion</p>

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Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>literature and guidelines (e.g. federal regulatory publications or professional society publications). The P&amp;T Committee assigns one of several clinical designations to a drug based on the drug’s safety/efficacy and place in therapy: Access, Include, Optional, or Exclude. These designations dictate whether, from a clinical perspective a drug must be covered on the formulary, or, alternatively, may, but is not required to be, covered on the formulary, and whether a drug may be covered more favorably than therapeutically alternative drugs. A drug designated “Include” or “Access” must be covered to the extent medically necessary, and alternative drugs may not be preferred over it through application of tier placement or step therapy. A drug designated “Optional” may or may not be covered on the formulary, and may be subject to a step therapy protocol that requires the use of alternative drugs.</p> <p>These formulary placement designations are more specifically defined as follows, and are subject to any overriding plan exclusions such as exclusions of over-the-counter drugs or prescription drugs with over-the-counter alternatives:</p> <p><b>Include:</b> A drug may be given an include designation if it meets at least one of the clinical bases enumerated</p>		<p>of MH/SUD and M/S drugs that are subject to utilization management), to ensure that there are no significant discrepancies in the outcomes of the NQTLs’ application across MH/SUD and M/S benefits that warrant further scrutiny of the formulary decision-making process. Finally, the P&amp;T Committee annually reviews the formularies to ensure that the CHP VAC adheres to its clinical designations, irrespective of whether they are MH/SUD or M/S drugs, when making formulary placement/tiering decisions for Cigna's formularies.</p> <p>Moreover, as further evidence of comparability and equivalent stringency in-operation, Cigna has also assessed as follows across its formularies: a comparable percentage of MH/SUD drugs are covered on v. off-formulary as compared to M/S drugs; a lower absolute number of MH/SUD drugs are covered off-formulary as compared to M/S drugs; a comparable, and indeed a lower, percentage of MH/SUD brand drugs are covered on the non-preferred brand tier (Tier 3) relative to the total number of MH/SUD drugs covered on Tiers 1 and 2 of the formulary, as compared to the proportion of M/S drugs covered on Tier 3 relative to the total M/S drugs covered on Tiers 1 and 2 of the formulary. As all generic drugs covered on the formulary are placed on Tier 1 and no brand drugs are placed on Tier 1, whether MH/SUD or M/S benefits, the placement of drugs on Tier 1 of the formulary is deemed to meet the NQTL stringency and comparability requirements</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>below and is anticipated, or validated via claims data, to treat relatively large patient population (i.e., greater than 1 in 50,000).</p> <p>The clinical bases include:</p> <ul style="list-style-type: none"><li>a. It has a unique indication for use addressing a clinically significant unmet treatment need;</li><li>b. Its efficacy is superior to that of existing therapy alternatives;</li><li>c. Its safety profile is superior to that of existing therapy alternatives, it has a unique place in therapy; and/or</li><li>d. It treats medical condition(s) that necessitate individualized therapy and for which there are multiple treatment options.</li></ul> <p>Include drugs must be placed on a tier of the applicable formulary by the Value Assessment Committee but may not be disadvantaged relative to other drugs in a drug grouping, as defined by the P&amp;T Committee, with a less favorable clinical designation. A drug grouping is a list of drugs that generally possess the same mechanism of action and a similar place in therapy.</p> <p><b>Access:</b> A drug may be given an access designation if it meets at least one of the clinical bases enumerated below AND the drug is either anticipated, or validated via claims data at the time the P&amp;T Committee</p>		<p>for formulary placement. Put differently, there are no differences in placement of covered generic drugs for MH/SUD or M/S drugs, as the evidentiary standard – which was consistently applied to the placement of MH/SUD and M/S drugs on the formulary – for Tier 1 placement is the generic status of a drug. Additionally, by including a psychiatrist on the clinical P&amp;T committee, Cigna ensures that comparable clinical expertise in treating MH/SUD conditions and M/S conditions is represented in the formulary decision-making process.</p> <p>While physicians, regardless of specialty, are qualified under their scope of licensure to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, Cigna acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&amp;T Committee. In the context of NQTL compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&amp;T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits.</p> <p>Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and</p>

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Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>renders a designation on the drug, to treat a relatively small sub-population. The clinical bases include:</p> <ul style="list-style-type: none"><li>a. It has a unique indication for use addressing a clinically significant unmet treatment need;</li><li>b. Its efficacy is superior to that of existing therapy alternatives;</li><li>c. Its safety profile is superior to that of existing therapy alternatives;</li><li>d. It has a unique place in therapy; and/or</li><li>e. It treats medical condition(s) that necessitate individualized therapy and for which there are multiple treatment options.</li></ul> <p>Access drugs are forwarded to the Value Assessment Committee for further analysis of whether the drug should be covered on the applicable formulary and, if covered on the formulary, on which tier. The Value Assessment Committee may either place the drug on the applicable formulary or designate the drug as non-formulary. If the Value Assessment Committee does not place the drug on the formulary, the P&amp;T Committee shall establish formulary exception clinical criteria.</p> <p><b>Optional:</b> A drug may be given an optional designation if a significant proportion of its use is similar in terms of safety and efficacy to other currently available drug alternatives. In certain instances, a drug designated as optional may have a unique use in a small subset of patients in relation to the overall use of the drug. The P&amp;T Committee shall</p>		<p>standards that inform Cigna's formulary management decisions. Moreover, Cigna does not distinguish, in writing, between M/S and MH/SUD benefits in its prescription drug formulary design for its large group plan formularies, and it takes steps to monitor the consistency of decision-making across MH/SUD and M/S drugs by performing policy reviews and assessing operational outcomes periodically. As described in detail under the narrative response to Steps 2 and 3, Cigna considers the same factors and accompanying evidentiary standards for MH/SUD and M/S drugs when designing its large group formularies pursuant to a uniform formulary decision-making process. The written process for reviewing drugs for coverage does not differ by whether the drug is used to treat an M/S condition or a MH/SUD condition, and in terms of the timing of decisions, the P&amp;T Committee and Value Assessment Committee typically review all new-to-market drugs, whether MH/SUD or M/S drugs, within six months of market availability, and typically reviews potential opportunities to make formulary changes of any kind outside the context of new-to-market drug entries up to twice per year.</p> <p>In summary, the comparative analyses documented here, which construe the application of the multi-tiered formulary design NQTL designed based on the factors articulated above, demonstrate the compliance in-writing and in-operation of the NQTL. While operational outcomes are not determinative of NQTL</p>

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Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>establish formulary exceptions to account for cases where the optional drug may have a unique use in a relatively small subset of patients. Optional drugs are forwarded to the Value Assessment Committee for further analysis of whether the drug should be covered on the applicable formulary and, if covered on the formulary, on which tier. The Value Assessment Committee may either place the drug on the formulary or designate the drug as non-formulary. If the drug is not placed on the formulary, the P&amp;T Committee shall establish formulary exception clinical criteria.</p> <p><b>Exclude:</b> Drugs may be given an exclude designation for one or more of the following clinical reasons: efficacy inferior to that of existing therapy alternatives, a safety profile inferior to that of existing therapy alternatives, and/or insufficient data to evaluate the drug. Drugs recalled from the market for safety reasons are automatically designated as “Exclude” drugs, pending further P&amp;T Committee review.</p> <ul style="list-style-type: none"><li>Economic implications to enrollees and Cigna. When assessing potential formulary placement decisions, the CHP VAC reviews based on projected drug expenditure information derived from available manufacturer revenue and claims costs whether a drug is a lower net cost option relative to any therapeutic alternatives.</li><li>Status of drug as a generic, brand, or specialty</li></ul>		<p>compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. In this case, there were comparable, and in some cases more advantageous, outcomes for the placement and tiering of MH/SUD drugs as compared to M/S drugs based on the absolute number of, and incidence of, non-formulary v. formulary and, for on-formulary drugs, Tier 2 v. Tier 3 drugs under large group formularies. These comparable outcomes, along with the confirmation that the evidentiary standards and factors were actually applied consistently to MH/SUD drugs as compared to M/S drugs in terms of the adherence to P&amp;T Committee clinical designations, evidence in-operation compliance in terms of comparability and equivalent stringency. Consequently, Cigna concludes that the NQTL of formulary management is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>drug. A drug is identified as generic or brand based on an algorithm that considers drug indicators made available by an external vendor called First DataBank. A drug is identified as a specialty drug based on the presence of one more of the following characteristics: the requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; the need for intensive patient training and compliance assistance to facilitate therapeutic goals; limited or exclusive specialty pharmacy distribution (if a drug is only available through limited specialty pharmacy distribution it is considered specialty, even if it doesn't have other specialty drug characteristics); or specialized product handling and/or administration requirements.</p> <ul style="list-style-type: none"><li>• Competitor/market practices. This factor refers to an assessment of how competitors are covering drugs on their formularies based on publicly available information, which, while never determinative, may be considered when making certain formulary decisions.</li><li>• Legal and regulatory requirements. This factor refers to any legal or regulatory requirements that mandate certain drug coverage, such as tier placement</li></ul>		





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>requirements.</p> <p>Cigna offers several formularies for its large group insured business. For most formularies, some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it doesn't warrant coverage on the formulary. If the P&amp;T Committee identifies a drug as "Exclude" or "Optional," for example, then the Cigna VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from claims/reimbursement information and available rebate revenue) to Cigna as compared to therapeutic alternatives.</p> <p>For large group insured plans, Tier 1 of the formulary includes covered generic drugs. Tier 2 of the formulary includes covered preferred brand drugs. Tier 3 of the formulary includes covered non-preferred brand drugs. The brand or generic status of</p>		



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	a drug is determined by reference to an algorithm that analyzes available drug indicators, currently including First DataBank’s drug indicator file, and not by reference to the drug’s status as an M/S or MH/SUD benefit. Once brand drug status is determined by application of the algorithm, a covered brand drug is typically placed on Tier 2 for one of several reasons, including, for example, if the drug lacks available generic alternatives or if Cigna maintains a rebate arrangement for the brand drug, even if the brand drug has generic alternatives. Conversely, a covered brand drug is typically placed on Tier 3 if it either has available generic alternatives or Cigna lacks a rebate arrangement for the brand drug. Tier 4, if elected by the client plan sponsor, includes specialty drugs identified based on application of the above-stated definition.		
<b>Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.</b>	Cigna applies, in addition to the formulary management and utilization management requirements in its prior responses regarding NQTL application to prescription drug benefits, several kinds of NQTLs. These include, as previously described, formulary placement/tiering, and application of step therapy, prior authorization, and quantity limits for medical necessity. Certain NQTLs, such as exclusions for drugs obtained outside of the United States, apply uniformly across M/S and MH/SUD drugs. Of note, and consistent with Connecticut insurance law, Cigna does not apply	<b>Same as Medical/Surgical</b>	<p>In addition to Cigna's explanations for how its formulary management decisions, and decisions to apply utilization management to certain drugs, complies with the cited parity standard, Cigna has also reviewed its utilization management process for compliance with the parity NQTL requirement.</p> <p>With respect to parity compliance as-written, Cigna employed the same medical necessity standard and operational policies and procedures for reviewing utilization management approval requests. Similarly to its process for formulary management, Cigna reviews coverage requests for MH/SUD and M/S</p>



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	mandatory mail order requirements to any drugs, including M/S and MH/SUD drugs.		drugs subject to a utilization management requirement using a uniform, consolidated process that leverages identical policies and procedures. A team called the Pharmacy Service Center reviews initial utilization review requests based on coverage criteria developed by a uniform approval process, and a team called the National Appeals Organization reviews any appeals of denied drug claims, regardless of whether a drug is an MH/SUD or M/S benefit. Both teams employ identical procedures, including turnaround time requirements for standard and expedited requests, the method by which prescribers can submit utilization management approval requests, the issuance of coverage approval or denial determinations to enrollees and prescribers, and quality/oversight protocols. Cigna reviews non-formulary and step therapy coverage exception requests for any drug, whether a M/S or MH/SUD benefit, that is non-formulary or subject to a step therapy requirement. The coverage exception process ensures that enrollees for which the covered, preferred alternative drugs are clinically inappropriate can obtain coverage for drugs otherwise subject to non-formulary status or a step therapy requirement. If the enrollee’s prescriber demonstrates that the non-formulary or, as applicable, drug subject to step therapy is medically necessary, generally by evidencing that the preferred drug(s) are inappropriate or were ineffective for treating the enrollee’s condition, then Cigna approves coverage of the requested drug as medically necessary regardless of



Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			<p>the drug’s status as an MH/SUD or M/S benefit.</p> <p>In terms of operational parity compliance, a review of utilization management data across a sampling of Cigna-administered plans revealed comparable, and, in fact, lower, medical necessity denial rates for MH/SUD drugs subject to prior authorization, step therapy, a quantity limit, or non-formulary status, as compared to M/S drugs subject to the same utilization management requirements.</p> <p>While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the prescription drug classification.</p>
What disciplines, such as primary care physicians (internists and	The clinical P&T committee assesses the utilization and appropriateness of therapeutic agents and	The clinical P&T committee assesses the utilization and appropriateness of therapeutic agents and	By including a psychiatrist on the clinical P&T committee, Cigna ensures that comparable clinical



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health, and substance use disorder conditions?</b>	provides the clinical parameters within which the CHP VAC’s decisions regarding formulary placement and application of utilization management must occur. The P&T committee is comprised of 16 independent, external providers, including 14 physicians and two pharmacists representing the following clinical practice areas: internal medicine, pulmonology, geriatrics, pediatrics, OB/GYN, endocrinology, gastroenterology, oncology, dermatology, rheumatology, cardiology, pharmacy (geriatrics), pharmacy (general), psychiatry, and neurology.	provides the clinical parameters within which the CHP VAC’s decisions regarding formulary placement and application of utilization management must occur. The P&T committee is comprised of 16 independent, external providers, including 14 physicians and two pharmacists representing the following clinical practice areas: internal medicine, pulmonology, geriatrics, pediatrics, OB/GYN, endocrinology, gastroenterology, oncology, dermatology, rheumatology, cardiology, pharmacy (geriatrics), pharmacy (general), psychiatry, and neurology.	<p>expertise in treating MH/SUD conditions and M/S conditions is represented in the formulary decision making process. While physicians, regardless of specialty, may be able to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, Cigna acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&amp;T Committee.</p> <p>In the context of NQL compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&amp;T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits. Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and standards that inform Cigna’s formulary management decisions.</p>
<b>Case Management</b>			
<b>What case management services are available?</b>  Case Management does not impact the scope of care, treatment or benefits delivered to MH/SUD services and	For Cigna enrollees with complex medical and/or behavioral health conditions, Cigna provides voluntary case management services which includes providing educational information, assessment/evaluation, planning, facilitation, care coordination, discharge planning and other services to meet an individual’s and family’s comprehensive	Cigna maintains active support and coaching programs for autism, eating disorders, intensive behavioral case management, opioid and pain management, substance use, and coaching support for parents and families with these disorders. Each program retains its own referral and eligibility criteria	Participation in case management services is not required, and an enrollee’s participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. Consequently, case management does not function as an NQL under the cited parity requirement.

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
does not function as an NQTL under the parity requirements.	health care needs through communication and sharing available resources to promote optimal patient care.	including self-referral which remains complimentary and voluntary.	
<b>What case management services are required?</b>	Health plan enrollees are not required to participate in case management services.	Health plan enrollees are not required to participate in case management services.	Participation in case management services is not required, and an enrollee's participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. . Consequently, case management does not function as an NQTL under the cited parity requirement.
<b>What are the eligibility criteria for case management services?</b>	Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex medical conditions.	Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex MH/SUD health conditions.	Participation in case management services is not required, and an enrollee's participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. Consequently, case management does not function as an NQTL under the cited parity requirement. Notwithstanding the inapplicability of the NQTL requirement to Cigna's voluntary case management program, Cigna offers case management services to enrollees with either complex MH/SUD or M/S conditions.
<b>Assessment of New Technologies</b>			
<b>Definition of experimental/investigational</b>	<b>Services Subject to the Assessment of New Technologies (Experimental, Investigational and Unproven, EIU)</b>  The evaluation of Experimental, Investigational and Unproven ("EIU") services are applicable to all M/S services, regardless of benefit classification.	<b>Services Subject to the Assessment of New Technologies (Experimental, Investigational and Unproven, EIU)</b>  The evaluation of Experimental, Investigational and Unproven ("EIU") services are applicable to all MH/SUD services, regardless of benefit classification.	The definition of experimental/investigational /unproven services is the same for MS and MH/SUD. A single review committee, Cigna's MTAC evaluates all new technologies for M/S and MH/SUD benefits. Cigna's methodology and processes for determining whether M/S interventions and MH/SUD interventions within a classification of benefits are experimental, investigational and/or unproven are

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>EIU services are medical, surgical, diagnostic, or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, to be:</p> <ul style="list-style-type: none"><li>not demonstrated through or an inadequate volume of, existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li><li>not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;</li><li>the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.</li></ul> <p><b>Process</b> Cigna's Medical Technology Assessment Committee (MTAC) applies a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical technologies. The MTAC</p>	<p>EIU services are psychiatric or substance abuse health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Cigna's Coverage Policy Unit (CPU), in partnership with Cigna's Medical Technology Assessment Committee, to be:</p> <ul style="list-style-type: none"><li>not demonstrated through or an inadequate volume of, existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;</li><li>not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;</li><li>the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.</li></ul> <p><b>Process</b> Cigna's Medical Technology Assessment Committee (MTAC) applies a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical technologies. The MTAC</p>	<p>comparable and no more stringent for MH/SUD services within a classification of benefits than for M/s services within the same classification of benefits as written and in operation.</p> <p>Cigna collects, tracks and trends relevant metrics on a semi-annual basis for services within each classification of M/S and MH/SUD benefits. Metrics may include initial EIU coverage denials, coverage denials upheld and overturned upon internal appeal and coverage denials upheld and overturned upon external appeal/review.</p> <p>An "in operation" review of claims data from a sampling of Cigna-administered plans revealed no excessive denial rates for MH/SUD claims denied as experimental, investigational and unproven as compared to M/S claims denied as experimental, investigational and unproven. An "in operation" review of Cigna's application of the Experimental, Investigational, and Unproven NQL, specifically approvals and denial information, in the "All Other Outpatient, Out-of-Network, Services" classification revealed no statistically significant discrepancies in EIU denial rates as-between MH/SUD and M/S benefits.</p> <p>While operational outcomes are not determinative of NQL compliance, and an insurer may comply with the NQL requirement notwithstanding a disparate outcome for an NQL applied to MH/SUD benefits</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC also consults with internal Cigna subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to, orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists, and psychiatrists.</p> <p>The committee reviews (i) FDA approval/clearance status, (ii) English language peer reviewed publications; and (iii) relevant documents prepared by specialty societies and evidence-based review centers and uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage policies. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven.</p> <p><b>Factors</b> Cigna considers the following factors in determining</p>	<p>committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines.</p> <p>MTAC also consults with internal Cigna subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to, orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists, and psychiatrists.</p> <p>The committee reviews (i) FDA approval/clearance status, (ii) English language peer reviewed publications; and (iii) relevant documents prepared by specialty societies and evidence-based review centers and uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage policies. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven.</p> <p><b>Factors</b> Cigna considers the following factors in determining</p>	<p>as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for M/S services within the same classification of benefits.</p> <p>The use of MTAC for development of evidence based Coverage Policies for M/S and MH/SUD demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>whether a services is experimental, investigational or unproven:</p> <ul style="list-style-type: none"><li>• inadequate 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;</li><li>• when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the in a clinical trial</li><li>• the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the clinical trials section below.</li></ul> <p><b>Sources</b> In approving new technology, MTAC uses principles of evidence-based medicine in its evaluation of the following sources:</p> <ul style="list-style-type: none"><li>• clinical literature</li><li>• FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven.</li><li>• FDA approval or clearance</li><li>• English language peer reviewed publications</li></ul>	<p>whether a services is experimental, investigational or unproven:</p> <ul style="list-style-type: none"><li>• inadequate 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;</li><li>• when subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use;</li><li>• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the in a clinical trial</li><li>• the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the clinical trials section below.</li></ul> <p><b>Sources</b> In approving new technology, MTAC uses principles of evidence-based medicine in its evaluation of the following sources:</p> <ul style="list-style-type: none"><li>• clinical literature</li><li>• FDA approval or clearance, as appropriate, is necessary, but not sufficient, for Cigna to consider a technology to be proven.</li><li>• FDA approval or clearance</li><li>• English language peer reviewed publications</li></ul>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>including documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality.</p> <p><b>Evidentiary Standard.</b> Levels of evidence are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes.</p> <p>Cigna considers other sources of internal and external information as part of its decision making process including input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed as part of the annual update process.</p>	<p>including documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality.</p> <p><b>Evidentiary Standard.</b> Levels of evidence are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes.</p> <p>Cigna considers other sources of internal and external information as part of its decision making process including input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed as part of the annual update process.</p>	
<b>Standards for Provider Credentialing and Contracting</b>			





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
Is the provider network open or closed?	<p>Cigna maintains an open network for M/S Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria ("Credentialing Criteria").</p> <p>When determining whether to admit a provider into its provider network, Cigna takes into consideration an array of factors including, but not limited to provider type and/or specialty; geographic market; supply of provider type and/or specialty; demand for provider type and/or specialty; and provider licensure and/or certification.</p>	<p>Cigna maintains an open network for MH/SUD Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria ("Credentialing Criteria").</p> <p>When determining whether to admit a provider into its provider network, Cigna takes into consideration an array of factors including, but not limited to provider type and/or specialty; geographic market; supply of provider type and/or specialty; demand for provider type and/or specialty; and provider licensure and/or certification.</p>	<p>Cigna maintains an open network for both M/S and MH/SUD Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria ("Credentialing Criteria").</p> <p>Cigna conducts an annual directory audit which includes a valid random sample to meet NCQA accreditation requirements.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<p><b>What are the credentialing standards for physicians?</b></p> <p>Network Admissions standards are designed and maintained by the Quality Programs &amp; Accreditation (“QP&amp;A”) team, which serves as an Accreditation Center of Excellence working with independent agents, such as the National Committee for Quality Assurance (“NCQA”), Utilization Review Accreditation Commission (“URAC”), the Centers for Medicare and Medicaid Services (“CMS”) and the National Alliance of HealthCare Purchaser Coalitions (“NAHPC”). Accreditation, certification and recognition by these organizations provides us with the external validation needed to show that we maintain high quality and meet nationally recognized industry standards. Cigna’s mission is to improve the health, well-being and peace of mind of those we serve through an integrated approach to healthcare quality and affordability</p>	<p>Credentialing criteria for M/S Network Providers includes the following standard requirements:</p> <ol style="list-style-type: none"><li>1. signed agreement to participate;</li><li>2. signed application and provider attestation;</li><li>3. verification of unrestricted state medical license with appropriate licensing agency;</li><li>4. verification of valid, unrestricted DEA certificate (if applicable);</li><li>5. verification of full, unrestricted admitting privileges at a Cigna participating hospital;</li><li>6. verification Board certification, (if applicable);</li><li>7. verification of highest level of education and training, if not board certified;</li><li>8. review and verification of malpractice claims history;</li><li>9. review of work history;</li><li>10. verification of adequate malpractice insurance; and</li><li>11. verification of prior and current sanction activities Additional criteria may be applicable pursuant to state credentialing and licensing requirements.</li></ol> <p>CHLIC maintains NCQA and URAC accreditation, which requires a comprehensive and rigorous audit of the Quality Program documents, policies, and other materials regarding Quality Management, Utilization Management, Case Management, Care Coordination, Credentialing, and Members’ Rights &amp; Responsibilities (approximately 250 documents).</p>	<p>Credentialing criteria for both MH/SUD Network Providers includes the following standard requirements:</p> <ol style="list-style-type: none"><li>1. signed agreement to participate;</li><li>2. signed application and provider attestation;</li><li>3. verification of unrestricted state medical license with appropriate licensing agency;</li><li>4. verification of valid, unrestricted DEA certificate (if applicable);</li><li>5. verification of full, unrestricted admitting privileges at a Cigna participating hospital;</li><li>6. verification Board certification, (if applicable);</li><li>7. verification of highest level of education and training, if not board certified;</li><li>8. review and verification of malpractice claims history;</li><li>9. review of work history;</li><li>10. verification of adequate malpractice insurance; and</li><li>11. verification of prior and current sanction activities Additional criteria may be applicable pursuant to state credentialing and licensing requirements.</li></ol> <p>Evernorth maintains NCQA Managed Behavioral Healthcare Organization (“MBHO”) and URAC accreditation and conducts an annual directory audit which includes a valid random sample to ensure the network and directory meet all NCQA MBHO accreditation requirements. MBHO Accreditation includes standards for Behavioral Health Care,</p>	<p>Cigna's methodology for credentialing for M/S providers and MH/SUD physician providers are the same.</p> <p>Cigna maintains one credentialing committee for the review of providers entering the network. Cigna does not routinely track credentialing exceptions for either M/S or MH/SUD Network Providers. Network Providers are re-credentialed on a three-year cycle as required by NCQA.</p> <p>NCQA Accreditation standards require that the organization maintain sufficient numbers and types of behavioral health, primary care and specialty care practitioners in its network. NCQA does not specifically dictate what the appropriate number/type should be. As a result, Cigna conducts review of its Network Adequacy standards at least annually to ensure requirements are sufficient for customer needs. Such analysis reviews external benchmarks (e.g., state laws or CMS requirements) as well as internal review of supply/demand and network adequacy enrollee complaints.</p> <p>Cigna's methodology for credentialing for M/S and MH/SUD physician providers are the same. 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. Moreover, the standard</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>This evidence spans a period of 2 years and the majority of the evidence has to be reviewed and approved by our Medical Management Quality Committee (“MMQC”), Integrated Health Management Quality Committee (“IHMQC”), and Clinical Advisory Committee (“CAC”). Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records).</p>	<p>Credentialing/Re-credentialing, Provider Accessibility and Availability Monitoring, and Provider Contracting and Satisfaction. Cigna conducts quality management activities for both medical and behavioral healthcare products. Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records).</p>	<p>credentialing process is used for both licensed physician providers and licensed non-physician providers, whether they are M/S or MH/SUD providers. Re-credentialing is required every three years for all providers, and except for work history and education and training verification, requires providers to meet the same criteria as the initial credentialing process, unless a new specialty is being requested.</p> <p>The credentialing application process is consistent between physicians and facilities providing M/S and MH/SUD services and the required licensing, experience, CAQH application and verifications are indistinguishable. No additional Cigna-specific credentialing requirements are applied to either M/S or MH/SUD physician providers, and, as relevant for certain MH/SUD services or specialties, 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. Consistency in credentialing standards and process evidences compliance with the NQTL in-writing requirement.</p> <p>An “in operation” review of Cigna’s credentialing applications, approvals and denials of providers revealed no disparate outcomes in credentialing approvals or denials as between M/S and MH/SUD physician providers. The average time it took Cigna to review and approve a credentialing application for</p>

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Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			<p>both M/S and MH/SUD providers was 15.5 days, an 18 day approval average for M/S providers and a shorter 13 day approval average for MH/SUD providers. The average time it took Cigna to review and deny a credentialing application for both M/S and MH/SUD providers was 100 days; 99 day approval average for M/S providers and 101 day approval average for MH/SUD providers. These credentialing process metrics indicate a comparable process in-operation based on the time to review, a significantly lower amount of denials of MH/SUD provider credentialing applications, and comparable incidences of denials of MH/SUD and M/S provider credentialing denial overturns on appeal. Consequently, Cigna concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.</p> <p>Consistent with the NQTL requirement for comparability/stringency, Cigna has confirmed that standards for provider admission into the MH/SUD provider network, including credentialing, for inpatient and outpatient services are comparable to, and applied no more stringently than, that of the M/S provider network as written and in operation. Put differently, Cigna’s network has the ability to meet the MH/SUD services needs of our enrollees by providing reasonable access to a sufficient number of in-network providers for both inpatient and outpatient services.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards (e.g., nurse practitioners, physician assistants, psychologists, clinical social workers)</b>	Cigna follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. The standard credentialing process is used for both licensed physician providers and licensed non-physician providers. See process above.	Cigna follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. The standard credentialing process is used for both licensed physician providers and licensed non-physician providers. See process above.	Cigna’s credentialing standards for licensed non-physician providers follows NCQA, CMS and state and federal requirements and guidelines for MS and MH/SUD providers. The credentialing application process is consistent between M/S and MH/SUD and such required licensing, experience, CAQH application and verifications are distinguishable only by differences in regulatory requirements. No additional Cigna-specific credentialing requirements are applied to either M/S or MH/SUD providers. Consistency in standards and process evidences compliance with the NQTL requirement.
<b>What are the credentialing/contracting standards for unlicensed personnel? (e.g., home health aides, qualified autism service professionals and paraprofessionals)</b>	Unlicensed providers may not be directly contracted, but may render services under a fully contracted and credentialed individual (supervising provider) or entity. For example, Home Health Aides are not individually credentialed or contracted directly, the Home Health Agency is contracted and credentialed as an entity (facility or clinic). Cigna does not contract directly with most of these types of providers but rather, with the entity they work for. If certifications are available for paraprofessionals, it is reviewed for credentialing purposes.	Unlicensed providers may not be directly contracted, but may render services under a fully contracted and credentialed individual (supervising provider) or entity. For example, Home Health Aides are not individually credentialed or contracted directly, the Home Health Agency is contracted and credentialed as an entity (facility or clinic). Cigna does not contract directly with most of these types of providers but rather, with the entity they work for. If certifications are available for paraprofessionals, it is reviewed for credentialing purposes.	Cigna does not distinguish between M/S and MH/SUD for purposes of credentialing unlicensed professionals and paraprofessionals. For M/S and MH/SUD, unlicensed providers may not be directly contracted or credentialed but may render services under a fully contracted and credentialed individual (supervising provider) or entity (clinic or facility)  Cigna’s credentialing standards for unlicensed professionals and paraprofessionals follows applicable NCQA, CMS and state and federal requirements and guidelines for MS and MH/SUD providers. The credentialing application process is consistent between M/S and MH/SUD and such required licensing, experience, CAQH application and verifications are distinguishable only by differences in regulatory requirements. No additional Cigna-specific credentialing requirements are applied

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			to either M/S or MH/SUD providers.  Consistency in standards and process evidences compliance with the NQL requirement.
<b>Exclusions for Failure to Complete a Course of Treatment</b>			
<b>Does the plan exclude benefits for failure to complete a course of treatment?</b>	Cigna does not exclude benefits for failure to complete treatment.	Cigna does not exclude benefits for failure to complete treatment.	Cigna does not exclude benefits for failure to complete treatment for M/S or MH/SUD Benefits. Cigna's process is consistent between M/S and MH/SUD, so Cigna does not apply such an NQL to MH/SUD benefits that warrants analysis under the NQL requirement.
<b>Restrictions that Limit Duration or Scope of Benefits for Services</b>			
<b>Does the plan restrict the geographic location in which services can be received? (e.g., service area, within a specific State, within the U.S.)</b>	Cigna has a National Network that includes providers within the United States. Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna has a National Network that includes providers within the United States. Cigna's policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	Cigna's geographic limitations on coverage for services apply uniformly across MH/SUD and M/S benefits.
<b>Does the plan restrict the type(s) of facilities in which enrollees can receive services?</b>	In Network facilities must meet applicable licensing, contracting/credentialing requirements. Services in facilities may need prior authorization and meet our medical necessity guidelines.	In Network facilities must meet applicable licensing, contracting/credentialing requirements. Services in facilities may need prior authorization and meet our medical necessity guidelines.	Cigna standardly covers medically necessary services rendered by licensed and/or certified healthcare providers for the treatment of M/S conditions and MH/SUD conditions. Services determined by Cigna not to be medically necessary would be excluded under the terms of the plan.
<b>Provider Specialties</b>			
<b>Does the plan restrict the types of provider specialties that can provide certain M/S or MH/SUD benefits?</b>	Providers are required to work within the scope of their licenses. No additional restrictions apply.	Providers are required to work within the scope of their licenses. No additional restrictions apply.	Cigna requires providers to work within the scope of their licenses for both M/S and MH/SUD benefits. The process is consistent between M/S and MH/SUD benefits. Cigna does not, in writing or in operation,

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
			further restrict provision of MH/SUD benefits to certain types of specialties so long as the rendering provider is acting within the scope of the provider’s license, and, in terms of stringency, Cigna confirms that it does not waive for any M/S providers the requirement that the M/S provider act within the scope of the provider’s license in order for services to be covered.
<b>Network Adequacy</b>			
<b>Explain how the plan ensure the provider network provides sufficient availability of providers within the service area</b>	<p>Cigna establishes and monitors clinically appropriate: (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine outpatient care for the various provider types and/or specialties, as prescribed by NCQA.</p> <p>For both its M/S provider network and its MH/SUD provider network, Cigna establishes and monitors clinically appropriate: (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine</p>	<p>Cigna establishes and monitors clinically appropriate: (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine outpatient care for the various provider types and/or specialties, as prescribed by NCQA.</p> <p>For both its M/S provider network and its MH/SUD provider network, Cigna establishes and monitors clinically appropriate: (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine</p>	<p>Cigna maintains an open network and will contract with any MH/SUD or M/S provider or facility. Cigna does not limit parties with whom it will contract and negotiate rates. The Behavioral Health medical cost budget and M/S cost budgets are established using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally new negotiations are reviewed in order to set budget metrics. Cigna does negotiate rates with parties that represent groups or sets of providers. There is no difference in how this process is handled for MH/SUD vs. M/S providers or representatives. When applicable, Cigna uses the same Consultant Agreement for both MH/SUD and M/S.</p> <p><b>As Written</b></p> <p>Cigna conducts oversight and monitoring of the adequacy of its M/S provider network(s) and MH/SUD provider network to assess whether they are meeting its internal and regulatory driven network</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTl)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>outpatient care for the various provider types and/or specialties, as prescribed by NCQA.</p> <p>Assessing supply and demand of M/S facilities, provider types and/or specialties and MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to, NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.</p> <p>Cigna considers the composition of its current M/S network providers by provider type and/or specialty, in addition to census (membership) data, to ensure it maintains an adequate M/S provider network to meet the clinical needs of its customers. Network adequacy analysis considers: geographic area, time/distance standards, provider/enrollee ratio, provider type and/or specialty and supply/demand.</p> <p><b>Ratio of Providers to Customers:</b> Providers to customer ratios are normally calculated with the Provider count constant at 1, where the Provider count is based on unique Provider and the Customer count is based on customer's home zip code. To convert to a ratio in this format, Cigna</p>	<p>outpatient care for the various provider types and/or specialties, as prescribed by NCQA.</p> <p>Assessing supply and demand of M/S facilities, provider types and/or specialties and MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to, NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.</p> <p>Cigna considers the composition of its current M/MH/SUD network providers by provider type and/or specialty, in addition to census (membership) data, to ensure it maintains an adequate MH/SUD provider network to meet the clinical needs of its customers. Network adequacy analysis considers: geographic area, time/distance standards, provider/enrollee ratio, provider type and/or specialty and supply/demand.</p> <p><b>Ratio of Providers to Customers:</b> Providers to customer ratios are normally calculated with the Provider count constant at 1, where the Provider count is based on unique Provider and the Customer count is based on customer's home zip code. To convert to a ratio in this format, Cigna</p>	<p>access standards. When access to care standards are not met, Cigna engages in active recruitment of the relevant provider type and/or specialty at issue.</p> <p>Enrollees are able to receive assistance in locating a provider or appointment by contacting the phone number on the back of their ID card. In the event the enrollee and/or a Cigna representative cannot locate a provider/appointment within the acceptable time/distance standards a request can be made for out-of-network care at the in-network benefit level for plans without out of network benefits.</p> <p><b>In Operation</b> A review of Cigna's Network Adequacy reports for Cigna's national network revealed sufficient access to M/S and MH/SUD providers. Cigna meets adequacy and accessibility requirements for M/S and MH/SUD providers using comparable standards, with M/S providers subject to more stringent standards.</p> <p>Cigna's Quality Programs and Accreditation team defines quality monitoring standards and provides guidance in initiating improvement initiatives when deficiencies are identified. Quality studies are designed and documented to objectively and systematically monitor, evaluate and improve the quality and appropriateness of care and service. Monitoring and driving improvements in quality of care and service to our customers is an integral component of Behavioral Accreditation, which</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>divides the customer count by the Provider count. For example, for an area with 3,000 customers and 30 Providers, – the ratio would be 1:100.</p> <p>In remote or rural areas, occasionally geographic availability guidelines are not able to be met due to lack of, or absence of, qualified Practitioners and/or Providers. The organization may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval. Annually, the Quality Management team reviews and assesses the behavioral health care professional network to determine if goals are met and if the network is robust enough to meet the needs of its customers. NCQA requires certain measures to assess availability for urban/suburban, rural, and ratios (behavioral health care professional to customers) across its networks. Likewise, the Network team reviews and assesses the medical health care professional network to determine if goals are met in 90% of the zip codes within the service area for each provider specialty category for PCPs, High Volume Specialist, High Impact Specialists, and Hospitals.</p>	<p>divides the customer count by the Provider count. For example, for an area with 3,000 customers and 30 Providers, – the ratio would be 1:100.</p> <p>In remote or rural areas, occasionally geographic availability guidelines are not able to be met due to lack of, or absence of, qualified Practitioners and/or Providers. The organization may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval. Annually, the Quality Management team reviews and assesses the behavioral health care professional network to determine if goals are met and if the network is robust enough to meet the needs of its customers. NCQA requires certain measures to assess availability for urban/suburban, rural, and ratios (behavioral health care professional to customers) across its networks. Likewise, the Network team reviews and assesses the medical health care professional network to determine if goals are met in 90% of the zip codes within the service area for each provider specialty category for PCPs, High Volume Specialist, High Impact Specialists, and Hospitals.</p>	<p>reflects the Cigna commitment to continuous quality improvement throughout the organization.</p> <p>At present, Cigna meets all provider ratio access requirements for Masters Level Clinicians, Psychologist/Nurse Practitioners with prescribing privileges, Physicians, Inpatient Facility and Residential Facility for the MH/SUD Network. Cigna also meets all provider ratio access requirements for adult and pediatric PCP; high volume specialty including cardiology, dermatology, ophthalmology, and orthopedics; and high impact specialty for hematology/oncology, infectious disease, nephrology, neurology and pulmonary. Holistically, when reviewing the current snapshot of both the M/S and MH/SUD networks, Cigna also meets provider access radius requirements. When reviewed individually by state, deficiencies are noted in rural areas such as Alaska, Idaho, Montana, South Dakota and Wyoming in both the M/S and MH/SUD Networks. Lastly, Cigna reviewed the percentages of exceptions for obtaining out-of-network M/S and MH/SUD services at the in-network benefit level to ensure operational parity compliance. Data revealed a significantly larger number of M/S network exceptions denied including both medical necessity and administrative denials than denials of MH/SUD network exceptions.</p>



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<b>In-Network Provider Reimbursement</b>			
<b>Explain the plan’s reimbursement approach for contracted providers</b>	<p>Cigna's in-network provider reimbursement methodology, exclusive of DRG reimbursement is based upon factors including, but not limited to: geographic market (i.e. market rate and payment type for provider type and/or specialty); type of provider (i.e. hospital, clinic and practitioner) and/or specialty; supply of provider type and/or specialty; network adequacy and current Medicare reimbursement rates.</p> <p><b>Factors and Evidentiary Standards.</b> Factors for reimbursement negotiation include:</p> <ol style="list-style-type: none"><li>Geographic market, which may be adjusted based upon Medicare Geographical Practice Cost Index (“GPCI”) Geographic Practice Cost Index (GPCI) reflects the relative cost of practicing in a locality against a national average. Each relative value is multiplied by the corresponding GPCI. The three component factors are then accumulated to arrive at an adjusted amount. This amount is then multiplied by the conversion factor to establish the Medicare full fee schedule amount in the Medicare Physician Fee Schedule Data Base (MPFSDB). CMS performs calculations on the fee schedule, with the exception of carrier-priced procedure codes, and provides fee schedule calculations to the Medicare Administrative Contractors (MACs). Geographic Practice Cost Index is not weighted for purposes of per diem reimbursement;</li><li>Type of provider and/or specialty (e.g. physician</li></ol>	<p>Cigna's in-network provider reimbursement methodology, exclusive of DRG reimbursement is based upon factors including, but not limited to: geographic market (i.e. market rate and payment type for provider type and/or specialty); type of provider (i.e. hospital, clinic and practitioner) and/or specialty; supply of provider type and/or specialty; network adequacy and current Medicare reimbursement rates.</p>	<p>All staff participating in a contract negotiation for M/S and MH/SUD Network Providers and facilities are trained on internal Cigna policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider specific reimbursement requests and escalate for justification and approval of any deviations.</p> <p><b>As Written.</b> Whether for initial negotiation or renegotiation, Cigna's Network Provider reimbursement methodology for MH/SUD and M/S Network Providers are based upon the same array of factors. Re-negotiations of reimbursement rates are conducted according to the terms of the contract, or if not specified in the contract, they are conducted at the request of either party. The number of Network Providers (Individual, Group or Facility) joining or already part of the network does not factor into initial rate offerings. M/S and MH/SUD facilities may be reimbursed per diem, Diagnosis Related Group or case rate. Per diem reimbursement involves a flat dollar amount for each day as reimbursement for the service.</p> <p>Cigna also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. In this process, variables including market demand, provider</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>practitioner v. non-physician practitioner v. facility); Provider types are dependent upon state licensing and credentialing requirements as outlined by the applicable state or NCQA. Cigna does not weight provider types or designate any additional provider and/or specialty designations (e.g. physician practitioner v. non-physician practitioner);</p> <p>3. Supply of provider type and/or specialty. 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. Provider specific or specialty fee schedules are used to retain providers if the providers are needed to meet network access requirements and/or increase membership. Supply of provider type and/or specialty are not weighted in relation to the other evidentiary standards for purposes of per diem reimbursement;</p> <p>4. Network need and/or demand for provider type and/or specialty. Network need and/or demand for provider type or specialty is defined by state adequacy requirements. Cigna contracts with practitioners and providers across all networks and for all product lines to meet the availability and cultural needs and preferences of customers, establishes availability standards and assesses its networks against those standards articulated in Cigna's <i>Measuring Availability of Practitioners and Providers Policy</i>. Need and/or demand for</p>		<p>specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across M/S and MH/SUD provider types.</p> <p><b>In Operation</b> Whether for initial negotiation or renegotiation, Cigna uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region.</p> <p>Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. Cigna's preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, BH pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested.</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>provider type and/or specialty are not weighted in relation to the other evidentiary standards for purposes of per diem reimbursement;</p> <p>5. Training, experience and licensure of providers billing for professional services under the facility agreement. Training, experience and licensure of providers billing for professional services under the facility agreement are not specifically weighted in relation to the other evidentiary standards for purposes of per diem reimbursement;</p> <p>6. Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit (“RVU”). RVUs are the basis of the RBRVS system. Unit values are assigned to each service (CPT code) by area of specialty and for some codes, different RVUs for site of service: facility and non-facility. RVUs are not weighted for per diem reimbursement.</p> <p><b>Medicare Baseline.</b> Cigna utilizes the Medicare Pricing Tool to determine if the provider’s (current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard Medicare Resource Based Relative Value Scale (“RBRVS”), a CMS created reimbursement methodology to reimburse providers for members</p>		<p><i>Provider Reimbursement – Outpatient</i> In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff participating in contract negotiation are trained on internal Cigna policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider-specific reimbursement requests and escalate for justification and approval any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting</p>

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Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>covered under the Medicare program and as a baseline for commercial reimbursement rates. Cigna’s RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually:</p> $[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice RVU} \times \text{Practice GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})] \times \text{Conversion Factor} = \text{Reimbursement}$ <p>RVUs are the basis of the RBRVS system. Unit values are assigned to each service (CPT code) by area of specialty and for some codes, different RVUs for site of service: facility and non-facility. Three components are used to make up a total RVU (1) Physician’s work – This component accounts for the providers time, technical skill, mental effort, and physiological stress; (2) Practice expense – This component includes office rent, wages, supplies, equipment; (3) Malpractice Expense - This component includes professional liability insurance cost. To fill gaps for codes not covered by RBRVS methodology Cigna uses relative values assigned by Optum (Ingenix) for M/S services. Optum (Ingenix), is a third party health data company, that uses the same methodology originally used to develop the values for Medicare covered services. For those services that cannot be valued using a resource- based methodology,</p>		<p>process ensures by policy the consideration of such factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies.</p> <p><i>Facility Reimbursement – Inpatient</i> In-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient’s insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc.</p> <p>Cigna’s methodology and process for negotiating in-network provider reimbursements for M/S and</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>values have been developed using alternative methodologies proprietary to Optum (Ingenix). In an RBRVS calculation, each component of an RVU is multiplied by its GPCI then totaled and multiplied by the conversion factor to determine the fee or payment. Cigna uses the same GPCIs as Medicare. There are approximately 89 GPCIs. Cigna uses Optum (Ingenix) values to fill gaps for codes not covered by RBRVS methodology</p> <p>Facility rate categories are industry standard with the market and economy dictating rates for both M/S and MH/SUD facilities. Cigna utilizes Medicare’s resource-based relative value scale (RBRVS) calculation (OP- BH &amp; Med). This calculation is premised on the principle that payments for services should vary with the resource cost for providing the services. In each instance, the fee schedule is separately reviewed and negotiated.</p> <p>DRG reimbursement is based upon Medicare DRG calculations, which assign payment levels to each DRG based on the average cost of treatment. Case rates, also referred to as <i>flat rates</i>, describe a reimbursement structure in which providers receive a flat reimbursement rate for every patient visit, regardless of the service (most often utilized in urgent care). Cigna does not determine or mandate the reimbursement type; selection of reimbursement type is determined by the facility. Generally, M/S facility</p>		<p>MH/SUD services within a classification of benefits are comparable and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. Cigna also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, Cigna’s Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across M/S and MH/SUD provider types.</p> <p>An ‘in operation” review of Cigna’s M/S and MH/SUD reimbursement rates from a sampling of Cigna-administered plans revealed that M/S providers are reimbursed on average at a higher percentage of Medicare than MH/SUD providers. While there is a disparate outcome in the in-operational review of Cigna’s M/S and MH/SUD reimbursement rates that results from differences in local market dynamics, such outcome does not mean the in-practice NQTL standards are non-comparable or being applied more stringently to MH/SUD benefits. Because in-network provider reimbursement is a factor relevant to NQTL</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>providers request DRG reimbursement, while MH/SUD facility providers request per diem reimbursement. More than 90% of MH/SUD Provider Network contracts reflect per diem reimbursement. The evidentiary factors taken into consideration in the negotiation of the per-diem rate are not weighted or prioritized one more than the other; however, additional consideration may be given to meet network adequacy standards.</p> <p>For DRG reimbursement, weighting is not calculated within the contract or at the time of contract rate negotiation, but instead occurs at the time of payment as DRG reimbursement is dependent on a variety of variable factors such as patient age and diagnosis. When behavioral contracts at a per diem rate, the population and type of care are distinguished in the contract and rates are negotiated separately. Cigna utilizes CMS grouping software (Optum) that takes the information from the claim and “groups it” into the correct DRG. Then that DRG information is used to calculate the reimbursement, based on the factor in the contract; by way of example: DRG 203 has a factor 17; CMS DRG weight x contracted factor = reimbursement.</p>		<p>compliance insofar as it impacts accessibility to in-network providers and Cigna's network admissions criteria, itself the relevant NQTL, Cigna emphasizes that the comparable out-of-network utilization over the recent measurement period across MH/SUD and M/S benefits and the achievement of applicable network adequacy requirements for MH/SUD and M/S providers, respectively, evidences that any discrepancies in rates offered to MH/SUD providers is not affecting Cigna's ability to admit a sufficient number of providers.</p>
<b>Usual, Customary &amp; Reasonable Charges</b>			
<b>Explain the plan’s method for determining usual, customary and reasonable charges</b>	The following information can vary by client election and/or state compliance rules, and Cigna's administration of any given client’s plan is subject to the client’s benefit plan elections. To the extent that	The following information can vary by client election and/or state compliance rules, and Cigna's administration of any given client’s plan is subject to the client’s benefit plan elections. To the extent that	Cigna has assessed across Cigna-administered plans the NQTL compliance of its standard out-of-network reimbursement methodology and has confirmed that its standard out-of-network reimbursement





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>a client makes a non-standard out-of-network benefit, the following information may not apply.</p> <p>Cigna's standard out-of-network reimbursement methodology incorporated by clients into their benefit plans is predicated on achieving two fundamental objectives: reducing costs for enrollees/plan sponsors while, wherever possible, protecting the enrollees in Cigna-administered plans from excessive balance bills from out-of-network providers. These objectives are achieved through a combination of techniques described more fully below.</p> <p>The Company may use a program provided by a partner entity that utilizes one of three methods to establish appropriate reimbursement levels for covered charges with non-contracted providers. These include the following:</p> <ol style="list-style-type: none"><li>1. The partner companies have standing agreements with providers that establish discounted rates which Cigna can access through its agreement with the partner company. This is an agreement where the provider remains non-contracted with Cigna, but agrees not to balance bill the member.</li><li>2. The partner company reviews claims received by Cigna from non-contracted providers and negotiates with the provider on the plan's behalf for a claim-specific discount. This is a direct discount agreement where the provider remains</li></ol>	<p>a client makes a non-standard out-of-network benefit, the following information may not apply.</p> <p>Cigna's standard out-of-network reimbursement methodology incorporated by clients into their benefit plans is predicated on achieving two fundamental objectives: reducing costs for enrollees/plan sponsors while, wherever possible, protecting the enrollees in Cigna-administered plans from excessive balance bills from out-of-network providers. These objectives are achieved through a combination of techniques described more fully below.</p> <p>The Company may use a program provided by a partner entity that utilizes one of three methods to establish appropriate reimbursement levels for covered charges with non-contracted providers. These include the following:</p> <ol style="list-style-type: none"><li>4. The partner companies have standing agreements with providers that establish discounted rates which Cigna can access through its agreement with the partner company. This is an agreement where the provider remains non-contracted with Cigna, but agrees not to balance bill the member.</li><li>5. The partner company reviews claims received by Cigna from non-contracted providers and negotiates with the provider on the plan's behalf for a claim-specific discount. This is a direct discount agreement where the provider remains</li></ol>	<p>methodology, both in-writing and in-operation, applies comparably to MH/SUD benefits and no more stringently than M/S benefits received out-of-network.</p> <p>More specifically, Cigna ensures consistency with the NQL requirement in, subject to client election, its design of its out-of-network reimbursement methodology with respect to any indirect discount arrangements with out-of-network providers for reimbursement of MH/SUD or M/S services in several ways. For one, for both MH/SUD and M/S benefits Cigna retains third party vendors with which it contracts for indirect discount arrangements, whether maintained pursuant to a standing agreement between the third party vendor and provider or negotiated on a case-by-case basis with the provider, to make available, as applicable, rates that are within Cigna's established target pricing for a service. The MRC and the established MRC target pricing within which an indirect discount arrangement may be used to calculate reimbursement rates for covered services are derived identically for an MH/SUD or M/S benefit. Specifically, under the MRC1 methodology the MRC is derived from the same process, factors and evidentiary standards across MH/SUD and M/S benefits, and the target pricing for a service is equivalent to the MRC, which means that if any indirect discount arrangement that the third party vendors achieve with a provider is lower than the MRC for the service then the amount</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>non-contracted but agrees not to balance bill the member.</p> <p>3. The partner company facilitates an electronic offer to the provider on the plan’s behalf whereby a provider is reimbursed at a market rate, as determined by the partner company, and deemed to have agreed to the reimbursement absent an objection by the provider.*</p> <p>If the claim cannot be adjudicated utilizing one of the above methodologies, then reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). A description of the MRC is included in the plan documents.</p> <p>The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount:</p> <ul style="list-style-type: none"><li>• MRC1<ul style="list-style-type: none"><li>○ Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna.</li><li>○ Clients select an MRC1 percentile: 70<sup>th</sup> or 80<sup>th</sup>. Standard offerings are 70<sup>th</sup> percentile for HMO and POS product claims and 80<sup>th</sup> percentile for PPO and EPO products claims.</li></ul></li></ul>	<p>non-contracted but agrees not to balance bill the member.</p> <p>6. The partner company facilitates an electronic offer to the provider on the plan’s behalf whereby a provider is reimbursed at a market rate, as determined by the partner company, and deemed to have agreed to the reimbursement absent an objection by the provider.*</p> <p>If the claim cannot be adjudicated utilizing one of the above methodologies, then reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). A description of the MRC is included in the plan documents.</p> <p>The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount:</p> <ul style="list-style-type: none"><li>• MRC1<ul style="list-style-type: none"><li>○ Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna.</li><li>○ Clients select an MRC1 percentile: 70<sup>th</sup> or 80<sup>th</sup>. Standard offerings are 70<sup>th</sup> percentile for HMO and POS product claims and 80<sup>th</sup> percentile for PPO and EPO products claims.</li></ul></li></ul>	<p>resulting from the indirect discount arrangement is the amount that Cigna calculates as reimbursement to the provider. Conversely, if the indirect discount arrangement equals an amount exceeding the MRC for the service, then the reimbursement amount due to the provider equals the MRC. That is, the reimbursement amount never exceeds, but may be lesser than, the client-elected percentile of the applicable MRC for any MH/SUD or M/S service under the MRC1 methodology, and the MRC itself is derived from the same process, factors, and standards across MH/SUD and M/S benefits.</p> <p>Likewise, under the MRC2 methodology – which is based on a Medicare pricing methodology across MH/SUD and M/S services – any negotiations resulting in indirect discount arrangements maintained by a third party vendor and a provider, whether rendering MH/SUD or M/S services, the same MRC2 target price for MH/SUD or M/S services is utilized. Similarly to the calculation of reimbursement under the MRC1 methodology, where the indirect discount arrangement amount meets or is lower than the target price – which target price is, again, the same percentage of the applicable Medicare rate whether it is an MH/SUD or M/S service – the amount resulting from the indirect discount arrangement is the allowable reimbursement amount, and where the indirect discount arrangement amount exceeds the target</p>

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## Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>• MRC2<ul style="list-style-type: none"><li>○ Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area.</li><li>○ Clients select an MRC2 percentage: 110 (standard), 150, 200, or 300.</li></ul></li></ul> <p>If the provider balance bills the member and the claim was paid utilizing either (1) the partner company's electronic offer and negotiation is not successful, or (2) the Maximum Reimbursable Charge (MRC), then:</p> <ul style="list-style-type: none"><li>• If the administration of the plan permits additional payment to protect the customer from balance billing, then Cigna's Offer &amp; Settlement policy may apply. An additional amount, up to the amount being balance billed, may be allowed. The customer copay/coinsurance and deductible may increase, based on the revised allowed amount, subject to state law.</li><li>• If the administration of the plan does not permit additional payment to protect the customer from balance billing, then the claim will be paid up to that amount and no additional amount will be allowed. The customer may be liable for any amount over the allowed amount, in addition to their copay/coinsurance and deductible.</li></ul> <p>Non-Par services that are subject to the No Surprises Act (NSA) are reimbursed at an amount negotiated with the</p>	<ul style="list-style-type: none"><li>• MRC2<ul style="list-style-type: none"><li>○ Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area.</li><li>○ Clients select an MRC2 percentage: 110 (standard), 150, 200, or 300.</li></ul></li></ul> <p>If the provider balance bills the member and the claim was paid utilizing either (1) the partner company's electronic offer and negotiation is not successful, or (2) the Maximum Reimbursable Charge (MRC), then:</p> <ul style="list-style-type: none"><li>• If the administration of the plan permits additional payment to protect the customer from balance billing, then Cigna's Offer &amp; Settlement policy may apply. An additional amount, up to the amount being balance billed, may be allowed. The customer copay/coinsurance and deductible may increase, based on the revised allowed amount, subject to state law.</li><li>• If the administration of the plan does not permit additional payment to protect the customer from balance billing, then the claim will be paid up to that amount and no additional amount will be allowed. The customer may be liable for any amount over the allowed amount, in addition to their copay/coinsurance and deductible.</li></ul> <p>Non-Par services that are subject to the No Surprises Act (NSA) are reimbursed at an amount negotiated with the</p>	<p>price the MRC is the allowable reimbursement amount.</p> <p>In terms of the stringency of the application of the NQL, when calculating out-of-network reimbursement for either MH/SUD or M/S benefits Cigna does not accommodate exceptions to the MRCs derived from the aforementioned sources/evidentiary standards (e.g., declining to use for a particular MH/SUD or M/S benefit claim the MRC derived from the database broadly used to derive an MRC) or the target price (e.g., agreeing through an indirect discount arrangement to pay a provider in excess of the target price for the service, which, for MRC1, would be the MRC) for M/S services or comparable MH/SUD services. That is, Cigna neither applies more stringently to MH/SUD services the limitation on the target price within which the third party vendor may negotiate with the provider for a discounted rate off of billed charges in return for an agreement not to balance-bill the patient for any difference between the billed charges and discounted rate, nor does Cigna use the methodology, including the process, factors, and evidentiary standards, for calculating reimbursement rates for covered MH/SUD benefits in a manner that disadvantages MH/SUD benefits relative to M/S benefits.</p> <p>To further support its conclusion of comparability/stringency, Cigna as also assessed</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>Non-Par provider. If an amount cannot be agreed upon, these services would generally be reimbursed based on the Qualifying Payment Amount (QPA) as defined in the NSA.</p> <p><i>* Important Note: Cigna's Offer &amp; Settlement policy does not apply to claims subject to the No Surprises Act.</i></p> <p>Cigna's out-of-network reimbursement methodology incorporated by clients into their benefit plans is predicated on achieving two fundamental objectives: reducing costs for enrollees/plan sponsors while, wherever possible, protecting the enrollees in Cigna-administered plans from excessive balance bills from out-of-network providers. In pursuing this objective, Cigna's out-of-network reimbursement methodology ultimately rests on ensuring that the Maximum Reimbursable Charge (or "MRC") for a service, commonly referred to in the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular MRC methodology adopted by the client. As noted in Cigna's prior response, Cigna makes available to client plans two MRC methodologies, MRC1 and MRC2, which serve as the foundation for Cigna's out-of-network reimbursement program.</p> <p><u>Maximum Reimbursable Charge 1 (MRC1)</u></p>	<p>Non-Par provider. If an amount cannot be agreed upon, these services would generally be reimbursed based on the Qualifying Payment Amount (QPA) as defined in the NSA.</p> <p><i>* Important Note: Cigna's Offer &amp; Settlement policy does not apply to claims subject to the No Surprises Act.</i></p> <p>Cigna's out-of-network reimbursement methodology incorporated by clients into their benefit plans is predicated on achieving two fundamental objectives: reducing costs for enrollees/plan sponsors while, wherever possible, protecting the enrollees in Cigna-administered plans from excessive balance bills from out-of-network providers. In pursuing this objective, Cigna's out-of-network reimbursement methodology ultimately rests on ensuring that the Maximum Reimbursable Charge (or "MRC") for a service, commonly referred to in the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular MRC methodology adopted by the client. As noted in Cigna's prior response, Cigna makes available to client plans two MRC methodologies, MRC1 and MRC2, which serve as the foundation for Cigna's out-of-network reimbursement program.</p> <p><u>Maximum Reimbursable Charge 1 (MRC1)</u></p>	<p>operational outcomes to validate that there are no potential disparities warranting closer scrutiny. Specifically, Cigna validated that across its commercial book-of-business it covers the full billed charges submitted by the MH/SUD providers at a comparable and, generally, higher rate than it pays the full billed charges for M/S providers as measured across inpatient and outpatient services paid for its entire book of business. Moreover, in the aggregate Cigna generally pays to MH/SUD providers a more favorable reimbursement amount than M/S providers as measured as a discount off the providers' billed charges. Finally, for comparable services like office visits for E&amp;M the average reimbursement for MH/SUD services across Cigna's commercial book-of-business is comparable to the average reimbursement for M/S services.</p> <p>The foregoing analysis evidences comparability and no less than equivalent stringency in the application of the out-of-network reimbursement process, factors, and standards across MH/SUD and M/S benefits, in-writing and in-operation, which established compliance with the NQTL requirement.</p>





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>In calculating the MRC for a service under the MRC1 methodology, Cigna applies a plan-sponsor-elected percentile to a charge (which is often referred to as a “U&amp;C” charge) as compiled in a national charges database. The charges in the database are derived based on factors including the service in question, charges submitted by providers located in the geographic area, specifically zip code groupings, if a charge for the zip code is available in which the claimant provider resides. That is, the evidentiary standard for the out-of-network MRC for the service is the charge set forth in a national charges database for the service in the geographic area of the claimant provider that aligns with the percentile elected by the client. Plan sponsors may select one of several possible MRC1 percentiles to apply to the applicable charge; these percentiles, which vary by plan, include as follows: 50th percentile, 60th percentile, 70th percentile, 80th percentile, etc.</p> <p>More specifically, to calculate the MRC for professional (i.e., non-facility) claims Cigna utilizes the FAIR Health database, which is a database maintained by a third party vendor. FAIR Health collects actual charge data through a data contribution program available to its payer clients. FAIR Health clients (including Cigna) submit an extensive layout, including the non-discounted fee-for-service billed charges that are submitted to them by providers. Once FAIR Health receives the submission, the data are run through a validation</p>	<p>In calculating the MRC for a service under the MRC1 methodology, Cigna applies a plan-sponsor-elected percentile to a charge (which is often referred to as a “U&amp;C” charge) as compiled in a national charges database. The charges in the database are derived based on factors including the service in question, charges submitted by providers located in the geographic area, specifically zip code groupings, if a charge for the zip code is available in which the claimant provider resides. That is, the evidentiary standard for the out-of-network MRC for the service is the charge set forth in a national charges database for the service in the geographic area of the claimant provider that aligns with the percentile elected by the client. Plan sponsors may select one of several possible MRC1 percentiles to apply to the applicable charge; these percentiles, which vary by plan, include as follows: 50th percentile, 60th percentile, 70th percentile, 80th percentile, etc.</p> <p>More specifically, to calculate the MRC for professional (i.e., non-facility) claims Cigna utilizes the FAIR Health database, which is a database maintained by a third party vendor. FAIR Health collects actual charge data through a data contribution program available to its payer clients. FAIR Health clients (including Cigna) submit an extensive layout, including the non-discounted fee-for-service billed charges that are submitted to them by providers. Once FAIR Health receives the submission, the data are run through a validation</p>	

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Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>process to validate zip code, procedure code, date of service, and other data.</p> <p><b>GeoZips:</b> FAIR Health GeoZips (geographical areas) are based on the first three digits of US ZIP codes. GeoZips may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. GeoZip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, local billing patterns and the quantity of available data are also taken into consideration. State boundaries are not crossed. FAIR Health currently has 494 GeoZips throughout the nation.</p> <p><b>Actual Charge Data:</b> Charges collected for a given period of time are sorted into appropriate GeoZips based on the provider zip codes.</p> <p>Once the charges are sorted by GeoZip, they are then sorted by CPT, ASA, ADA, or HCPCS procedure code. For each code, the charges are sorted in ascending order (lowest to highest). After the charges are sorted a total count of the charges is obtained. Each charge is assigned a number based on rank within the total count. To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.</p> <p>For example, if there are 200 charges for Procedure</p>	<p>process to validate zip code, procedure code, date of service, and other data.</p> <p><b>GeoZips:</b> FAIR Health GeoZips (geographical areas) are based on the first three digits of US ZIP codes. GeoZips may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. GeoZip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, local billing patterns and the quantity of available data are also taken into consideration. State boundaries are not crossed. FAIR Health currently has 494 GeoZips throughout the nation.</p> <p><b>Actual Charge Data:</b> Charges collected for a given period of time are sorted into appropriate GeoZips based on the provider zip codes.</p> <p>Once the charges are sorted by GeoZip, they are then sorted by CPT, ASA, ADA, or HCPCS procedure code. For each code, the charges are sorted in ascending order (lowest to highest). After the charges are sorted a total count of the charges is obtained. Each charge is assigned a number based on rank within the total count. To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.</p> <p>For example, if there are 200 charges for Procedure</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on line 160 is the 80<sup>th</sup> percentile. <math>200 \times .80 = 160</math></p> <p>Any other percentile can be found the same way: <math>200 \times .70 = 140</math> (The charge on line 140 is the 70<sup>th</sup> percentile) <math>200 \times .90 = 180</math> (The charge on line 180 is the 90<sup>th</sup> percentile)</p> <p>If there are at least 9 charges for a Procedure Code/GeoZip combination, then that is considered to be statistically valid.</p> <p><b>Actual Charge Data (National/USA values):</b> Charges collected for a given period of time are sorted by CPT, ASA, ADA, or HCPCS procedure code. For each code, the charges are sorted in ascending order (lowest to highest). After the charges are sorted, a total count of the charges is obtained. Each charge is assigned a number based on rank within the total count.</p> <p>To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.</p> <p>For example, if there are 200 charges for Procedure Code, the lowest charge is assigned #1 and the</p>	<p>Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on line 160 is the 80<sup>th</sup> percentile. <math>200 \times .80 = 160</math></p> <p>Any other percentile can be found the same way: <math>200 \times .70 = 140</math> (The charge on line 140 is the 70<sup>th</sup> percentile) <math>200 \times .90 = 180</math> (The charge on line 180 is the 90<sup>th</sup> percentile)</p> <p>If there are at least 9 charges for a Procedure Code/GeoZip combination, then that is considered to be statistically valid.</p> <p><b>Actual Charge Data (National/USA values):</b> Charges collected for a given period of time are sorted by CPT, ASA, ADA, or HCPCS procedure code. For each code, the charges are sorted in ascending order (lowest to highest). After the charges are sorted, a total count of the charges is obtained. Each charge is assigned a number based on rank within the total count.</p> <p>To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.</p> <p>For example, if there are 200 charges for Procedure Code, the lowest charge is assigned #1 and the</p>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on the line assigned to #160 is the 80<sup>th</sup> percentile. <math>200 \times .80 = 160</math>.</p> <p>Any other percentile can be found the same way: <math>200 \times .70 = 140</math> (The charge on line 140 is the 70<sup>th</sup> percentile) <math>200 \times .90 = 180</math> (The charge on line 180 is the 90<sup>th</sup> percentile)</p> <p>If there are at least 9 charges for a Procedure Code, then that is considered to be statistically valid.</p> <p><b>Derived Charge Data</b> If there are fewer than 9 charges for a Procedure Code, then data that is derived from charges for other services may be used. See next page for detailed description of FAIR Health’s derived charge methodology.</p> <p><b>FAIR Health Relative Value Methodology (Derived Data)</b> FAIR Health employs a relative value methodology to calculate benchmarks in its FH Benchmarks modules when the actual data for a procedure code/geozip combination are insufficient to produce a benchmark. This methodology uses the relationships between procedure codes to determine the benchmark rates. Relative value methodologies are standard industry methods that use data for more</p>	<p>highest charge is assigned #200. For the 80<sup>th</sup> percentile, the total number of charges is multiplied by 80% (.80). The charge on the line assigned to #160 is the 80<sup>th</sup> percentile. <math>200 \times .80 = 160</math>.</p> <p>Any other percentile can be found the same way: <math>200 \times .70 = 140</math> (The charge on line 140 is the 70<sup>th</sup> percentile) <math>200 \times .90 = 180</math> (The charge on line 180 is the 90<sup>th</sup> percentile)</p> <p>If there are at least 9 charges for a Procedure Code, then that is considered to be statistically valid.</p> <p><b>Derived Charge Data</b> If there are fewer than 9 charges for a Procedure Code, then data that is derived from charges for other services may be used. See next page for detailed description of FAIR Health’s derived charge methodology.</p> <p><b>FAIR Health Relative Value Methodology (Derived Data)</b> FAIR Health employs a relative value methodology to calculate benchmarks in its FH Benchmarks modules when the actual data for a procedure code/geozip combination are insufficient to produce a benchmark. This methodology uses the relationships between procedure codes to determine the benchmark rates. Relative value methodologies are standard industry methods that use data for more</p>	

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Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>frequently performed services in a specific geographic area and specific time period to derive values for less frequently performed services for the same geographic area and time period.</p> <p><b>Derivation Process</b> Derived Charge Data is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed, to get the relative value for the procedure code. The relative value is then multiplied by the Geozip area Conversion Factor to get the derived charge.</p> <p><b>Code Range</b> FAIR Health groups related procedure codes into a series of ranges. Using a range of codes, FAIR Health can model less frequently performed services using the billing patterns of frequently performed similar services in the same geographic area and time period. All charge data for the codes within a range are used to derive the percentile values for each of the codes under this methodology.</p> <p><b>Relative Value</b> Each code has a relative value, a number designed to represent the resources used to provide the service represented by the code. FAIR Health uses a third-party relative value scale that is commonly used in the industry.</p>	<p>frequently performed services in a specific geographic area and specific time period to derive values for less frequently performed services for the same geographic area and time period.</p> <p><b>Derivation Process</b> Derived Charge Data is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed, to get the relative value for the procedure code. The relative value is then multiplied by the Geozip area Conversion Factor to get the derived charge.</p> <p><b>Code Range</b> FAIR Health groups related procedure codes into a series of ranges. Using a range of codes, FAIR Health can model less frequently performed services using the billing patterns of frequently performed similar services in the same geographic area and time period. All charge data for the codes within a range are used to derive the percentile values for each of the codes under this methodology.</p> <p><b>Relative Value</b> Each code has a relative value, a number designed to represent the resources used to provide the service represented by the code. FAIR Health uses a third-party relative value scale that is commonly used in the industry.</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p><b>Geozip</b> FAIR Health defines geographic areas for its data generally on the basis of the first three digits of a ZIP code. Referred to as a geozip, an area may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. Geozip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, similarities in billing patterns and the quantity of available data are also taken into consideration. In most cases, geozips do not cross state boundaries. FAIR Health currently divides the United States into 493 geozips.</p> <p><b>Conversion Factor</b> The conversion factor is determined by dividing each of the billed charges for every code in a range by its associated relative value.</p> <p><b>Note:</b> A code must have a relative value in order for FAIR Health to develop a derived rate. Examples of codes with no relative value are unlisted CPT codes and unlisted HCPCS codes.</p> <p>For any client plan that has adopted the MRC1 methodology, FAIR Health’s charges database is used to calculate the MRC for either outpatient MH/SUD or M/S services rendered by health care professionals (i.e., non-facility). If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will</p>	<p><b>Geozip</b> FAIR Health defines geographic areas for its data generally on the basis of the first three digits of a ZIP code. Referred to as a geozip, an area may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. Geozip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, similarities in billing patterns and the quantity of available data are also taken into consideration. In most cases, geozips do not cross state boundaries. FAIR Health currently divides the United States into 493 geozips.</p> <p><b>Conversion Factor</b> The conversion factor is determined by dividing each of the billed charges for every code in a range by its associated relative value.</p> <p><b>Note:</b> A code must have a relative value in order for FAIR Health to develop a derived rate. Examples of codes with no relative value are unlisted CPT codes and unlisted HCPCS codes.</p> <p>For any client plan that has adopted the MRC1 methodology, FAIR Health’s charges database is used to calculate the MRC for either outpatient MH/SUD or M/S services rendered by health care professionals (i.e., non-facility). If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will</p>	





**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>dictate the allowable reimbursement rate for any otherwise covered outpatient professional claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient professional claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Outpatient facility claims are calculated by reference to a database maintained by Viant, which is a business unit within MultiPlan and derives MRC amounts for outpatient facility services in a similar way to how FAIR Health derives MRC amounts for outpatient professional services. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered outpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient facility claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Inpatient facility claims, including acute hospital services or subacute services are not subject to an MRC under the MRC1 methodology. Instead, the reimbursement rates for inpatient facility claims are</p>	<p>dictate the allowable reimbursement rate for any otherwise covered outpatient professional claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient professional claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Outpatient facility claims are calculated by reference to a database maintained by Viant, which is a business unit within MultiPlan and derives MRC amounts for outpatient facility services in a similar way to how FAIR Health derives MRC amounts for outpatient professional services. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered outpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered outpatient facility claim will be paid at the lesser of the applicable MRC benefit level or the provider’s billed charges.</p> <p>Inpatient facility claims, including acute hospital services or subacute services are not subject to an MRC under the MRC1 methodology. Instead, the reimbursement rates for inpatient facility claims are</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>calculated based on any indirect discount arrangement that Cigna accesses through a vendor or, if one is unavailable or exceeds the facility’s billed charges, the facility’s billed charges. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered inpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered inpatient facility claim will be paid at the provider’s billed charges.</p> <p><u>Maximum Reimbursable Charge 2 (MRC2)</u></p> <p>Under MRC2, the plan applies to a covered inpatient or outpatient service a percentage of a charge based on a methodology similar to that used by CMS to pay Medicare claims, in which a charge is derived similarly to CMS’ fee schedule methodology in that factors like service type, place of service, and geographic location impact the charge used to calculate the MRC, which are defined generally by reference to CMS’ fee schedule methodology. Most of CMS’ methodologies adjust payments based on regional costs and whether the claimant is a practitioner or a facility. Specifically, physician fees are adjusted based on the geographic practice cost index (GPCI) in about 100 localities, and</p>	<p>calculated based on any indirect discount arrangement that Cigna accesses through a vendor or, if one is unavailable or exceeds the facility’s billed charges, the facility’s billed charges. If any indirect discount arrangement available is equal to, or lesser than, the client-elected percentile of the applicable MRC, then the indirect discount arrangement will dictate the allowable reimbursement rate for any otherwise covered inpatient facility claim. Conversely, if any indirect discount arrangement is not equal to, or lesser than, the client-elected percentile of the applicable MRC, then any otherwise covered inpatient facility claim will be paid at the provider’s billed charges.</p> <p><u>Maximum Reimbursable Charge 2 (MRC2)</u></p> <p>Under MRC2, the plan applies to a covered inpatient or outpatient service a percentage of a charge based on a methodology similar to that used by CMS to pay Medicare claims, in which a charge is derived similarly to CMS’ fee schedule methodology in that factors like service type, place of service, and geographic location impact the charge used to calculate the MRC, which are defined generally by reference to CMS’ fee schedule methodology. Most of CMS’ methodologies adjust payments based on regional costs and whether the claimant is a practitioner or a facility. Specifically, physician fees are adjusted based on the geographic practice cost index (GPCI) in about 100 localities, and</p>	



**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>institutional payments are adjusted for wage variations in about 200 core-based statistical areas (CBSA). Additionally, durable medical equipment (DME) and lab fees are adjusted by state, and ambulance fees are adjusted by GPCI and by the degree of urbanization.</p> <p>The evidentiary standards for the aforementioned factors informing the MRC are reflected in the Medicare fee schedule or, where no Medicare fee exists for a service (e.g. a service not covered by Medicare), a charge generally developed by reference to the Medicare methodology. Specifically, Cigna obtains Medicare fees for inpatient facility services from the CMS Inpatient Prospective Payment System (IPPS) schedule, outpatient facility services from the CMS Outpatient Prospective Payment System (OPPS) schedule, and outpatient professional services from the CMS Physician Fee Schedule. And for services without an available Medicare fee, Cigna generally utilizes a methodology similar to Medicare, whereby, along with the Geographic Practice Cost Indices and conversion factors, Cigna utilizes a derived Relative Value Unit (RVU) using the RVU for a similar service or calculating what the RVU should be based on an assessment of the factors informing the RVU figure. Under MRC2, plan sponsor clients can select the percentage of the MRC paid to out-of-network health care providers for non-emergency services. The standard percentages, subject to plan</p>	<p>institutional payments are adjusted for wage variations in about 200 core-based statistical areas (CBSA). Additionally, durable medical equipment (DME) and lab fees are adjusted by state, and ambulance fees are adjusted by GPCI and by the degree of urbanization.</p> <p>The evidentiary standards for the aforementioned factors informing the MRC are reflected in the Medicare fee schedule or, where no Medicare fee exists for a service (e.g. a service not covered by Medicare), a charge generally developed by reference to the Medicare methodology. Specifically, Cigna obtains Medicare fees for inpatient facility services from the CMS Inpatient Prospective Payment System (IPPS) schedule, outpatient facility services from the CMS Outpatient Prospective Payment System (OPPS) schedule, and outpatient professional services from the CMS Physician Fee Schedule. And for services without an available Medicare fee, Cigna generally utilizes a methodology similar to Medicare, whereby, along with the Geographic Practice Cost Indices and conversion factors, Cigna utilizes a derived Relative Value Unit (RVU) using the RVU for a similar service or calculating what the RVU should be based on an assessment of the factors informing the RVU figure. Under MRC2, plan sponsor clients can select the percentage of the MRC paid to out-of-network health care providers for non-emergency services. The standard percentages, subject to plan</p>	

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQT)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. These percentages are applied uniformly to the MRC for MH/SUD and M/S inpatient and outpatient services.	sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. These percentages are applied uniformly to the MRC for MH/SUD and M/S inpatient and outpatient services.	
<b>Restrictions on Provider Billing Codes</b>			
<b>Explain any restrictions the plan places on provider billing codes</b>	<p>Cigna does not place restrictions on provider billing codes or place restrictions on M/S providers that would limit the scope of their practice.</p> <p>Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes or applicable Centers for Medicare &amp; Medicaid Services (CMS) medical reporting code requirements. Appropriate billing instructions are set forth in the provider's contract.</p>	<p>Cigna does not place restrictions on provider billing codes or place restrictions on MH/SUD providers that would limit the scope of their practice.</p> <p>Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes or applicable Centers for Medicare &amp; Medicaid Services (CMS) medical reporting code requirements. Appropriate billing instructions are set forth in the provider's contract.</p>	<p>Cigna requires claims to be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes for both M/S and MH/SUD providers. Cigna does not place any additional restrictions on provider billing codes for M/S or MH/SUD.</p> <p>Consistency in provider billing process evidences compliance with the NQT requirement that the medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services.</p>
<b>Restrictions on Provider Specialty</b>			
<b>Explain any restrictions the plan places on services provided by specialty providers.</b>	Cigna does not place any restrictions on provider		
<b>Post Claim Payment Retrospective Review (Fraud, Waste and Abuse)</b>			

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLS) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
<p>Cigna maintains corporate-wide policies applicable to multiple business segments including Cigna Healthcare (M/S) and Behavioral Health (MH/SUD), and policies applicable to specific business segments only. Cigna defines Post-Payment Retrospective Review as its medical necessity review of a claim after a service has already been provided and after the claim for that service has already been paid.</p>	<p>Cigna does not routinely impose post payment medical necessity review on a retrospective basis. All M/S and MH/SUD services and providers are subject to fraud, waste and abuse compliance.</p> <p>Cigna Healthcare and Evernorth Behavioral Health maintain one Anti-Fraud Plan and one Special Investigations Unit (“SIU”), which is part of the Corporate Audit Department. SIU is responsible for anti-fraud detection and investigation, prepayment saving and post payment recovery services.</p> <p>The only instance in which a post-claim payment retrospective review might occur would be the result of application of the protocols implemented by Cigna’s SIU program, which serves, as relevant here, to identify and prevent the payment of fraudulent claims. Only those benefits that are flagged through an SIU program, which are generally agnostic to whether the benefit is MH/SUD or M/S, would be subject to retrospective review to determine whether fraud was involved. Importantly, Cigna does not believe that its SIU program constitutes an NQL because the program does not in any way limit the duration or scope of benefits that are available under the plan.</p> <p>To the extent fraud, waste, or abuse is identified and any overpayments are recovered, this is entirely outside the terms and conditions of the plan or coverage. By definition, this cannot be an NQL.</p>	<p>Same as Medical/Surgical</p>	<p><b>As written:</b> While Cigna maintains that the SIU’s programs do not constitute NQLs because they do not in any way limit benefits, the overall process for identifying potentially fraudulent claims is identical for both MH/SUD and M/S services. As made clear in Cigna policies, different approaches may be taken for certain types of benefits that reflect the variance in the manner in which fraud, waste, and abuse might occur in any given setting. For example, overbilling related to IOP might be investigated in a manner that differs from the way in which non-routine laboratory work is investigated.</p> <p><b>In Operation:</b> Cigna applies general policies without regard to whether a given service is a MH/SUD or M/S service. Cigna has developed specific written policies governing the investigation of substance use disorder benefits and laboratory services where potentially fraudulent activity is commonly reported. In operation, the SIU has investigated a significantly larger number of potentially fraudulent M/S claims as compared to MH/SUD claims.</p> <p>As noted herein, Cigna applies the same general principals to identifying and investigating potentially fraudulent claims behavior by providers and facilities without regard to whether the provider or facility is MH/SUD or M/S. The operation of Cigna’s SIU, which results in retrospective review of claims, is identical for both MH/SUD and M/S services and therefore meets the comparability requirement. In</p>

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<p>which is broadly defined as a limitation on benefits under the plan. Nevertheless, Cigna has prepared this NQTL comparative analysis to describe its Post-Payment Retrospective Review program, and therefore its SIU program.</p> <p>Cigna does not incorporate language related to fraud detection in its certificate or benefits booklet. There are no terms related to post-claim payment retrospective review contained in the GSA. Information related to Health Care Fraud is posted online including how to report health care fraud on the Cigna website: <a href="https://www.cigna.com/legal/members/report-fraud">https://www.cigna.com/legal/members/report-fraud</a>.</p> <p><b>Factors</b> The SIU provides anti-fraud detection and investigation, pre-payment savings, and post-payment recovery services. As part of Cigna’s corporate audit department, the SIU actively detects, investigates, and deters fraud. The SIU performs the following activities:</p> <ul style="list-style-type: none"><li>• conducting investigations and analyzing cases to determine the scope of potential fraud</li><li>• flagging health care providers/facilities/members in claim systems to ensure payments suspected of fraud are addressed prior to releasing funds</li><li>• obtaining evidence for referrals to law enforcement, regulatory agencies, and associations</li><li>• pursuing civil recoveries</li></ul>		<p>operation, the SIU program is applied no more stringently to MH/SUD benefits as it is to M/S benefits, as evidenced by the significantly higher number of claims investigated for M/S services as compared to MH/SUD services.</p> <p>Cigna maintains that detection of fraud, waste, or abuse and claims overpayment recovery is outside the scope of MHPAEA and its NQTL requirements because these things are outside the scope of covered benefits under the plan, and NQTLs by definition only limit valid benefits under the plan. However, to the extent fraud, waste, and abuse detection and claims overpayment recovery could be considered an NQTL, Cigna concludes that the SIU process nevertheless meets the requirements of the NQTL rule in MHPAEA.</p>

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Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>delivering anti-fraud training and communicating current fraud schemes to Cigna employees</li><li>using advanced technology and data-mining techniques to identify suspect behavior or patterns of possible fraudulent providers/facilities</li><li>serving as a founding member of the National Health Care Anti-Fraud Association (NHCAA), an organization made up of health care experts from the public and private sectors</li><li>partnering with the Health Insurance Counter Fraud Group, which includes participants from 32 health insurance companies to prevent and detect health care fraud</li><li>working with clients and members who inform us of discrepancies that may reveal potential fraud</li></ul> <p>The SIU works in partnership with dedicated resources within our claim, legal, and clinical management teams to establish guidelines and controls to assist in the fight against fraud and abuse. While the SIU leads Cigna’s anti-fraud activities, its efforts are complemented by almost two million individual standards-based (e.g., National Correct Coding Initiative, CMS) claim edits incorporated as a part of the claim payment process and by multiple targeted prepayment programs to address areas of potential risk (DRGs, implantable devices, complex claims, and specialties).</p> <p><b>Evidentiary Standards</b> SIU relies on the following definitions:</p>		

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**Mental Health Parity and Addiction Equity Act (MHPAEA)  
Non-Quantitative Treatment Limitations (NQTLs) Comparative Analysis**

Non-Quantitative Treatment Limitation (NQTL)	Medical/Surgical Benefits (M/S)	Mental Health/Substance Use Disorder Benefits (MH/SUD)	Comparative Analysis Conclusions
	<ul style="list-style-type: none"><li>• Fraud: Knowingly and wilfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretences, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.</li><li>• Waste: Practices that, directly or indirectly, result in unnecessary costs to the underlying health plan, such as overusing services. Waste is generally considered a misuse of resources.</li><li>• Abuse: Actions that may, directly or indirectly, result in unnecessary costs such as paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment.</li></ul> <p>Cigna does not establish thresholds for any one of these factors but instead utilizes analytics to identify areas of risk and those areas are analyzed for potential investigation. Analytics assess risk to the portfolio and risk to individual clients. SIU also maintains a fraud hotline and all referrals to the hotline or similar intake capability are assessed.</p>		

## **Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)**

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### **About This Tool**

The goal of this self-compliance tool is to help group health plans, plan sponsors, plan administrators, group and individual market health insurance issuers, state regulators, and other parties determine whether a group health plan or health insurance issuer complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) and additional related requirements under the Employee Retirement Income Security Act of 1974 (ERISA) that apply to group health plans. The requirements described in this tool generally apply to group health plans, group health insurance issuers, and individual market health insurance issuers. However, requirements that do not apply as broadly are so noted.

This tool does not provide legal advice. Rather, it gives the user a basic understanding of

MHPAEA to assist in evaluating compliance with its requirements. For more information on MHPAEA, or related guidance issued by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments), please visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-usedisorder-parity>.

Furthermore, as directed by Section 13001(a) of the 21st Century Cures Act, this publicly available tool is a compliance program guidance document intended to improve compliance with MHPAEA. DOL will update the self-compliance tool biennially to provide additional guidance on MHPAEA's requirements, as appropriate.

MHPAEA, as a federal law, sets minimum standards for group health plans and issuers with respect to parity requirements. However, many states have enacted their own laws to advance parity between mental health and substance use disorder benefits and medical/surgical benefits by supplementing the requirements of MHPAEA. Insured group health plans and issuers should consult with their state regulators to understand the full scope of applicable parity requirements.

This tool provides a number of examples that demonstrate how the law applies in certain situations and how a plan or issuer might or might not comply with the law. Additional examples are included in the Appendix I. The fact patterns used as examples are intended to help group health plans and health insurance issuers identify and address important MHPAEA issues.

Examples of MHPAEA enforcement actions that the DOL has undertaken are included in the MHPAEA Enforcement Fact Sheets, available at <https://www.dol.gov/agencies/ebsa/laws-andregulations/laws/mental-health-and-substance-use-disorder-parity>. Examples of MHPAEA enforcement actions that HHS has taken are included in the Department of Health and Human Services' MHPAEA Reports at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-andOther-Resources#mental-health-parity>.

## **Introduction**

MHPAEA, as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans and group and individual health insurance issuers that provide coverage for MH/SUD benefits in addition to medical/surgical benefits. DOL has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans, while HHS has primary enforcement authority over nonfederal governmental group health plans, such as those sponsored by state and local government employers. HHS also has primary enforcement authority for MHPAEA over issuers



selling products in the individual and fully insured group markets in states that have notified HHS' Centers for Medicare & Medicaid Services that they do not have the authority to enforce or are not otherwise enforcing MHPAEA. In all other states, generally the state is responsible for directly enforcing MHPAEA with respect to issuers.

Unless a plan is otherwise exempt, MHPAEA generally applies to both grandfathered and nongrandfathered group health plans and large group health insurance coverage. Also, the Affordable Care Act requires all issuers offering coverage in the individual and small group markets to cover certain essential health benefits (EHB), including MH/SUD benefits. Final rules issued by HHS implementing EHB requirements specify that MH/SUD benefits must be consistent with the requirements of the MHPAEA regulations. *See 45 CFR 156.115(a)(3).*

Under the MHPAEA regulations, if a plan or issuer provides MH/SUD benefits in any classification described in the MHPAEA final regulation, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. Under PHS Act section 2713, as added by the Affordable Care Act, non-grandfathered group health plans and group and individual health insurance coverage are required to cover certain preventive services with no cost-sharing, which include, among other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening. However, the MHPAEA regulations do not require a group health plan or a health insurance issuer that provides MH/SUD benefits only to the extent required under PHS Act section 2713, to provide additional MH/SUD benefits in any classification. *See 29 CFR 2590.712(e)(3)(ii), 45 CFR 146.136(e)(3)(ii), 26 CFR 54.9812-1(e)(3)(ii).*

### **Definitions**

***Aggregate lifetime dollar limit*** means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.

***Annual dollar limit*** means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.

***Cumulative financial requirements*** are financial requirements that determine whether or to what extent benefits are provided based on certain accumulated amounts, and they include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

***Cumulative quantitative treatment limitations*** are treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts, such as annual or lifetime day or visit limits.

***Financial requirements*** include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

***Medical/surgical benefits*** means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but not including MH/SUD benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or state guidelines).

***Mental health benefits*** means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or state guidelines).

***NOTE:*** If a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits for purposes of MHPAEA. For example, if a plan defines autism spectrum disorder (ASD) as a mental health condition, it must treat benefits for ASD as mental health benefits. Therefore, for example, any exclusion by the plan for experimental treatment that applies to ASD should be evaluated for compliance as a nonquantitative treatment limitation (NQTL) (and the processes, strategies, evidentiary standards, and other factors used by the plan to determine whether a particular treatment for ASD is experimental, as written and in operation, must be comparable to and no more stringently applied than those used for exclusions of experimental treatments of medical/surgical conditions in the same classification). See *FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q1*, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/ouractivities/resource-center/faqs/aca-part-39-final.pdf>. Additionally, if a plan defines ASD as a mental health condition, any aggregate annual or lifetime dollar limit or any quantitative treatment limitation (QTL) imposed on benefits for ASD (for example, an annual dollar cap on benefits for Applied Behavioral Analysis (ABA) therapy for ASD of \$35,000, or a 50-visit annual limit for ABA therapy for ASD) should also be evaluated for compliance with MHPAEA.

***Substance use disorder benefits*** means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).

***Treatment limitations*** include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both QTLs, which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

## SECTION A. APPLICABILITY

**Question 1. Is the group health plan or group or individual health insurance coverage exempt from MHPAEA? If so, please indicate the reason (e.g. retiree-only plan, excepted benefits, small employer exception, increased cost exception, HIPAA opt-out).**

No, the Plan is not exempt from MHPAEA.
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If a group health plan or group or individual health insurance coverage provides either MH/SUD benefits, in addition to medical/surgical benefits, the plan may be subject to the MHPAEA parity requirements. However, **retiree-only group health plans**, self-insured non-federal governmental plans that have elected to exempt the plan from MHPAEA, and group health plans and group or individual health insurance coverage offering only **excepted benefits**, are generally not subject to the MHPAEA parity requirements. (**Note:** if under an arrangement(s) to provide medical care benefits by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and MH/SUD benefits, the MHPAEA parity requirements apply separately with respect to each combination of medical/surgical benefits and MH/SUD benefits and all such combinations are considered to be a single group health plan. *See 26 CFR 54.9812-1(e), 29 CFR 2590.712(e), 45 CFR 146.136(e).*)

Under ERISA, the MHPAEA requirements do not apply to **small employers**, defined as employers who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employ at least 1 employee on the first day of the plan year. *See 26 CFR 54.9812-1(f)(1), 29 CFR 2590.712(f)(1), 45 CFR 146.136(f)(1).* However, under HHS final rules governing the Affordable Care Act requirement to provide EHBs, non-grandfathered health insurance coverage in the individual and small group markets must provide all categories of EHBs, including MH/SUD benefits. The final EHB rules require that such benefits be provided in compliance with the requirements of the MHPAEA rules. *45 CFR 156.115(a)(3); see also ACA Implementation FAQs Part XVII, Q6, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/acapart-xvii.pdf>.* In practice, this means that employees in group health plans offered by small employers who purchase non-grandfathered health insurance coverage in the small group market (within the meaning of section 2791 of the PHS Act) that must provide EHBs have coverage that is subject to the requirements of MHPAEA.

MHPAEA also contains an **increased cost exemption** available to group health plans and issuers that meet the requirements for the exemption. The MHPAEA regulations establish standards and procedures for claiming an increased cost exemption. *See 26 CFR 54.9812-1(g), 29 CFR 2590.712(g), 45 CFR 146.136(g).*

Sponsors of self-funded, non-federal governmental plans are permitted to elect to exempt those plans from certain provisions of the PHS Act, including MHPAEA. An exemption election is commonly called a “HIPAA opt-out.” The HIPAA opt-out election was authorized under section

2722(a)(2) of the PHS Act (42 USC § 300gg-21(a)(2)). *See also* 45 CFR 146.180. The procedures and requirements for self-funded, non-federal governmental plans to opt out may be found at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#SelfFunded%20Non-Federal%20Governmental%20Plans>.

**Question 2. If not exempt from MHPAEA, does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in addition to providing medical/surgical benefits?**

Yes, the Plan provides both M/S and MH/SUD coverage.
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**Unless the group health plan or group or individual health insurance coverage is exempt from MHPAEA or does not provide MH/SUD benefits, continue to the following sections to examine compliance with requirements under MHPAEA.**

## **SECTION B. COVERAGE IN ALL CLASSIFICATIONS**

**Question 3. Does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in every classification in which medical/surgical benefits are provided?**

Yes, MH/SUD benefits are covered in the same classifications of benefits as M/S benefits are covered under the Plan, including, 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs. Outpatient benefits are sub classified into Outpatient Office Visit and Outpatient All Other.
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**Cigna Response:** Services covered under a Cigna-administered benefit plan, including M/S and MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.

### ***Inpatient:***

All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification based upon high cost, high risk and complexity for members receiving the service. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Inpatient is whether application of



prior authorization produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business.

***Outpatient All Other:***

To determine whether a service may be subject to prior authorization, one or more of the following variables such as (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. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0. Services covered under a Cigna-administered benefit plan, including M/S and MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.

***Inpatient:***

All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification based upon high cost, high risk and complexity for members receiving the service. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Inpatient is whether application of prior authorization produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business.

***Outpatient All Other:***

To determine whether a service may be subject to prior authorization, one or more of the following variables such as (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. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0.

Under the MHPAEA regulations, if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulation, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).*

Under the MHPAEA regulations, the six classifications\* of benefits are:

- 1) inpatient, in-network;
- 2) inpatient, out-of-network;
- 3) outpatient, in-network;
- 4) outpatient, out-of-network;
- 5) emergency care; and
- 6) prescription drugs.

*See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).*

*\*See special rules related to the classifications discussed below.*

**NOTE:** If a plan or coverage generally excludes all benefits for a particular mental health condition or substance use disorder, but nevertheless includes prescription drugs for treatment of that condition or disorder on its formulary, the plan or coverage covers MH/SUD benefits in only one classification (prescription drugs). Therefore, the plan or coverage would generally be required to provide mental health or substance use disorder benefits with respect to that condition or disorder for each of the other five classifications for which the plan also provides medical/surgical benefits. However, if a prescription drug that may be used for a particular MH/SUD condition and may also be used for other unrelated conditions is included on a plan's or coverage's formulary, the drug's inclusion on the formulary alone would not be considered to override the plan or coverage's general exclusion for a particular mental health condition or substance use disorder unless the plan or coverage covers prescription drugs specifically to treat that condition.

**ILLUSTRATION:** A Plan provides for medically necessary medical/surgical benefits as well as MH/SUD benefits. While the Plan covers medical/surgical benefits in all benefit classifications, it does not cover outpatient services for MH/SUD benefits for either in-network or out-of-network providers. In this example, since the Plan fails to provide MH/SUD benefits in outpatient, in-network and outpatient, out-of-network classifications in which medical/surgical benefits are provided, the Plan fails to meet MHPAEA's parity requirements. The Plan could come into compliance by covering outpatient services for MH/SUD benefits both in- and out-of-network in a manner comparable to covered medical/surgical outpatient in- and out-of-network services.

**Classifying benefits.** In determining the classification in which a particular benefit belongs, a group health plan or group or individual market health insurance issuer must apply the same standards to medical/surgical benefits as to MH/SUD benefits. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).* This rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must assign covered intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) to the existing six classifications in the same way that they assign intermediate medical/surgical benefits to these classifications. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well. A plan or issuer must also comply with MHPAEA's NQTL rules, discussed in Section F, in assigning any benefits to a particular classification. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4).*

### **Medication Assisted Treatment (MAT) is subject to MHPAEA**

Plans and issuers that offer MAT benefits to treat opioid use disorder are subject to MHPAEA requirements, including the special rule for multi-tiered prescription drug benefits that applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as appropriate for purposes of MHPAEA. Plans and issuers should ensure there are NO impermissible QTLs, such as visit limits, or impermissible NQTLs, such as limits on treatment dosage and duration. For example, a limitation providing that coverage of medication for the treatment of opioid use disorder is contingent upon the availability of behavioral or psychosocial therapies or services or upon the patient's acceptance of such services would generally not be permissible unless a comparable process was used to determine limitations for the coverage of medications for the treatment of medical/surgical conditions.

**ILLUSTRATION:** An issuer did not cover methadone for opioid addiction, though it did cover methadone for pain management. The issuer failed to demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions. The issuer re-evaluated the medical necessity of methadone maintenance treatment programs and developed medical-necessity criteria that mirrors federal guidelines (including the Substance Abuse and Mental Health Services Administration treatment improvement protocol 63 for medication for opioid use disorder) for opioid treatment programs to replace the methadone-maintenance treatment exclusion.

**ILLUSTRATION:** A plan uses nationally recognized clinical standards to determine coverage for prescription drugs to treat medical/surgical benefits based on the recommendations of a

Pharmacy and Therapeutics (P&T) committee. However, the plan deviates from such standards for buprenorphine/naloxone to treat opioid use disorder based on the P&T committee's recommendations. This deviation should be evaluated for compliance with MHPAEA's NQTL standard in practice, including the determination of (1) whether the P&T committee has comparable expertise in MH/SUD conditions as it has in medical/surgical conditions, and (2) whether the committee's evaluation of the nationally-recognized clinical standards and decision processes to deviate from those standards for MH/SUD conditions is comparable to and no more stringent than the processes it follows for medical/surgical conditions.

**Treatment for eating disorders is subject to MHPAEA** Eating disorders are mental health conditions, and treatment of an eating disorder is a "mental health benefit" as that term is defined by MHPAEA. *See ACA Implementation FAQs Part 38, Q1, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resourcecenter/faqs/aca-part-38.pdf>.* Section 13007 of the 21st Century Cures Act provides that if a plan or an issuer provides coverage for eating disorders, including residential treatment, they must provide these benefits in accordance with MHPAEA requirements. For example, an exclusion under a plan of all inpatient, out-of-network treatment outside of a hospital setting for eating disorders would generally not be permissible if the plan did not employ a comparable process to determine if a similar limitation on treatment outside hospital settings for medical/surgical benefits warranted. *See FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q8, available at*

*<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/acapart-39-final.pdf>.*

### Compliance Tips

- If the plan or issuer does not contract with a network of providers, all benefits are out-of-network. If a plan or issuer that has no network imposes a financial requirement or treatment limitation on inpatient or outpatient benefits, the plan or issuer is imposing the requirement or limitation within classifications (inpatient, out-of-network or outpatient, out-of-network), and the rules for parity will be applied separately for the different classifications. *See 26 CFR 54.9812-1(c)(2)(ii)(C), 29 CFR 2590.712(c)(2)(ii)(C), 45 CFR 146.136(c)(2)(ii)(C) Example 1.*
- If a plan or issuer covers the full range of medical/surgical benefits (in all classifications, both in-network and out-of-network), beware of exclusions on out-of-network MH/SUD benefits.
- Benefits for intermediate services (such as non-hospital inpatient and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

**\*NOTE: Special rules related to classifications**

**1. Special rule for outpatient sub-classifications:**

- For purposes of determining parity for outpatient benefits (in-network and out-of-network), a plan or issuer may divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules. *26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*
- After the sub-classifications are established, the plan or issuer may not impose any financial requirement or QTL on MH/SUD benefits in any sub-classification (*i.e.*, office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the MHPAEA regulations. *See 26 CFR 54.9812-1(c)(3)(i), 29 CFR 2590.712(c)(3)(i), 45 CFR 146.136(c)(3)(i), 45 CFR 146.136(c)(3)(iii).*
- Other than as explicitly permitted under the final rules, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, separate sub-classifications for generalists and specialists are not permitted.

**2. Special rule for prescription drug benefits:**

- There is a special rule for multi-tiered prescription drug benefits. Multi-tiered drug formularies involve different levels of drugs that are classified based primarily on cost, with the lowest-tier (Tier 1) drugs having the lowest cost-sharing. If a plan or issuer applies different levels of financial requirements to different tiers of prescription drug benefits, the plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for medical/surgical or MH/SUD benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. *See 26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*

**3. Special rule for multiple network tiers:**

- There is a special rule for multiple network tiers. If a plan or issuer provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-



network participating providers), the plan or issuer may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or MH/SUD benefits. After the tiers are established, the plan or issuer may not impose any financial requirement or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

**NOTE:** As explained in the Introduction to this section, nothing in MHPAEA requires a nongrandfathered group health plan or health insurance coverage that provides MH/SUD benefits only to the extent required under PHS Act section 2713 to provide additional MH/SUD benefits in any classification.

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## SECTION C. LIFETIME AND ANNUAL LIMITS

**Question 4. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding lifetime and annual dollar limits on MH/SUD benefits?**

Yes, the Plan complies with mental health parity requirements, annual and/or lifetime dollar limits are not applied to MH/SUD benefits.

A plan or issuer generally may not impose a lifetime dollar limit or an annual dollar limit on MH/SUD benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. *See 26 CFR 9812-1(b), 29 CFR 2590.712(b), 45 CFR 146.136(b).* (This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged.) If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits, or it includes one that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. *26 CFR 54.9812-1(b)(2), 29 CFR 2590.712(b)(2), 45 CFR 146.136(b)(2).*

**ILLUSTRATION:** Plan Z limits outpatient substance use disorder treatments to a maximum of \$1,000,000 per calendar year. With the exception of a \$500,000 per year limit on chiropractic services (which applies to less than one-third of all medical/surgical benefits), Plan Z does not impose such annual dollar limits with respect to other outpatient medical/surgical benefits. In this example, Plan Z is in violation of MHPAEA since the outpatient substance use disorder dollar limit is not in parity with outpatient medical/surgical dollar limits.

### **Compliance Tip**

- There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at **Question 6**. A plan or issuer may impose annual out-of-pocket dollar limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.

**NOTE:** These provisions are affected by section 2711 of the PHS Act, as amended by the Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime and annual dollar limits on EHB, which includes MH/SUD services. Accordingly, the parity requirements regarding lifetime and annual dollar limits apply only to the provision of MH/SUD benefits that are not EHBs.

Note also that, for plan years beginning in 2021, the annual limitation on an individual's maximum out-of-pocket (MOOP) costs in effect under the Affordable Care Act is \$8,550 for self-only coverage and \$17,100 for coverage other than self-only coverage. The annual limitation on out-of-pocket costs is increased annually by the premium adjustment percentage

described under Affordable Care Act section 1302(c)(4), and this updated amount is detailed each year in regulations issued by the Department of Health and Human Services.

## **SECTION D. FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT**

### **LIMITATIONS**

**Question 5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding financial requirements or QTLs on MH/SUD benefits?**

Yes, the Plan's cost sharing requirements comply with MHPAEA financial requirements and are not more restrictive than the predominant limit (at least 2/3) that applies to substantially all (more than 50%) medical/surgical benefits. The Plan does not apply any type of QTLs such as age, day, visit, or dollar limits to services rendered to treat a MH/SUD condition.

- A plan or issuer may not impose a financial requirement or QTL applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of that type that is applied to substantially all medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(2), 29 CFR 2590.712(c)(2), 45 CFR 146.136(c)(2).*
- Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
- Types of QTLs include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
- The six classifications and the sub-classifications outlined in Section B, above, are the only classifications that may be used when determining the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits. *See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).* A plan or issuer may not use a separate sub-classification under these classifications for generalists and specialists. *See 26 CFR 54.9812-1(c)(3)(iii)(C), 29 CFR 2590.712(c)(3)(iii)(C), 45 CFR 146.136(c)(3)(iii)(C).*

### Compliance Tips

- Ensure that the plan or issuer does not impose financial requirements or QTLs that are applicable only to MH/SUD benefits.
- Identify all benefit packages and health insurance coverage to which MHPAEA applies.

### Detailed steps for applying this rule:

To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification. *See 26 CFR 54.9812-1(c)(2)(i), 29 CFR 2590.712(c)(2)(i), 45 CFR 146.136(c)(2)(i).* Coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions, for example, self-only, family, or employee plus spouse. *See 26 CFR 54.9812-1(c)(1)(iv), 29 CFR 2590.712(c)(1)(iv), 45 CFR 146.136(c)(1)(iv).* If a plan applies different levels of a financial requirement or QTL to different coverage units in a classification of medical/surgical benefits (for example, a \$15 copayment for self-only and a \$20 copayment for family coverage), the predominant level is determined separately for each coverage unit. *See 26 CFR 54.9812-1(c)(3)(ii), 29 CFR 2590.712(c)(3)(ii), 45 CFR 146.136(c)(3)(ii).*

- **STEP ONE (“substantially all” test):** First determine if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits.
- Generally, a financial requirement or QTL is considered to apply to substantially all medical/surgical benefits if it applies to at least two-thirds of the medical/surgical benefits in the classification. *See 26 CFR 54.9812-1(c)(3)(i)(A), 29 CFR 2590.712(c)(3)(i)(A), 45 CFR 146.136(c)(3)(i)(A).* This two-thirds calculation is generally based on the dollar amount of plan payments expected to be paid for the plan year within the classification. *See 26 CFR 54.9812-1(c)(3)(i)(C), 29 CFR 2590.712(c)(3)(i)(C), 45 CFR 146.136(c)(3)(i)(C).* Any reasonable method can be used for this calculation. *See 26 CFR 54.9812-1(c)(3)(i)(E), 29 CFR 2590.712(c)(3)(i)(E), 45 CFR 146.136(c)(3)(i)(E).*
- **STEP TWO (“predominant” test):** If the type of financial requirement or QTL applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or QTL that applies to the medical/surgical benefits that are subject to that type of financial requirement or QTL in that classification of benefits. (**Note:** If the type of financial requirement or QTL does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to MH/SUD benefits in that classification.)
- Generally, the level of a financial requirement or QTL that is considered the predominant level of that type is the level that applies to more than one-half of the

medical/surgical benefits in that classification subject to the financial requirement or QTL. *See 26 CFR 54.9812-1(c)(3)(i)(B)(1), 29 CFR 2590.712(c)(3)(i)(B)(1), 45 CFR 146.136(c)(3)(i)(B)(1).* If there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or QTL in the classification. In that case, the least restrictive level within the combination is considered the predominant level. *See 26 CFR 54.9812-1(c)(3)(i)(B)(2), 29 CFR 2590.712(c)(3)(i)(B)(2), 45 CFR 146.136(c)(3)(i)(B)(2).* For a simpler method of compliance, a plan may treat the least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.

#### Compliance Tip: Book of Business

- When performing the “substantially all” and “predominant” tests for financial requirements and QTLs, basing the analysis on an issuer’s entire book of business is generally not a reasonable method if a plan or issuer has sufficient claims data regarding a specific plan for a reasonable projection of future claims costs for the substantially all and predominant analysis. However, there may be insufficient reliable claims data for a group health plan, in which case the analyses will require utilizing reasonable data from outside the group health plan. A plan or issuer must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice. *See ACA Implementation FAQs Part 34, Q3, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/ouractivities/resource-center/faqs/aca-part-34.pdf>.*

**ILLUSTRATION:** Plan Z requires copayments for out-patient, in-network MH/SUD benefits. In order to determine if the plan meets the parity requirements, take the following steps:

1. **STEP ONE: Determine if the particular type of financial requirement applies to substantially all (that is, 2/3 of) medical /surgical benefits in the relevant classification.**

Based on its prior claims experience, Plan Z expects \$1 million in medical/surgical benefits to be paid in the outpatient, in-network classification and \$700,000 of those benefits are expected to be subject to copayments. Because the amount of medical/surgical benefits expected to be subject to a copayment, which is \$700,000, is at least 2/3 of the \$1 million total medical/surgical benefits expected to be paid, a copayment can be applied to outpatient, in-network MH/SUD benefits.



2. **STEP TWO: Determine what level of the financial requirement is predominant (that is, the level that applies to more than half the medical/surgical benefits subject to the financial requirement in the relevant classification).**

In the outpatient, in-network classification where \$1 million in medical/surgical benefits is expected to be paid, \$700,000 of those benefits are expected to be subject to copayments. Out of the \$700,000, Plan Z expects that 25 percent will be subject to a \$15 copayment and 75 percent will be subject to a \$30 copayment. Since 75 percent is more than half, the \$30 copayment is the predominant level.

**CONCLUSION:** Plan Z cannot impose a copayment on MH/SUD benefits in this classification that is higher than \$30.

**Warning Sign:** If a plan or issuer applies a specialist copayment requirement for all MH/SUD benefits within a classification but applies a specialist copayment only for certain medical/surgical benefits within a classification, this may be indicative of noncompliance and warrant further review. See “Compliance Tips” below for further guidance on specialist copay requirements.

### Compliance Tips

- Ensure that when conducting the predominant/substantially all tests, the dollar amount of all plan payments for medical/surgical benefits expected to be paid in that classification for the relevant plan year are analyzed.
- A plan may be able to impose the specialist level of a financial requirement or QTL to MH/SUD benefits in a classification (or an office visit sub-classification) if it is the predominant level that applies to substantially all medical/surgical benefits within the office visit sub-classification. For example, if the specialist level of copay is the predominant level of copay that applies to substantially all medical/surgical benefits in the office visit, in-network sub-classification, the plan may apply the specialist level copay to MH/SUD benefits in the office visit, in-network sub-classification. *See 26 CFR 54.9812-1(c)(3), 29 CFR 2590.712(c)(3).*

## SECTION E. CUMULATIVE FINANCIAL REQUIREMENTS AND TREATMENT

### LIMITATIONS

**Question 6. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding cumulative financial requirements or cumulative QTLs for MH/SUD benefits?**

Yes, the Plan complies with the requirements for cumulative financial requirements and QTLs. All M/S and MH/SUD benefits accumulate to the same deductible and out-of-pocket requirement. The Plan does not apply any type of QTLs such as age, day, visit or dollar limits to services rendered to treat an MH/SUD condition.

- A plan or issuer may not apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(3)(v), 29 CFR 2590.712(c)(3)(v), 45 CFR 146.136(c)(3)(v).* For example, a plan may not impose an annual \$250 deductible on medical/surgical benefits in a classification and a separate \$250 deductible on MH/SUD benefits in the same classification.
- Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements). *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*
- Cumulative QTLs are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*

**ILLUSTRATION:** A plan offers three benefit options, all of which provide medical/surgical as well as MH/SUD benefits. For all three benefit options, the plan provides for in-network treatment limitations of 30 days per year with respect to inpatient mental health services, and in-network treatment limitations of 20 visits per year with respect to outpatient mental health services. No such limitations are imposed on outpatient or inpatient, in-network medical/surgical benefits in any of the three benefit options.

In this example, the plan improperly imposes cumulative treatment limitations on the number of visits for outpatient and inpatient, in-network and out-of-network mental health benefits in all three benefit options. The plan could come into compliance by removing the day and visit limits for mental health services.

## **SECTION F. NONQUANTITATIVE TREATMENT LIMITATIONS**

### **Question 7. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding NQTLs on MH/SUD benefits?**

Services covered under a Cigna-administered benefit plan, including M/S and MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.

#### ***Inpatient:***

All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification based upon high cost, high risk and complexity for members receiving the service. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Inpatient is whether application of prior authorization produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business.

#### ***Outpatient All Other:***

To determine whether a service may be subject to prior authorization, one or more of the following variables such as (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. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0.

Yes, the Plan complies with mental health parity requirements regarding the application of an NQTL on MH/SUD benefits. The Plan has conducted a comparative analysis and determined NQTLs are comparable to and applied no more stringently than NQTLs for M/S benefits in writing and in operation.

An NQTL is generally a limitation on the scope or duration of benefits for treatment. The MHPAEA regulations prohibit a plan or an issuer from imposing NQTLs on MH/SUD benefits in any classification unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification. See 26 CFR 54.9812-1(c)(4)(i), 29 CFR 2590.712(c)(4)(i), 45 CFR 146.136(c)(4)(i).

The following is an illustrative, non-exhaustive list of NQTLs:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization or ongoing authorization requirements;
- Concurrent review standards;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or issuer methods for determining usual, customary, and reasonable charges;
- 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);
- Exclusions of specific treatments for certain conditions;
- Restrictions on applicable provider billing codes;
- Standards for providing access to out-of-network providers;
- Exclusions based on failure to complete a course of treatment; and
- 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.

*See 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), 45 CFR 146.136(c)(4)(ii).* For additional examples of plan provisions that may operate as NQTLs see *Warning Signs*, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/warningsigns-plan-or-policy-nqtl-that-require-additional-analysis-to-determine-mhpaca-compliance.pdf>.

While NQTLs are generally defined as treatment limitations that are not expressed numerically, the application of an NQTL in a numerical way does not modify its nonquantitative character. For example, standards for provider admission to participate in a network are NQTLs because such standards are treatment limitations that typically are not expressed numerically. *See 29 CFR 2590.712 (c)(4)(ii), 45 CFR 146.136(c)(4)(ii).* Nevertheless, these standards sometimes rely on numerical standards, for example, numerical reimbursement rates. In this case, the numerical expression of reimbursement rates does not modify the nonquantitative character of the provider admission standards; accordingly, standards for provider admission, including associated reimbursement rates to which a participating provider must agree, are to be evaluated in accordance with the rules for NQTLs.

A group health plan or issuer may consider a wide array of factors in designing medical management techniques for both MH/SUD benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider

discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these or other factors in a comparable fashion, an NQTL, such as prior authorization, may be required for some (but not all) MH/SUD benefits, as well as for some (but not all) medical/ surgical benefits. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4), Example 8.*

**NOTE** – To comply with MHPAEA, a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network and outof-network providers for both medical/surgical and MH/SUD benefits. For example, if reimbursement rates for medical/surgical benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule. Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, or market need or availability (demand) must be comparable and applied no more stringently to MH/SUD benefits than medical/surgical benefits.

**NOTE** - Plans and issuers may attempt to address shortages in medical/surgical specialist providers and ensure reasonable patient wait times for appointments by adjusting provider admission standards, through increasing reimbursement rates, and by developing a process for accelerating enrollment in their networks to improve network adequacy. To comply with MHPAEA, plans and issuers must take measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers, even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan’s network. The Departments note that substantially disparate results—for example, a network that includes far fewer MH/SUD providers than medical/surgical providers—are a red flag that a plan or issuer may be imposing an impermissible NQTL. *See FAQs Part 39, Q6 and Q7, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resourcecenter/faqs/aca-part-39-final.pdf>.*

**Warning Signs:** The following plan provisions related to provider reimbursements may be indicative of noncompliance and warrant further review:

1. *Inequitable reimbursement rates established via a comparison to Medicare:* A plan or issuer generally pays at or near Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for medical/surgical benefits. For assistance comparing a plan or coverage’s reimbursement schedule to Medicare, see the PROVIDER REIMBURSEMENT RATE WARNING SIGNS in Appendix II.



2. *Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes:* A plan or issuer reimburses psychiatrists, on average, less than medical/surgical physicians for the same E&M codes.
3. *Consideration of different sets of factors to establish reimbursement rates:* A plan or issuer generally considers market dynamics, supply and demand, and geographic location to set reimbursement rates for medical/surgical benefits, but considers only quality measures and treatment outcomes in setting reimbursement rates for MH/SUD benefits.

**In order to determine compliance with MHPAEA, the following analysis should be applied to each NQTL identified under the plan or coverage:**

**Step One:**

- Identify the NQTL.

Please see Cigna's Mental Health Parity NQTL Comparative Analysis Disclosure Document included with this submission.

Identify in the plan documents all the services (both MH/SUD and medical/surgical) to which the NQTL applies in each classification.

**NOTE:** NQTLs may also be included in other documents, such as internal guidelines or provider contracts.

**Compliance Tips**

- Ask for information about what medical/surgical benefits are also subject to these requirements or restrictions.
- If a benefit includes multiple components (*e.g.*, outpatient and prescription drug classifications), and each component is subject to a different type of NQTL (*e.g.*, prior authorization and limits on treatment dosage or duration), each NQTL must be analyzed separately.
- Find out how these requirements are implemented, who makes the decisions, and what the decision-maker's qualifications are.

Determine which benefits are treated as medical/surgical and which are treated as MH/SUD, and analyze the NQTLs under each benefit classification. Plans and issuers should clearly define which benefits are treated as medical/surgical and which benefits are treated as MH/SUD under

the plan. Benefits (such as inpatient treatment at a skilled nursing facility or other non-hospital facility and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

#### Compliance Tip

- Any separate NQTL that applies to only the MH/SUD benefits within any particular classification does not comply with MHPAEA.

**NOTE:** If a plan classifies covered intermediate levels of care, such as skilled nursing care and residential treatment, as inpatient benefits, and covers room and board for all inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction only on MH/SUD benefits and therefore violates MHPAEA.<sup>1</sup> The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment.

#### Step Two:

- Identify the factors considered in the design of the NQTL.

Please see Cigna's Mental Health Parity NQTL Comparative Analysis Disclosure Document included with this submission.

*Examples of factors include but are not limited to the following:*

- Excessive utilization;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- Lack of adherence to quality standards;
- Claim types with

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<sup>1</sup> See 29 CFR 2590.712(c)(iii) Ex. 9.

high percentage of fraud; and ○ Current and projected demand for services.

### Compliance Tips

- If only certain benefits are subject to an NQTL, such as meeting a fail-first protocol or requiring preauthorization, plans and issuers should have information available to substantiate how the applicable factors were used to apply the specific NQTL to medical/surgical and MH/SUD benefits.
- Determine whether any factors were given more weight than others and the reason(s) for doing so, including evaluating the specific data used in the determination (if any).

### Step Three:

- Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified above to design the NQTL.

Comments: Please see Cigna's Mental Health Parity NQTL Comparative Analysis Disclosure Document included with this submission.

*Examples of sources of factors include, but are not limited to, the following:*

- Internal claims analysis; ○ Medical expert reviews; ○ State and federal requirements; ○ National accreditation standards; ○ Internal market and competitive analysis; ○ Medicare physician fee schedules; and
- Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

If these factors are utilized, they must be applied comparably to MH/SUD and medical/surgical benefits.

**NOTE:** Plans and issuers have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ a particular source or evidentiary standard), as long as they are applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits. For example, a plan utilizes a panel of medical experts, with equivalent expertise in both medical/surgical and MH/SUD benefits, to assess whether preauthorization (an NQTL) is appropriate to apply to certain services, based on the factors of cost and safety. The panel recommends that the plan require preauthorization for electroconvulsive therapy (ECT), because ECT is high cost and its use presents legitimate safety concerns. The plan does not require documentation or studies to support these concerns and instead relies on established medical best practices. As long as the plan similarly relies on established medical best practices to define high cost, identify legitimate safety concerns, and impose preauthorization requirements on medical/surgical benefits in the same classification, then the NQTL is applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits.

### Compliance Tips

- Evidentiary standards and processes that a plan or issuer relies upon may include any evidence that a plan or issuer considers in developing its medical management techniques, including recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials), and published research studies.
- If there is any variation in the application of a guideline or standard being relied upon by the plan or issuer, the plan or issuer should explain the process and factors relied upon for establishing that variation.
- If the plan or issuer relies on any experts, the plan or issuer should assess the experts' qualifications and the extent to which the expert evaluations in setting recommendations are ultimately relied upon regarding both MH/SUD and medical/surgical benefits.

**NOTE:** When identifying the sources of the factors considered in designing the NQTL, also identify any threshold at which each factor will implicate the NQTL. For example, if high cost is identified as a factor used in designing a prior authorization requirement, the threshold dollar amount at which prior authorization will be required for any service should also be identified. You may also wish to consider the following:

- What data, if any, are used to determine if the benefit is “high cost”?
- How, if at all, is the amount that is to be considered “high cost” or the calculation for determining that amount different for MH/SUD benefits as compared to medical/surgical benefits, and how is the difference justified?

*Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to, the following:*

- Excessive utilization as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care.
- Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased 10 percent or more per year for two years.
- Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30 percent of the time based on clinical chart reviews.
  - High level of variation in length of stay may be considered as a factor when claims data shows that 25 percent of patients stayed longer than the median length of stay for acute hospital episodes of care.
- High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period.
- Lack of clinical efficacy may be considered as a factor when more than 50 percent of outpatient episodes of care for specific diseases are not based on evidence based interventions (as defined by nationally accepted best practices) in a 12month sample of claims data.

#### **Step Four:**

- Are the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical/surgical benefits, both as written and in operation?

Yes, the processes, strategies and evidentiary standards applied to the applicable NQTLs are comparable and applied no more stringently to MH/SUD benefits than to M/S benefits, both in writing and in operation. Please see Cigna's Mental Health Parity NQTL Comparative Analysis Disclosure Document included with this submission.
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Plans and issuers should demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD services and medical/surgical services.



### Compliance Tips

- If utilization review is conducted by different entities or individuals for medical/surgical and MH/SUD benefits provided under the plan or coverage, ensure that there are measures in place to ensure comparable application of utilization review policies.
- Determine what consequences or penalties apply to the benefits when the NQTL requirement is not met.

*These are examples of methods/analyses substantiating that factors, evidentiary standards, and processes are comparable:*

- Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and medical/surgical benefits subject to the NQTL.
- Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL.
- A consistent methodology for analyzing which MH/SUD and medical/surgical benefits had “high cost variability” and were therefore subject to the NQTL.
- Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and medical/surgical benefits were the same, both as developed and applied.
- Internal Quality Control Reports showing that the factors, evidentiary standards, and processes regarding MH/SUD and medical/surgical benefits are comparable and no more stringently applied to MH/SUD benefits.
- Summaries of research or peer-reviewed medical journal articles, if considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was utilized similarly for both MH/SUD and medical/surgical benefits.

### Compliance Tips

- Look for compliance as written **AND IN OPERATION**.
- Determine whether there are exception processes available and when they may be applied.
- Determine how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and medical/surgical benefits claims.
- Determine who makes denial determinations and if the decision-makers have comparable expertise with respect to MH/SUD and medical/surgical benefits.

- Check sample claims to determine whether a particular NQTL warrants additional review. A plan may have written processes that are compliant on their face, but those processes may not be compliant in practice.
- Determine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/surgical benefits.
- Document your analysis, as a best practice.

**NOTE:** While outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational MHPAEA parity noncompliance. For example, if a plan has a 34 percent denial rate on concurrent reviews of psychiatric hospital stays in a 12-month period and a 5 percent denial rate on concurrent review for medical hospital stays in that same 12-month period, the concurrent review process for both psychiatric and medical hospital stays should be carefully examined to ensure that the concurrent review standard is not being applied more stringently to MH/SUD benefits than to medical/surgical benefits in operation.

**Warning Signs:** The following plan provisions related to NQTLs may be indicative of noncompliance and warrant further review:

1. *Prior authorization for medication for opioid use disorder:* A plan or issuer imposes prior authorization for medications for opioid use disorder but does not require prior authorization for comparable medications for medical/surgical conditions.
2. *Different medical necessity review requirements:* A plan or issuer imposes medical necessity review requirements on outpatient MH/SUD benefits after a certain number of visits, despite permitting a greater number of visits before requiring any such review for outpatient medical/surgical benefits.

#### **Compliance Tip**

- **Do not focus solely on results.** Look at the **underlying processes and strategies** used in applying NQTLs. Are there arbitrary or discriminatory differences in how the plan or issuer is applying those processes and strategies to medical/surgical benefits versus MH/SUD benefits? While results alone are not determinative of noncompliance, measuring and evaluating results and quantitative outcomes can be helpful to identify potential areas of noncompliance.

## SECTION G. DISCLOSURE REQUIREMENTS

### **Question 8. Does the group health plan or group or individual health insurance issuer comply with the MHPAEA disclosure requirements?**

Yes, a disclosure document explaining our plan's NQTLs is available to current/potential enrollees, clients, and providers upon request. The document is provided within 30 days of request.
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- The plan administrator or health insurance issuer must make **available the criteria for medical necessity determinations** made under a group health plan or group or individual health insurance coverage with respect to MH/SUD benefits to any current or potential participant, beneficiary, enrollee, or contracting provider **upon request**. *See 29 CFR 2590.712(d)(1), 45 CFR 146.136 (d)(1).*

The plan administrator (or health insurance issuer) must make available **the reason for any denial** under a group health plan or group or individual health insurance coverage of reimbursement or payment for services with respect to MH/SUD benefits to any participant, beneficiary, or enrollee, and may do so in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the DOL claims procedure rule) and 29 CFR 2590.715-2719 (internal claims and appeals and external review processes).

- Pursuant to the internal claims and appeals and external review rules under the Affordable Care Act applicable to all non-grandfathered group health plans and to all non-grandfathered group and individual health insurance coverage, claims related to medical judgment (including MH/SUD) are eligible for external review. The **internal claims and appeals** rules include the right of claimants (or their authorized representatives) to be provided **upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits**. This includes documents with information about the **processes, strategies, evidentiary standards, and other factors used to apply an NQTL** with respect to medical/surgical benefits and MH/SUD benefits under the plan. *See 26 CFR 54.9812-1(d)(3), 29 CFR 2560.5301- 2590.712(d)(3), 45 CFR 146.136(d)(3), 147.136(b).*
- With respect to group health plans that are subject to ERISA, if coverage is denied based on medical necessity, **medical necessity criteria** for the MH/SUD benefits at issue and for medical/surgical benefits in the same classification must be provided **within 30 days of the request** to the participant, beneficiary, provider, or authorized representative of the beneficiary or participant. *See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).*

- If a plan or a plan administrator or health insurance issuer fails to provide these documents, a court may hold it liable for up to \$110 a day from the date of failure to provide these documents. *See ERISA Sec. 502(c)(1)*.

### **Compliance Tips**

- The reasons for benefit denials include applicable medical necessity criteria as applied to that participant, beneficiary, or enrollee.
- Under ERISA, plans and issuers cannot refuse to disclose information necessary for the parity analysis on the basis that the information is proprietary or has commercial value.
- Under ERISA, plans and issuers can provide summary descriptions of the medical necessity criteria in a layperson's terms.

### **Make Showing Compliance Simple**

#### **Documents or Plan Instruments Participants and Beneficiaries or DOL may Request Include the following:**

Under ERISA section 104(b), participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with MHPAEA, and copies must be furnished within 30 days of the request. These documents and plan instruments may include documentation that illustrates how the health plan has determined that any financial requirement, QTL, or NQTL complies with MHPAEA. For example, participants and beneficiaries may request the following:

- An analysis showing that the plan meets the predominant/substantially all tests. The plan may need to provide information regarding the amount of medical/surgical claims subject to a certain type of financial requirement, such as a co-payment, in the prior year for a classification or the plan's basis for calculating claims expected to be subject to a certain type of QTL in the current plan year for a classification, for purposes of determining the plan's compliance with the predominant/substantially all tests;
- A description of an applicable requirement or limitation, such as preauthorization or concurrent review, that the plan applies for MH/SUD benefits and medical/surgical benefits within the relevant classification (for example, in- or out-of-network, or in- or outpatient). These might include references to specific plan documents: for example provisions as stated on specified pages of the summary plan description (SPD), or other underlying guidelines or criteria not included in the SPD that the plan has consulted or relied upon;
- Information regarding factors, such as cost or recommended standards of care, that are relied upon by a plan for determining which medical/surgical or MH/SUD benefits are subject to a specific requirement or limitation. These might include references to specific related factors or guidelines, such as applicable utilization review criteria;

- A description of the applicable requirement or limitation that the plan believes has been used in any given MH/SUD service adverse benefit determination (ABD) within the relevant classification; and
- Medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.

### Compliance Tips

- Find out how the plan administrator handles general information requests about coverage limitations as well as specific information or disclosure requests with respect to denied benefit claims.
- Review a sample of appeals files and examine what was disclosed to participants, including the criteria for medical necessity determinations and reasons for claim denials.
- Determine how long it took the plan or the plan administrator to furnish requested documents to participants.

As directed by the 21st Century Cures Act, and in response to comments received from the regulated community, the Departments continue to issue additional guidance regarding disclosures, in particular with respect to NQTLs. Based on requests from various stakeholders for model MHPAEA disclosure forms and for guidance on processes for requesting disclosures in a more uniform, streamlined, or otherwise simplified way, the Departments issued a model disclosure request form (available at <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-healthparity/mhpaea-disclosure-template.pdf>). For the most current version of the form please visit the DOL's dedicated MH/SUD parity webpage, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

This form can, but is not required to, be used to request MHPAEA-related information from group plans and group and individual health insurance issuers, including general information about coverage limitations or specific information that may have resulted in denial of MH/SUD benefit claims.

### Compliance Tips

- Participants, beneficiaries, enrollees, dependents, and contracting providers may request information to determine whether benefits under a plan are being provided in parity even in the absence of any specific ABD.
- Group health plans may need to work with insurance issuers providing coverage on behalf of an insured group health plan or with third party administrators administering the plan to ensure that such service providers either directly or in coordination with the plan are providing participants and beneficiaries any documents or information to which they are entitled.



- If a group health plan or group or individual health insurance issuer uses MH/SUD vendors and carve-out service providers, the plan must ensure that all combinations of benefits comport with MHPAEA. Therefore, vendors and carve-out providers should provide documentation of the necessary information to the plan to ensure that all combinations of benefits comport with parity.

**NOTE:** Compliance with the disclosure requirements of MHPAEA is not determinative of compliance with any other provision of other applicable federal or state law. Be sure that the plan or issuer, in addition to these disclosure requirements, is disclosing all information relevant to medical/surgical, mental health, and substance use disorder benefits as required pursuant to other applicable provisions of law. For example, if a plan document states it covers benefits consistent with generally accepted standards of care (for both medical/surgical and MH/SUD benefits), and the plan has developed internal guidelines that are more restrictive than the generally accepted standards of care for both medical/surgical and MH/SUD benefits, the plan might comply with MHPAEA but fail to comply with Part 4 of ERISA, which requires that the plan be administered in accordance with its plan documents. Plans should be prepared to disclose their medical necessity criteria and should ensure that, to the extent the plan document specifies a specific treatment guideline, it follows that as well.

#### Compliance Tip

- Under ERISA, ERISA-covered plans must provide an SPD that describes plan provisions related to the use of network providers and describe the composition of the provider network (*i.e.*, a provider directory). The provider directory may be distributed as a separate document from the SPD and, in many circumstances, may be provided electronically. However, the provider directory must be up-to-date, accurate, and complete (using reasonable efforts). *See e.g.*, 29 CFR 2520.102-3; *FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q10*, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resourcecenter/faqs/aca-part-39-final.pdf>; ERISA Secs. 102, 104, and 404(a).

## **SECTION H. ESTABLISHING AN INTERNAL MHPAEA COMPLIANCE PLAN**

Although not required by MHPAEA, an internal compliance plan that promotes the prevention, detection, and resolution of potential MHPAEA violations can help plans and issuers improve compliance with the law. Compliance plans for group health plans or issuers may differ, but many successful compliance plans share the following characteristics:

1. **Conducting effective training and education.** Successful compliance programs provide ongoing training and education to all individuals responsible for ensuring MHPAEA compliance, including those who are responsible for making decisions related

to medical/surgical and MH/SUD benefits on behalf of the plan or issuer (such as claims reviewers). EBSA provides many educational materials, webcasts, and in-person compliance assistance events that may assist in these trainings and can also be made available to participants and beneficiaries to inform them of their parity protections under MHPAEA.<sup>2</sup>

2. **Ensuring retention of records and information.** ERISA Section 107 requires the retention of certain documents. These documents should be retained for at least six years after the Form 5500 for the relevant plan year has been filed.
3. **Conducting internal monitoring and compliance reviews on a regular basis.** A plan or issuer may monitor compliance on an ongoing basis by conducting internal reviews for potential non-compliance and identification of problem areas related to MHPAEA and by auditing samples of adverse benefit determinations to assess the application of medical necessity criteria, the level of detail provided to claimants, and the correctness of determinations. Plans and issuers may wish to establish an internal consumer ombudsmen program to assist participants and beneficiaries in navigating their benefits and for elevating complaints of noncompliance. Plans and issuers that delegate management of MH/SUD benefits to another entity should have clear protocols to ensure that the service providers for both medical/surgical and MH/SUD benefits provide documentation of the necessary information to the plan or issuer (and to the entity that adjudicates MH/SUD benefit claims, if necessary) to ensure that all combinations of benefits that a participant or beneficiary can elect comport with MHPAEA and to ensure that plans and issuers are able to comply with disclosure requirements.
4. **Responding promptly to detected offenses and developing corrective action.** If a plan or issuer discovers a violation of MHPAEA, it should take steps to correct the violation promptly, including providing retroactive relief and notice to potentially affected participants and beneficiaries. EBSA Benefits Advisors may be able to assist plans and issuers in voluntarily complying with MHPAEA. They can be contacted at (866) 444-3272.

**If a group health plan is audited by DOL investigators for MHPAEA compliance, DOL may ask for at least the following, among other items:**

1. Plan materials related to the plan's compliance with MHPAEA, including the following:
  - a) Information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the plan or coverage.

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<sup>2</sup> See <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorderparity>.

- b) Records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under state law. Such records may also be helpful to plans and issuers in responding to inquiries from participants, beneficiaries, enrollees, and dependents regarding benefits under the plan or coverage.
- c) Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer has relied upon as the basis for determining its compliance with the requirement that any NQTL applicable to MH/SUD benefits be comparable to and applied no more stringently than the NQTL as applied to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or issuer to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits. If the standards that are applied to MH/SUD benefits are more stringent than those in nationally recognized medical guidelines, but the standards that are applied to medical/surgical benefits are not, plans and issuers should include any applicable explanation of the reason(s) for the application of the more stringent standard for MH/SUD benefits.
- d) Samples of covered and denied MH/SUD and medical/surgical benefit claims.
- e) Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of MH/SUD benefits to another entity).
- f) Any applicable MHPAEA testing completed by the plan or the issuer for financial requirements or QTLs applied to MH/SUD benefits.

In addition to this Self-Compliance Tool, the National Association of Insurance Commissioners (NAIC) has developed tools (such as a Data Collection Tool, which includes a Non-Quantitative Treatment Limitations Chart) to assist issuers in evaluating MHPAEA compliance. For more information regarding NAIC compliance assistance efforts, please visit its website at <https://content.naic.org/>.

## **APPENDIX I: ADDITIONAL ILLUSTRATIONS**

**ILLUSTRATION 1:** A Plan covers neuropsychological testing but excludes such testing for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing, for example, clinical efficacy of such testing for different conditions and the degree

to which such testing is used for educational purposes with regard to different conditions. Does the plan rely on criteria and evidence from comparable sources with respect to medical/surgical and mental health conditions? Does the plan have documentation indicating the criteria used and evidence supporting the plan's determination of the diagnoses for which the plan will cover this service and the rationale for excluding certain diagnoses? The result may be that the plan permissibly covers neuropsychological testing for some medical/surgical or mental health conditions, but not for all.

**Conclusion:** This outcome may be permissible to the extent the plan has based the exclusion of this testing for certain conditions on clinical efficacy and/or other factors if the factors are designed and applied in a comparable manner with respect to the conditions for which testing is covered and those for which it is excluded.

**ILLUSTRATION 2:** A Plan uses diagnosis related group (DRG) codes in their standard utilization review process to actively manage hospitalization utilization. For all non-DRG hospitalizations (whether due to an underlying medical/surgical condition or a MH/SUD condition), the plan requires precertification for hospital admission and incremental concurrent review. The precertification and concurrent review processes review unique clinical presentation, condition severity, expected course of recovery, quality, and efficiency. The evidentiary standards and other factors used in the development of the concurrent review process are comparable across medical/surgical benefits and MH/SUD benefits, and are well documented. These evidentiary standards and other factors are available to participants and beneficiaries free of charge upon request.

**Conclusion:** In this example, it appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its precertification and concurrent review of hospitalizations are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

**ILLUSTRATION 3:** A Plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical conditions as inpatient benefits and likewise treats any covered care in residential treatment facilities for MH/SUD as an inpatient benefit. In addition, the plan treats home health care as an outpatient benefit and treats intensive outpatient and partial hospitalization for MH/SUD services as outpatient benefits.

**Conclusion:** In this example, the plan assigns covered intermediate MH/SUD benefits to the six classifications in the same way that it assigns comparable intermediate medical/surgical benefits to the classifications.

**ILLUSTRATION 4:** Master's degree training and state licensing requirements often vary among provider types. The plan consistently applies its standard that any provider must meet the most

stringent licensing requirement standard in the applicable state related to supervised clinical experience requirements in order to participate in the network. Therefore, the plan requires master's-level therapists to have post-degree, supervised clinical experience in order to join its provider network. There is no parallel requirement for master's-level general medical providers because their licensing requires supervised clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD level psychologists since their licensing already requires supervised training.

**Conclusion:** The requirement that master's-level therapists must have supervised clinical experience to join the network is permissible, as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers whose state licensing does not require this experience.

**ILLUSTRATION 5:** A patient with chronic depression has not responded to five different antidepressant medications and therefore was referred for outpatient treatment with repetitive transcranial magnetic stimulation (TMS). This specific treatment has been approved by the FDA and has been the subject of more than six randomized controlled trials published in peer reviewed journals. The plan denies the treatment as experimental. The plan states that it used the same criteria to deny TMS as it does to approve or deny any MH/SUD or medical/surgical benefits under the plan. The plan identifies its standard for both medical/surgical benefits and MH/SUD benefits as requiring that at least two randomized controlled trials showing efficacy of a treatment be published in peer reviewed journals for any new treatment. However, the plan indicates that while more than two randomized controlled trials regarding TMS have been published in peer reviewed journals, a committee of medical experts involved in plan utilization management reviews reviewed the journals and determined that only one of the articles provided sufficient evidence of efficacy. The plan did not identify what specific standards were used to assess whether a peer review had adequately evidenced efficacy and what the qualifications of the plan's experts are. Lastly, the plan does not impose this additional level of scrutiny with respect to reviewing medical/surgical treatments beyond the initial requirement that the treatment has been the subject of the requisite number and type of trials.

**Conclusion:** The plan's exclusion fails to comply with MHPAEA's NQTL requirements because, in practice, the plan applies an additional level of scrutiny with respect to MH/SUD benefits and therefore applies the NQTL more stringently to mental health benefits than to medical/surgical benefits without additional justification. To come into compliance, the plan could ensure that any additional levels of scrutiny are imposed on both medical/surgical and MH/SUD benefits comparably, including by establishing standards for when a peer review has adequately evidenced efficacy, and that the qualifications of the plan's experts are similar for both MH/SUD and medical/surgical benefits.

**ILLUSTRATION 6:** A plan imposes prior authorization for certain MH/SUD and medical/surgical services. The medical/surgical outpatient services that require prior authorization include habilitative and rehabilitative services such as physical therapy. Physical therapy services were selected for prior authorization because of findings that physical



therapists' documentation of medical necessity is often inadequate. In addition, there has been an increase in litigation regarding physical therapy claims. Prior authorization is conducted telephonically and authorization determinations are reviewed by a physician in consultation with a licensed physical therapist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of sessions authorized is tailored to the specific medical/surgical condition treated, consistent with generally accepted national clinical guidelines. Determinations to approve or deny coverage are made by physicians with consultation from a licensed physical therapist.

Psychological testing also requires prior authorization. Psychological testing was selected for prior authorization because of recent Medicare fraud schemes and consistent with the Medicare Improper Payment Reports, which found improper payments with respect to psychological testing claims because of inadequate documentation from psychologists. Prior authorization is conducted telephonically and reviewed by a licensed psychologist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of hours authorized for psychological testing are tailored to the age of the client and type of evaluation requested and range from two to five hours for an average evaluation (on the basis of the average number of hours for evaluation as included in generally accepted national clinical guidelines). Determinations to approve or deny coverage are made by licensed psychologists with at least five years of experience in psychological testing.

**Conclusion:** In this example, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its preauthorization requirements, particularly the use of prior authorization to detect fraud and abuse, are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

## **APPENDIX II: PROVIDER REIMBURSEMENT RATE WARNING SIGNS**

The Departments have noted that, while outcomes are not determinative of a MHPAEA violation, they can often serve as red flags or warning signs to alert the plan or issuer that a particular provision may warrant further review. With respect to provider reimbursement, comparing a plan or issuer's average reimbursement rates for both medical/surgical and MH/SUD providers against an external benchmark of reimbursement rates, such as Medicare, may help identify whether the underlying methodology used to determine the plan's or issuer's reimbursement rates warrants additional review for compliance with MHPAEA. Furthermore, evaluating how medical/surgical and MH/SUD providers are reimbursed for the same or similar services may also help a plan or issuer determine if the plan's or issuer's underlying methodology for provider reimbursement warrants further review.

Accordingly, the following framework for comparison may assist plans and issuers in identifying information they might consider when comparing reimbursement rates for certain MH/SUD and medical/surgical services based on Current Procedural Terminology (CPT) codes. This is not the only framework for analyzing provider reimbursement rates, and it is not determinative of compliance. This framework utilizes Medicare reimbursement rates as its benchmark for comparison. If a plan's or issuer's comparison of reimbursement rates indicates that the reimbursement rate is lower for MH/SUD providers, either as compared to medical/surgical providers or as compared to an external benchmark, such as Medicare, the plan or issuer should consider further review to ensure that the processes, strategies, evidentiary standards, and other factors used with respect to provider reimbursement for MH/SUD benefits are comparable to, and applied no more stringently than, those used with respect to provider reimbursement for medical/surgical benefits. Please see Section F. Nonquantitative Treatment Limitations for information on how to further evaluate provider reimbursement rates for compliance with MHPAEA.

Specialty	CPT Code	Average Plan rate for Georgia	Medicare rate for Georgia	Plan rate as a percentage of Medicare
Orthopedic Surgery	99203	\$ 189	\$ 113	167 %
	99213	\$ 128	\$ 92	140%
Cardiologists	99203	\$ 204	\$ 113	180%
	99213	\$ 130	\$ 92	141%
Internists MD	99203	\$ 156	\$ 113	138%
	99213	\$ 115	\$ 92	126%
Endocrinologists	99203	\$ 178	\$ 113	157%
	99213	\$ 130	\$ 92	142%
Gastroenterologist	99203	\$ 185	\$ 113	163%
	99213	\$ 124	\$ 92	135%
Neurologists	99203	\$ 170	\$ 113	150%
	99213	\$ 117	\$ 92	128%
Pediatrician	99203	\$ 197	\$ 113	174%
	99213	\$ 99	\$ 92	108%
Dermatologists	99203	\$ 174	\$ 113	154%
	99213	\$ 123	\$ 92	134%
Psychiatrists	99203	\$ 155	\$ 114	136%
	99213	\$ 80	\$ 92	87%
Psychologists	90832 (based on 1 hr)	\$ 78	\$ 78	100%
	90791 (based on ½ hour)	\$ 105	\$ 179	59%

Specialty	CPT Code	Average Plan rate for Georgia	Medicare rate for	Plan rate as a percentage of Medicare
LCSW	90832 (based on 1 hr) 90791 (based on ½ hour)	\$ 53 \$ 91	\$ 78 \$ 179	68% 51%
Podiatrists	99203 99213	\$ 183 \$ 126	\$ 113 \$ 92	161% 138%
Chiropractor	99203 99213	\$ 133 \$ 86	\$ 113 \$ 92	117% 93%
Occupational Therapy	97165 97166 97167 97168	\$ 89 \$ 112 \$ 120 \$ 68	\$ 103 \$ 103 \$ 103 \$ 71	86% 109% 117% 96%
Physical Therapy	97161 97162 97163 97164	\$ 110 \$ 87 \$ 70 \$ 52	\$ 102 \$ 102 \$ 102 \$ 70	108% 85% 69% 74%
Speech Therapy	Initial Office Visit Codes do not exist. Analysis of specific tests or follow- up may be useful to consider.			

## **Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)**

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### **About This Tool**

The goal of this self-compliance tool is to help group health plans, plan sponsors, plan administrators, group and individual market health insurance issuers, state regulators, and other parties determine whether a group health plan or health insurance issuer complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) and additional related requirements under the Employee Retirement Income Security Act of 1974 (ERISA) that apply to group health plans. The requirements described in this tool generally apply to group health plans, group health insurance issuers, and individual market health insurance issuers. However, requirements that do not apply as broadly are so noted.

This tool does not provide legal advice. Rather, it gives the user a basic understanding of

MHPAEA to assist in evaluating compliance with its requirements. For more information on MHPAEA, or related guidance issued by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments), please visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-usedisorder-parity>.

Furthermore, as directed by Section 13001(a) of the 21st Century Cures Act, this publicly available tool is a compliance program guidance document intended to improve compliance with MHPAEA. DOL will update the self-compliance tool biennially to provide additional guidance on MHPAEA's requirements, as appropriate.

MHPAEA, as a federal law, sets minimum standards for group health plans and issuers with respect to parity requirements. However, many states have enacted their own laws to advance parity between mental health and substance use disorder benefits and medical/surgical benefits by supplementing the requirements of MHPAEA. Insured group health plans and issuers should consult with their state regulators to understand the full scope of applicable parity requirements.

This tool provides a number of examples that demonstrate how the law applies in certain situations and how a plan or issuer might or might not comply with the law. Additional examples are included in the Appendix I. The fact patterns used as examples are intended to help group health plans and health insurance issuers identify and address important MHPAEA issues.

Examples of MHPAEA enforcement actions that the DOL has undertaken are included in the MHPAEA Enforcement Fact Sheets, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>. Examples of MHPAEA enforcement actions that HHS has taken are included in the Department of Health and Human Services' MHPAEA Reports at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#mental-health-parity>.

## **Introduction**

MHPAEA, as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans and group and individual health insurance issuers that provide coverage for MH/SUD benefits in addition to medical/surgical benefits. DOL has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans, while HHS has primary enforcement authority over nonfederal governmental group health plans, such as those sponsored by state and local government employers. HHS also has primary enforcement authority for MHPAEA over issuers



selling products in the individual and fully insured group markets in states that have notified HHS' Centers for Medicare & Medicaid Services that they do not have the authority to enforce or are not otherwise enforcing MHPAEA. In all other states, generally the state is responsible for directly enforcing MHPAEA with respect to issuers.

Unless a plan is otherwise exempt, MHPAEA generally applies to both grandfathered and nongrandfathered group health plans and large group health insurance coverage. Also, the Affordable Care Act requires all issuers offering coverage in the individual and small group markets to cover certain essential health benefits (EHB), including MH/SUD benefits. Final rules issued by HHS implementing EHB requirements specify that MH/SUD benefits must be consistent with the requirements of the MHPAEA regulations. *See 45 CFR 156.115(a)(3).*

Under the MHPAEA regulations, if a plan or issuer provides MH/SUD benefits in any classification described in the MHPAEA final regulation, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. Under PHS Act section 2713, as added by the Affordable Care Act, non-grandfathered group health plans and group and individual health insurance coverage are required to cover certain preventive services with no cost-sharing, which include, among other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening. However, the MHPAEA regulations do not require a group health plan or a health insurance issuer that provides MH/SUD benefits only to the extent required under PHS Act section 2713, to provide additional MH/SUD benefits in any classification. *See 29 CFR 2590.712(e)(3)(ii), 45 CFR 146.136(e)(3)(ii), 26 CFR 54.9812-1(e)(3)(ii).*

## **Definitions**

***Aggregate lifetime dollar limit*** means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.

***Annual dollar limit*** means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.

***Cumulative financial requirements*** are financial requirements that determine whether or to what extent benefits are provided based on certain accumulated amounts, and they include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

***Cumulative quantitative treatment limitations*** are treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts, such as annual or lifetime day or visit limits.

***Financial requirements*** include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

***Medical/surgical benefits*** means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but not including MH/SUD benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or state guidelines).

***Mental health benefits*** means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or state guidelines).

***NOTE:*** If a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits for purposes of MHPAEA. For example, if a plan defines autism spectrum disorder (ASD) as a mental health condition, it must treat benefits for ASD as mental health benefits. Therefore, for example, any exclusion by the plan for experimental treatment that applies to ASD should be evaluated for compliance as a nonquantitative treatment limitation (NQTL) (and the processes, strategies, evidentiary standards, and other factors used by the plan to determine whether a particular treatment for ASD is experimental, as written and in operation, must be comparable to and no more stringently applied than those used for exclusions of experimental treatments of medical/surgical conditions in the same classification). See *FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q1*, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/ouractivities/resource-center/faqs/aca-part-39-final.pdf>. Additionally, if a plan defines ASD as a mental health condition, any aggregate annual or lifetime dollar limit or any quantitative treatment limitation (QTL) imposed on benefits for ASD (for example, an annual dollar cap on benefits for Applied Behavioral Analysis (ABA) therapy for ASD of \$35,000, or a 50-visit annual limit for ABA therapy for ASD) should also be evaluated for compliance with MHPAEA.

***Substance use disorder benefits*** means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).

***Treatment limitations*** include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both QTLs, which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

## SECTION A. APPLICABILITY

**Question 1. Is the group health plan or group or individual health insurance coverage exempt from MHPAEA? If so, please indicate the reason (e.g. retiree-only plan, excepted benefits, small employer exception, increased cost exception, HIPAA opt-out).**

No, the Plan is not exempt from MHPAEA.
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If a group health plan or group or individual health insurance coverage provides either MH/SUD benefits, in addition to medical/surgical benefits, the plan may be subject to the MHPAEA parity requirements. However, **retiree-only group health plans**, self-insured non-federal governmental plans that have elected to exempt the plan from MHPAEA, and group health plans and group or individual health insurance coverage offering only **excepted benefits**, are generally not subject to the MHPAEA parity requirements. (*Note*: if under an arrangement(s) to provide medical care benefits by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and MH/SUD benefits, the MHPAEA parity requirements apply separately with respect to each combination of medical/surgical benefits and MH/SUD benefits and all such combinations are considered to be a single group health plan. *See 26 CFR 54.9812-1(e), 29 CFR 2590.712(e), 45 CFR 146.136(e).*)

Under ERISA, the MHPAEA requirements do not apply to **small employers**, defined as employers who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employ at least 1 employee on the first day of the plan year. *See 26 CFR 54.9812-1(f)(1), 29 CFR 2590.712(f)(1), 45 CFR 146.136(f)(1).* However, under HHS final rules governing the Affordable Care Act requirement to provide EHBs, non-grandfathered health insurance coverage in the individual and small group markets must provide all categories of EHBs, including MH/SUD benefits. The final EHB rules require that such benefits be provided in compliance with the requirements of the MHPAEA rules. *45 CFR 156.115(a)(3); see also ACA Implementation FAQs Part XVII, Q6, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/acapart-xvii.pdf>.* In practice, this means that employees in group health plans offered by small employers who purchase non-grandfathered health insurance coverage in the small group market (within the meaning of section 2791 of the PHS Act) that must provide EHBs have coverage that is subject to the requirements of MHPAEA.

MHPAEA also contains an **increased cost exemption** available to group health plans and issuers that meet the requirements for the exemption. The MHPAEA regulations establish standards and procedures for claiming an increased cost exemption. *See 26 CFR 54.9812-1(g), 29 CFR 2590.712(g), 45 CFR 146.136(g).*

Sponsors of self-funded, non-federal governmental plans are permitted to elect to exempt those plans from certain provisions of the PHS Act, including MHPAEA. An exemption election is commonly called a “HIPAA opt-out.” The HIPAA opt-out election was authorized under section

2722(a)(2) of the PHS Act (42 USC § 300gg-21(a)(2)). *See also* 45 CFR 146.180. The procedures and requirements for self-funded, non-federal governmental plans to opt out may be found at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#SelfFunded%20Non-Federal%20Governmental%20Plans>.

**Question 2. If not exempt from MHPAEA, does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in addition to providing medical/surgical benefits?**

Yes, the Plan provides both M/S and MH/SUD coverage.
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**Unless the group health plan or group or individual health insurance coverage is exempt from MHPAEA or does not provide MH/SUD benefits, continue to the following sections to examine compliance with requirements under MHPAEA.**

## **SECTION B. COVERAGE IN ALL CLASSIFICATIONS**

**Question 3. Does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in every classification in which medical/surgical benefits are provided?**

Yes, MH/SUD benefits are covered in the same classifications of benefits as M/S benefits are covered under the Plan, including, 1) inpatient, in-network; 2) outpatient, in-network; 3) emergency care; and 4) prescription drugs. Outpatient benefits are sub classified into Outpatient Office Visit and Outpatient All Other.
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**Cigna Response:** Services covered under a Cigna-administered benefit plan, including M/S and MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.

### ***Inpatient:***

All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification based upon high cost, high risk and complexity for members receiving the service. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Inpatient is whether application of



prior authorization produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business.

***Outpatient All Other:***

To determine whether a service may be subject to prior authorization, one or more of the following variables such as (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. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0. Services covered under a Cigna-administered benefit plan, including M/S and MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.

***Inpatient:***

All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification based upon high cost, high risk and complexity for members receiving the service. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Inpatient is whether application of prior authorization produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business.

***Outpatient All Other:***

To determine whether a service may be subject to prior authorization, one or more of the following variables such as (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. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0.

Under the MHPAEA regulations, if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulation, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).*

Under the MHPAEA regulations, the six classifications\* of benefits are:

- 1) inpatient, in-network;
- 2) inpatient, out-of-network;
- 3) outpatient, in-network;
- 4) outpatient, out-of-network;
- 5) emergency care; and
- 6) prescription drugs.

*See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).*

*\*See special rules related to the classifications discussed below.*

***NOTE:*** If a plan or coverage generally excludes all benefits for a particular mental health condition or substance use disorder, but nevertheless includes prescription drugs for treatment of that condition or disorder on its formulary, the plan or coverage covers MH/SUD benefits in only one classification (prescription drugs). Therefore, the plan or coverage would generally be required to provide mental health or substance use disorder benefits with respect to that condition or disorder for each of the other five classifications for which the plan also provides medical/surgical benefits. However, if a prescription drug that may be used for a particular MH/SUD condition and may also be used for other unrelated conditions is included on a plan's or coverage's formulary, the drug's inclusion on the formulary alone would not be considered to override the plan or coverage's general exclusion for a particular mental health condition or substance use disorder unless the plan or coverage covers prescription drugs specifically to treat that condition.

***ILLUSTRATION:*** A Plan provides for medically necessary medical/surgical benefits as well as MH/SUD benefits. While the Plan covers medical/surgical benefits in all benefit classifications, it does not cover outpatient services for MH/SUD benefits for either in-network or out-of-network providers. In this example, since the Plan fails to provide MH/SUD benefits in outpatient, in-network and outpatient, out-of-network classifications in which medical/surgical benefits are provided, the Plan fails to meet MHPAEA's parity requirements. The Plan could come into compliance by covering outpatient services for MH/SUD benefits both in- and out-of-network in a manner comparable to covered medical/surgical outpatient in- and out-of-network services.

**Classifying benefits.** In determining the classification in which a particular benefit belongs, a group health plan or group or individual market health insurance issuer must apply the same standards to medical/surgical benefits as to MH/SUD benefits. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).* This rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must assign covered intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) to the existing six classifications in the same way that they assign intermediate medical/surgical benefits to these classifications. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well. A plan or issuer must also comply with MHPAEA's NQTL rules, discussed in Section F, in assigning any benefits to a particular classification. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4).*

### **Medication Assisted Treatment (MAT) is subject to MHPAEA**

Plans and issuers that offer MAT benefits to treat opioid use disorder are subject to MHPAEA requirements, including the special rule for multi-tiered prescription drug benefits that applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as appropriate for purposes of MHPAEA. Plans and issuers should ensure there are NO impermissible QTLs, such as visit limits, or impermissible NQTLs, such as limits on treatment dosage and duration. For example, a limitation providing that coverage of medication for the treatment of opioid use disorder is contingent upon the availability of behavioral or psychosocial therapies or services or upon the patient's acceptance of such services would generally not be permissible unless a comparable process was used to determine limitations for the coverage of medications for the treatment of medical/surgical conditions.

**ILLUSTRATION:** An issuer did not cover methadone for opioid addiction, though it did cover methadone for pain management. The issuer failed to demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions. The issuer re-evaluated the medical necessity of methadone maintenance treatment programs and developed medical-necessity criteria that mirrors federal guidelines (including the Substance Abuse and Mental Health Services Administration treatment improvement protocol 63 for medication for opioid use disorder) for opioid treatment programs to replace the methadone-maintenance treatment exclusion.

**ILLUSTRATION:** A plan uses nationally recognized clinical standards to determine coverage for prescription drugs to treat medical/surgical benefits based on the recommendations of a

Pharmacy and Therapeutics (P&T) committee. However, the plan deviates from such standards for buprenorphine/naloxone to treat opioid use disorder based on the P&T committee's recommendations. This deviation should be evaluated for compliance with MHPAEA's NQTL standard in practice, including the determination of (1) whether the P&T committee has comparable expertise in MH/SUD conditions as it has in medical/surgical conditions, and (2) whether the committee's evaluation of the nationally-recognized clinical standards and decision processes to deviate from those standards for MH/SUD conditions is comparable to and no more stringent than the processes it follows for medical/surgical conditions.

**Treatment for eating disorders is subject to MHPAEA** Eating disorders are mental health conditions, and treatment of an eating disorder is a "mental health benefit" as that term is defined by MHPAEA. *See ACA Implementation FAQs Part 38, Q1, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resourcecenter/faqs/aca-part-38.pdf>.* Section 13007 of the 21st Century Cures Act provides that if a plan or an issuer provides coverage for eating disorders, including residential treatment, they must provide these benefits in accordance with MHPAEA requirements. For example, an exclusion under a plan of all inpatient, out-of-network treatment outside of a hospital setting for eating disorders would generally not be permissible if the plan did not employ a comparable process to determine if a similar limitation on treatment outside hospital settings for medical/surgical benefits warranted. *See FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q8, available at*

*<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/acapart-39-final.pdf>.*

### Compliance Tips

- If the plan or issuer does not contract with a network of providers, all benefits are out-of-network. If a plan or issuer that has no network imposes a financial requirement or treatment limitation on inpatient or outpatient benefits, the plan or issuer is imposing the requirement or limitation within classifications (inpatient, out-of-network or outpatient, out-of-network), and the rules for parity will be applied separately for the different classifications. *See 26 CFR 54.9812-1(c)(2)(ii)(C), 29 CFR 2590.712(c)(2)(ii)(C), 45 CFR 146.136(c)(2)(ii)(C) Example 1.*
- If a plan or issuer covers the full range of medical/surgical benefits (in all classifications, both in-network and out-of-network), beware of exclusions on out-of-network MH/SUD benefits.
- Benefits for intermediate services (such as non-hospital inpatient and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

**\*NOTE: Special rules related to classifications**

**1. Special rule for outpatient sub-classifications:**

- For purposes of determining parity for outpatient benefits (in-network and out-of-network), a plan or issuer may divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules. *26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*
- After the sub-classifications are established, the plan or issuer may not impose any financial requirement or QTL on MH/SUD benefits in any sub-classification (*i.e.*, office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the MHPAEA regulations. *See 26 CFR 54.9812-1(c)(3)(i), 29 CFR 2590.712(c)(3)(i), 45 CFR 146.136(c)(3)(i), 45 CFR 146.136(c)(3)(iii).*
- Other than as explicitly permitted under the final rules, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, separate sub-classifications for generalists and specialists are not permitted.

**2. Special rule for prescription drug benefits:**

- There is a special rule for multi-tiered prescription drug benefits. Multi-tiered drug formularies involve different levels of drugs that are classified based primarily on cost, with the lowest-tier (Tier 1) drugs having the lowest cost-sharing. If a plan or issuer applies different levels of financial requirements to different tiers of prescription drug benefits, the plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for medical/surgical or MH/SUD benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. *See 26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*

**3. Special rule for multiple network tiers:**

- There is a special rule for multiple network tiers. If a plan or issuer provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-



network participating providers), the plan or issuer may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or MH/SUD benefits. After the tiers are established, the plan or issuer may not impose any financial requirement or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

**NOTE:** As explained in the Introduction to this section, nothing in MHPAEA requires a nongrandfathered group health plan or health insurance coverage that provides MH/SUD benefits only to the extent required under PHS Act section 2713 to provide additional MH/SUD benefits in any classification.

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## SECTION C. LIFETIME AND ANNUAL LIMITS

**Question 4. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding lifetime and annual dollar limits on MH/SUD benefits?**

Yes, the Plan complies with mental health parity requirements, annual and/or lifetime dollar limits are not applied to MH/SUD benefits.

A plan or issuer generally may not impose a lifetime dollar limit or an annual dollar limit on MH/SUD benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. *See 26 CFR 9812-1(b), 29 CFR 2590.712(b), 45 CFR 146.136(b).* (This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged.) If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits, or it includes one that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. *26 CFR 54.9812-1(b)(2), 29 CFR 2590.712(b)(2), 45 CFR 146.136(b)(2).*

**ILLUSTRATION:** Plan Z limits outpatient substance use disorder treatments to a maximum of \$1,000,000 per calendar year. With the exception of a \$500,000 per year limit on chiropractic services (which applies to less than one-third of all medical/surgical benefits), Plan Z does not impose such annual dollar limits with respect to other outpatient medical/surgical benefits. In this example, Plan Z is in violation of MHPAEA since the outpatient substance use disorder dollar limit is not in parity with outpatient medical/surgical dollar limits.

### **Compliance Tip**

- There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at **Question 6**. A plan or issuer may impose annual out-of-pocket dollar limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.

**NOTE:** These provisions are affected by section 2711 of the PHS Act, as amended by the Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime and annual dollar limits on EHB, which includes MH/SUD services. Accordingly, the parity requirements regarding lifetime and annual dollar limits apply only to the provision of MH/SUD benefits that are not EHBs.

Note also that, for plan years beginning in 2021, the annual limitation on an individual's maximum out-of-pocket (MOOP) costs in effect under the Affordable Care Act is \$8,550 for self-only coverage and \$17,100 for coverage other than self-only coverage. The annual limitation on out-of-pocket costs is increased annually by the premium adjustment percentage

described under Affordable Care Act section 1302(c)(4), and this updated amount is detailed each year in regulations issued by the Department of Health and Human Services.

## **SECTION D. FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT**

### **LIMITATIONS**

**Question 5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding financial requirements or QTLs on MH/SUD benefits?**

Yes, the Plan's cost sharing requirements comply with MHPAEA financial requirements and are not more restrictive than the predominant limit (at least 2/3) that applies to substantially all (more than 50%) medical/surgical benefits. The Plan does not apply any type of QTLs such as age, day, visit, or dollar limits to services rendered to treat a MH/SUD condition.

- A plan or issuer may not impose a financial requirement or QTL applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of that type that is applied to substantially all medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(2), 29 CFR 2590.712(c)(2), 45 CFR 146.136(c)(2).*
- Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
- Types of QTLs include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
- The six classifications and the sub-classifications outlined in Section B, above, are the only classifications that may be used when determining the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits. *See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).* A plan or issuer may not use a separate sub-classification under these classifications for generalists and specialists. *See 26 CFR 54.9812-1(c)(3)(iii)(C), 29 CFR 2590.712(c)(3)(iii)(C), 45 CFR 146.136(c)(3)(iii)(C).*

### Compliance Tips

- Ensure that the plan or issuer does not impose financial requirements or QTLs that are applicable only to MH/SUD benefits.
- Identify all benefit packages and health insurance coverage to which MHPAEA applies.

#### Detailed steps for applying this rule:

To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification. *See 26 CFR 54.9812-1(c)(2)(i), 29 CFR 2590.712(c)(2)(i), 45 CFR 146.136(c)(2)(i).* Coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions, for example, self-only, family, or employee plus spouse. *See 26 CFR 54.9812-1(c)(1)(iv), 29 CFR 2590.712(c)(1)(iv), 45 CFR 146.136(c)(1)(iv).* If a plan applies different levels of a financial requirement or QTL to different coverage units in a classification of medical/surgical benefits (for example, a \$15 copayment for self-only and a \$20 copayment for family coverage), the predominant level is determined separately for each coverage unit. *See 26 CFR 54.9812-1(c)(3)(ii), 29 CFR 2590.712(c)(3)(ii), 45 CFR 146.136(c)(3)(ii).*

- **STEP ONE (“substantially all” test):** First determine if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits.
- Generally, a financial requirement or QTL is considered to apply to substantially all medical/surgical benefits if it applies to at least two-thirds of the medical/surgical benefits in the classification. *See 26 CFR 9812-1(c)(3)(i)(A), 29 CFR 2590.712(c)(3)(i)(A), 45 CFR 146.136(c)(3)(i)(A).* This two-thirds calculation is generally based on the dollar amount of plan payments expected to be paid for the plan year within the classification. *See 26 CFR 54.9812-1(c)(3)(i)(C), 29 CFR 2590.712(c)(3)(i)(C), 45 CFR 146.136(c)(3)(i)(C).* Any reasonable method can be used for this calculation. *See 26 CFR 54.9812-1(c)(3)(i)(E), 29 CFR 2590.712(c)(3)(i)(E), 45 CFR 146.136(c)(3)(i)(E).*
- **STEP TWO (“predominant” test):** If the type of financial requirement or QTL applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or QTL that applies to the medical/surgical benefits that are subject to that type of financial requirement or QTL in that classification of benefits. (**Note:** If the type of financial requirement or QTL does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to MH/SUD benefits in that classification.)
- Generally, the level of a financial requirement or QTL that is considered the predominant level of that type is the level that applies to more than one-half of the

medical/surgical benefits in that classification subject to the financial requirement or QTL. *See 26 CFR 54.9812-1(c)(3)(i)(B)(1), 29 CFR 2590.712(c)(3)(i)(B)(1), 45 CFR 146.136(c)(3)(i)(B)(1).* If there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or QTL in the classification. In that case, the least restrictive level within the combination is considered the predominant level. *See 26 CFR 54.9812-1(c)(3)(i)(B)(2), 29 CFR 2590.712(c)(3)(i)(B)(2), 45 CFR 146.136(c)(3)(i)(B)(2).* For a simpler method of compliance, a plan may treat the least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.

#### Compliance Tip: Book of Business

- When performing the “substantially all” and “predominant” tests for financial requirements and QTLs, basing the analysis on an issuer’s entire book of business is generally not a reasonable method if a plan or issuer has sufficient claims data regarding a specific plan for a reasonable projection of future claims costs for the substantially all and predominant analysis. However, there may be insufficient reliable claims data for a group health plan, in which case the analyses will require utilizing reasonable data from outside the group health plan. A plan or issuer must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice. *See ACA Implementation FAQs Part 34, Q3, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/ouractivities/resource-center/faqs/aca-part-34.pdf>.*

**ILLUSTRATION:** Plan Z requires copayments for out-patient, in-network MH/SUD benefits. In order to determine if the plan meets the parity requirements, take the following steps:

- 1. STEP ONE: Determine if the particular type of financial requirement applies to substantially all (that is, 2/3 of) medical /surgical benefits in the relevant classification.**

Based on its prior claims experience, Plan Z expects \$1 million in medical/surgical benefits to be paid in the outpatient, in-network classification and \$700,000 of those benefits are expected to be subject to copayments. Because the amount of medical/surgical benefits expected to be subject to a copayment, which is \$700,000, is at least 2/3 of the \$1 million total medical/surgical benefits expected to be paid, a copayment can be applied to outpatient, in-network MH/SUD benefits.



2. **STEP TWO: Determine what level of the financial requirement is predominant (that is, the level that applies to more than half the medical/surgical benefits subject to the financial requirement in the relevant classification).**

In the outpatient, in-network classification where \$1 million in medical/surgical benefits is expected to be paid, \$700,000 of those benefits are expected to be subject to copayments. Out of the \$700,000, Plan Z expects that 25 percent will be subject to a \$15 copayment and 75 percent will be subject to a \$30 copayment. Since 75 percent is more than half, the \$30 copayment is the predominant level.

**CONCLUSION:** Plan Z cannot impose a copayment on MH/SUD benefits in this classification that is higher than \$30.

**Warning Sign:** If a plan or issuer applies a specialist copayment requirement for all MH/SUD benefits within a classification but applies a specialist copayment only for certain medical/surgical benefits within a classification, this may be indicative of noncompliance and warrant further review. See “Compliance Tips” below for further guidance on specialist copay requirements.

### Compliance Tips

- Ensure that when conducting the predominant/substantially all tests, the dollar amount of all plan payments for medical/surgical benefits expected to be paid in that classification for the relevant plan year are analyzed.
- A plan may be able to impose the specialist level of a financial requirement or QTL to MH/SUD benefits in a classification (or an office visit sub-classification) if it is the predominant level that applies to substantially all medical/surgical benefits within the office visit sub-classification. For example, if the specialist level of copay is the predominant level of copay that applies to substantially all medical/surgical benefits in the office visit, in-network sub-classification, the plan may apply the specialist level copay to MH/SUD benefits in the office visit, in-network sub-classification. *See 26 CFR 54.9812-1(c)(3), 29 CFR 2590.712(c)(3).*

## SECTION E. CUMULATIVE FINANCIAL REQUIREMENTS AND TREATMENT

### LIMITATIONS

**Question 6. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding cumulative financial requirements or cumulative QTLs for MH/SUD benefits?**

Yes, the Plan complies with the requirements for cumulative financial requirements and QTLs. All M/S and MH/SUD benefits accumulate to the same deductible and out-of-pocket requirement. The Plan does not apply any type of QTLs such as age, day, visit or dollar limits to services rendered to treat an MH/SUD condition.

- A plan or issuer may not apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(3)(v), 29 CFR 2590.712(c)(3)(v), 45 CFR 146.136(c)(3)(v).* For example, a plan may not impose an annual \$250 deductible on medical/surgical benefits in a classification and a separate \$250 deductible on MH/SUD benefits in the same classification.
- Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements). *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*
- Cumulative QTLs are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*

**ILLUSTRATION:** A plan offers three benefit options, all of which provide medical/surgical as well as MH/SUD benefits. For all three benefit options, the plan provides for in-network treatment limitations of 30 days per year with respect to inpatient mental health services, and in-network treatment limitations of 20 visits per year with respect to outpatient mental health services. No such limitations are imposed on outpatient or inpatient, in-network medical/surgical benefits in any of the three benefit options.

In this example, the plan improperly imposes cumulative treatment limitations on the number of visits for outpatient and inpatient, in-network and out-of-network mental health benefits in all three benefit options. The plan could come into compliance by removing the day and visit limits for mental health services.

## **SECTION F. NONQUANTITATIVE TREATMENT LIMITATIONS**

### **Question 7. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding NQTLs on MH/SUD benefits?**

Services covered under a Cigna-administered benefit plan, including M/S and MH/SUD benefits, may require Prior Authorization to achieve a variety of objectives, including the verification of the appropriate utilization of services by type/level of care and place/setting of service under benefit plans administered by Cigna, as well as verification that a service will be rendered for a covered benefit.

#### ***Inpatient:***

All Inpatient admissions are subject to prior authorization review, without service/procedure level distinctions for the inpatient benefit classification based upon high cost, high risk and complexity for members receiving the service. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Inpatient is whether application of prior authorization produces positive financial savings, as measured in the aggregate across the Cigna-administered book-of-business.

#### ***Outpatient All Other:***

To determine whether a service may be subject to prior authorization, one or more of the following variables such as (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. The factors used to determine that the Prior Authorization NQTL will apply to either MH/SUD or M/S benefits in the Outpatient All Other benefit classifications is whether at least one of the non-quantitative variables set forth above, plus the projected return on investment (ROI) to review the service must generally exceed a ratio of 3.0.

Yes, the Plan complies with mental health parity requirements regarding the application of an NQTL on MH/SUD benefits. The Plan has conducted a comparative analysis and determined NQTLs are comparable to and applied no more stringently than NQTLs for M/S benefits in writing and in operation.

An NQTL is generally a limitation on the scope or duration of benefits for treatment. The MHPAEA regulations prohibit a plan or an issuer from imposing NQTLs on MH/SUD benefits in any classification unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(4)(i), 29 CFR 2590.712(c)(4)(i), 45 CFR 146.136(c)(4)(i).*

The following is an illustrative, non-exhaustive list of NQTLs:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization or ongoing authorization requirements;
- Concurrent review standards;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or issuer methods for determining usual, customary, and reasonable charges;
- 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);
- Exclusions of specific treatments for certain conditions;
- Restrictions on applicable provider billing codes;
- Standards for providing access to out-of-network providers;
- Exclusions based on failure to complete a course of treatment; and
- 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.

*See 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), 45 CFR 146.136(c)(4)(ii).* For additional examples of plan provisions that may operate as NQTLs see *Warning Signs*, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/warningsigns-plan-or-policy-nqtl-that-require-additional-analysis-to-determine-mhpaca-compliance.pdf>.

While NQTLs are generally defined as treatment limitations that are not expressed numerically, the application of an NQTL in a numerical way does not modify its nonquantitative character. For example, standards for provider admission to participate in a network are NQTLs because such standards are treatment limitations that typically are not expressed numerically. *See 29 CFR 2590.712 (c)(4)(ii), 45 CFR 146.136(c)(4)(ii).* Nevertheless, these standards sometimes rely on numerical standards, for example, numerical reimbursement rates. In this case, the numerical expression of reimbursement rates does not modify the nonquantitative character of the provider admission standards; accordingly, standards for provider admission, including associated reimbursement rates to which a participating provider must agree, are to be evaluated in accordance with the rules for NQTLs.

A group health plan or issuer may consider a wide array of factors in designing medical management techniques for both MH/SUD benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider

discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these or other factors in a comparable fashion, an NQTL, such as prior authorization, may be required for some (but not all) MH/SUD benefits, as well as for some (but not all) medical/ surgical benefits. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4), Example 8.*

**NOTE** – To comply with MHPAEA, a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network and outof-network providers for both medical/surgical and MH/SUD benefits. For example, if reimbursement rates for medical/surgical benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule. Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, or market need or availability (demand) must be comparable and applied no more stringently to MH/SUD benefits than medical/surgical benefits.

**NOTE** - Plans and issuers may attempt to address shortages in medical/surgical specialist providers and ensure reasonable patient wait times for appointments by adjusting provider admission standards, through increasing reimbursement rates, and by developing a process for accelerating enrollment in their networks to improve network adequacy. To comply with MHPAEA, plans and issuers must take measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers, even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan’s network. The Departments note that substantially disparate results—for example, a network that includes far fewer MH/SUD providers than medical/surgical providers—are a red flag that a plan or issuer may be imposing an impermissible NQTL. *See FAQs Part 39, Q6 and Q7, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resourcecenter/faqs/aca-part-39-final.pdf>.*

**Warning Signs:** The following plan provisions related to provider reimbursements may be indicative of noncompliance and warrant further review:

1. *Inequitable reimbursement rates established via a comparison to Medicare:* A plan or issuer generally pays at or near Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for medical/surgical benefits. For assistance comparing a plan or coverage’s reimbursement schedule to Medicare, see the PROVIDER REIMBURSEMENT RATE WARNING SIGNS in Appendix II.



2. *Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes:* A plan or issuer reimburses psychiatrists, on average, less than medical/surgical physicians for the same E&M codes.
3. *Consideration of different sets of factors to establish reimbursement rates:* A plan or issuer generally considers market dynamics, supply and demand, and geographic location to set reimbursement rates for medical/surgical benefits, but considers only quality measures and treatment outcomes in setting reimbursement rates for MH/SUD benefits.

**In order to determine compliance with MHPAEA, the following analysis should be applied to each NQTL identified under the plan or coverage:**

**Step One:**

- Identify the NQTL.

Please see Cigna's Mental Health Parity NQTL Comparative Analysis Disclosure Document included with this submission.

Identify in the plan documents all the services (both MH/SUD and medical/surgical) to which the NQTL applies in each classification.

**NOTE:** NQTLs may also be included in other documents, such as internal guidelines or provider contracts.

**Compliance Tips**

- Ask for information about what medical/surgical benefits are also subject to these requirements or restrictions.
- If a benefit includes multiple components (*e.g.*, outpatient and prescription drug classifications), and each component is subject to a different type of NQTL (*e.g.*, prior authorization and limits on treatment dosage or duration), each NQTL must be analyzed separately.
- Find out how these requirements are implemented, who makes the decisions, and what the decision-maker's qualifications are.

Determine which benefits are treated as medical/surgical and which are treated as MH/SUD, and analyze the NQTLs under each benefit classification. Plans and issuers should clearly define which benefits are treated as medical/surgical and which benefits are treated as MH/SUD under

the plan. Benefits (such as inpatient treatment at a skilled nursing facility or other non-hospital facility and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

#### Compliance Tip

- Any separate NQTL that applies to only the MH/SUD benefits within any particular classification does not comply with MHPAEA.

**NOTE:** If a plan classifies covered intermediate levels of care, such as skilled nursing care and residential treatment, as inpatient benefits, and covers room and board for all inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction only on MH/SUD benefits and therefore violates MHPAEA.<sup>1</sup> The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment.

#### Step Two:

- Identify the factors considered in the design of the NQTL.

Please see Cigna's Mental Health Parity NQTL Comparative Analysis Disclosure Document included with this submission.

*Examples of factors include but are not limited to the following:*

- Excessive utilization;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- Lack of adherence to quality standards;
- Claim types with

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<sup>1</sup> See 29 CFR 2590.712(c)(iii) Ex. 9.

high percentage of fraud; and ○ Current and projected demand for services.

### Compliance Tips

- If only certain benefits are subject to an NQTL, such as meeting a fail-first protocol or requiring preauthorization, plans and issuers should have information available to substantiate how the applicable factors were used to apply the specific NQTL to medical/surgical and MH/SUD benefits.
- Determine whether any factors were given more weight than others and the reason(s) for doing so, including evaluating the specific data used in the determination (if any).

### Step Three:

- Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified above to design the NQTL.

Comments: Please see Cigna's Mental Health Parity NQTL Comparative Analysis Disclosure Document included with this submission.

*Examples of sources of factors include, but are not limited to, the following:*

- Internal claims analysis; ○ Medical expert reviews; ○ State and federal requirements; ○ National accreditation standards; ○ Internal market and competitive analysis; ○ Medicare physician fee schedules; and
- Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

If these factors are utilized, they must be applied comparably to MH/SUD and medical/surgical benefits.

**NOTE:** Plans and issuers have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ a particular source or evidentiary standard), as long as they are applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits. For example, a plan utilizes a panel of medical experts, with equivalent expertise in both medical/surgical and MH/SUD benefits, to assess whether preauthorization (an NQTL) is appropriate to apply to certain services, based on the factors of cost and safety. The panel recommends that the plan require preauthorization for electroconvulsive therapy (ECT), because ECT is high cost and its use presents legitimate safety concerns. The plan does not require documentation or studies to support these concerns and instead relies on established medical best practices. As long as the plan similarly relies on established medical best practices to define high cost, identify legitimate safety concerns, and impose preauthorization requirements on medical/surgical benefits in the same classification, then the NQTL is applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits.

### Compliance Tips

- Evidentiary standards and processes that a plan or issuer relies upon may include any evidence that a plan or issuer considers in developing its medical management techniques, including recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials), and published research studies.
- If there is any variation in the application of a guideline or standard being relied upon by the plan or issuer, the plan or issuer should explain the process and factors relied upon for establishing that variation.
- If the plan or issuer relies on any experts, the plan or issuer should assess the experts' qualifications and the extent to which the expert evaluations in setting recommendations are ultimately relied upon regarding both MH/SUD and medical/surgical benefits.

**NOTE:** When identifying the sources of the factors considered in designing the NQTL, also identify any threshold at which each factor will implicate the NQTL. For example, if high cost is identified as a factor used in designing a prior authorization requirement, the threshold dollar amount at which prior authorization will be required for any service should also be identified. You may also wish to consider the following:

- What data, if any, are used to determine if the benefit is “high cost”?
- How, if at all, is the amount that is to be considered “high cost” or the calculation for determining that amount different for MH/SUD benefits as compared to medical/surgical benefits, and how is the difference justified?

*Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to, the following:*

- Excessive utilization as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care.
- Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased 10 percent or more per year for two years.
- Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30 percent of the time based on clinical chart reviews.
  - High level of variation in length of stay may be considered as a factor when claims data shows that 25 percent of patients stayed longer than the median length of stay for acute hospital episodes of care.
- High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period.
- Lack of clinical efficacy may be considered as a factor when more than 50 percent of outpatient episodes of care for specific diseases are not based on evidence based interventions (as defined by nationally accepted best practices) in a 12month sample of claims data.

#### **Step Four:**

- Are the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical/surgical benefits, both as written and in operation?

Yes, the processes, strategies and evidentiary standards applied to the applicable NQTLs are comparable and applied no more stringently to MH/SUD benefits than to M/S benefits, both in writing and in operation. Please see Cigna's Mental Health Parity NQTL Comparative Analysis Disclosure Document included with this submission.
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Plans and issuers should demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD services and medical/surgical services.



### Compliance Tips

- If utilization review is conducted by different entities or individuals for medical/surgical and MH/SUD benefits provided under the plan or coverage, ensure that there are measures in place to ensure comparable application of utilization review policies.
- Determine what consequences or penalties apply to the benefits when the NQTL requirement is not met.

*These are examples of methods/analyses substantiating that factors, evidentiary standards, and processes are comparable:*

- Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and medical/surgical benefits subject to the NQTL.
- Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL.
- A consistent methodology for analyzing which MH/SUD and medical/surgical benefits had “high cost variability” and were therefore subject to the NQTL.
- Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and medical/surgical benefits were the same, both as developed and applied.
- Internal Quality Control Reports showing that the factors, evidentiary standards, and processes regarding MH/SUD and medical/surgical benefits are comparable and no more stringently applied to MH/SUD benefits.
- Summaries of research or peer-reviewed medical journal articles, if considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was utilized similarly for both MH/SUD and medical/surgical benefits.

### Compliance Tips

- Look for compliance as written **AND IN OPERATION**.
- Determine whether there are exception processes available and when they may be applied.
- Determine how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and medical/surgical benefits claims.
- Determine who makes denial determinations and if the decision-makers have comparable expertise with respect to MH/SUD and medical/surgical benefits.

- Check sample claims to determine whether a particular NQTL warrants additional review. A plan may have written processes that are compliant on their face, but those processes may not be compliant in practice.
- Determine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/surgical benefits.
- Document your analysis, as a best practice.

**NOTE:** While outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational MHPAEA parity noncompliance. For example, if a plan has a 34 percent denial rate on concurrent reviews of psychiatric hospital stays in a 12-month period and a 5 percent denial rate on concurrent review for medical hospital stays in that same 12-month period, the concurrent review process for both psychiatric and medical hospital stays should be carefully examined to ensure that the concurrent review standard is not being applied more stringently to MH/SUD benefits than to medical/surgical benefits in operation.

**Warning Signs:** The following plan provisions related to NQTLs may be indicative of noncompliance and warrant further review:

1. *Prior authorization for medication for opioid use disorder:* A plan or issuer imposes prior authorization for medications for opioid use disorder but does not require prior authorization for comparable medications for medical/surgical conditions.
2. *Different medical necessity review requirements:* A plan or issuer imposes medical necessity review requirements on outpatient MH/SUD benefits after a certain number of visits, despite permitting a greater number of visits before requiring any such review for outpatient medical/surgical benefits.

#### **Compliance Tip**

- **Do not focus solely on results.** Look at the **underlying processes and strategies** used in applying NQTLs. Are there arbitrary or discriminatory differences in how the plan or issuer is applying those processes and strategies to medical/surgical benefits versus MH/SUD benefits? While results alone are not determinative of noncompliance, measuring and evaluating results and quantitative outcomes can be helpful to identify potential areas of noncompliance.

## SECTION G. DISCLOSURE REQUIREMENTS

### **Question 8. Does the group health plan or group or individual health insurance issuer comply with the MHPAEA disclosure requirements?**

Yes, a disclosure document explaining our plan's NQTLs is available to current/potential enrollees, clients, and providers upon request. The document is provided within 30 days of request.

- The plan administrator or health insurance issuer must make **available the criteria for medical necessity determinations** made under a group health plan or group or individual health insurance coverage with respect to MH/SUD benefits to any current or potential participant, beneficiary, enrollee, or contracting provider **upon request**. *See 29 CFR 2590.712(d)(1), 45 CFR 146.136 (d)(1).*

The plan administrator (or health insurance issuer) must make available **the reason for any denial** under a group health plan or group or individual health insurance coverage of reimbursement or payment for services with respect to MH/SUD benefits to any participant, beneficiary, or enrollee, and may do so in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the DOL claims procedure rule) and 29 CFR 2590.715-2719 (internal claims and appeals and external review processes).

- Pursuant to the internal claims and appeals and external review rules under the Affordable Care Act applicable to all non-grandfathered group health plans and to all non-grandfathered group and individual health insurance coverage, claims related to medical judgment (including MH/SUD) are eligible for external review. The **internal claims and appeals** rules include the right of claimants (or their authorized representatives) to be provided **upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits**. This includes documents with information about the **processes, strategies, evidentiary standards, and other factors used to apply an NQTL** with respect to medical/surgical benefits and MH/SUD benefits under the plan. *See 26 CFR 54.9812-1(d)(3), 29 CFR 2560.5301- 2590.712(d)(3), 45 CFR 146.136(d)(3), 147.136(b).*
- With respect to group health plans that are subject to ERISA, if coverage is denied based on medical necessity, **medical necessity criteria** for the MH/SUD benefits at issue and for medical/surgical benefits in the same classification must be provided **within 30 days of the request** to the participant, beneficiary, provider, or authorized representative of the beneficiary or participant. *See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).*

- If a plan or a plan administrator or health insurance issuer fails to provide these documents, a court may hold it liable for up to \$110 a day from the date of failure to provide these documents. *See ERISA Sec. 502(c)(1).*

### **Compliance Tips**

- The reasons for benefit denials include applicable medical necessity criteria as applied to that participant, beneficiary, or enrollee.
- Under ERISA, plans and issuers cannot refuse to disclose information necessary for the parity analysis on the basis that the information is proprietary or has commercial value.
- Under ERISA, plans and issuers can provide summary descriptions of the medical necessity criteria in a layperson's terms.

### **Make Showing Compliance Simple**

#### **Documents or Plan Instruments Participants and Beneficiaries or DOL may Request Include the following:**

Under ERISA section 104(b), participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with MHPAEA, and copies must be furnished within 30 days of the request. These documents and plan instruments may include documentation that illustrates how the health plan has determined that any financial requirement, QTL, or NQTL complies with MHPAEA. For example, participants and beneficiaries may request the following:

- An analysis showing that the plan meets the predominant/substantially all tests. The plan may need to provide information regarding the amount of medical/surgical claims subject to a certain type of financial requirement, such as a co-payment, in the prior year for a classification or the plan's basis for calculating claims expected to be subject to a certain type of QTL in the current plan year for a classification, for purposes of determining the plan's compliance with the predominant/substantially all tests;
- A description of an applicable requirement or limitation, such as preauthorization or concurrent review, that the plan applies for MH/SUD benefits and medical/surgical benefits within the relevant classification (for example, in- or out-of-network, or in- or outpatient). These might include references to specific plan documents: for example provisions as stated on specified pages of the summary plan description (SPD), or other underlying guidelines or criteria not included in the SPD that the plan has consulted or relied upon;
- Information regarding factors, such as cost or recommended standards of care, that are relied upon by a plan for determining which medical/surgical or MH/SUD benefits are subject to a specific requirement or limitation. These might include references to specific related factors or guidelines, such as applicable utilization review criteria;

- A description of the applicable requirement or limitation that the plan believes has been used in any given MH/SUD service adverse benefit determination (ABD) within the relevant classification; and
- Medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.

### Compliance Tips

- Find out how the plan administrator handles general information requests about coverage limitations as well as specific information or disclosure requests with respect to denied benefit claims.
- Review a sample of appeals files and examine what was disclosed to participants, including the criteria for medical necessity determinations and reasons for claim denials.
- Determine how long it took the plan or the plan administrator to furnish requested documents to participants.

As directed by the 21st Century Cures Act, and in response to comments received from the regulated community, the Departments continue to issue additional guidance regarding disclosures, in particular with respect to NQTLs. Based on requests from various stakeholders for model MHPAEA disclosure forms and for guidance on processes for requesting disclosures in a more uniform, streamlined, or otherwise simplified way, the Departments issued a model disclosure request form (available at <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-healthparity/mhpaea-disclosure-template.pdf>). For the most current version of the form please visit the DOL's dedicated MH/SUD parity webpage, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

This form can, but is not required to, be used to request MHPAEA-related information from group plans and group and individual health insurance issuers, including general information about coverage limitations or specific information that may have resulted in denial of MH/SUD benefit claims.

### Compliance Tips

- Participants, beneficiaries, enrollees, dependents, and contracting providers may request information to determine whether benefits under a plan are being provided in parity even in the absence of any specific ABD.
- Group health plans may need to work with insurance issuers providing coverage on behalf of an insured group health plan or with third party administrators administering the plan to ensure that such service providers either directly or in coordination with the plan are providing participants and beneficiaries any documents or information to which they are entitled.



- If a group health plan or group or individual health insurance issuer uses MH/SUD vendors and carve-out service providers, the plan must ensure that all combinations of benefits comport with MHPAEA. Therefore, vendors and carve-out providers should provide documentation of the necessary information to the plan to ensure that all combinations of benefits comport with parity.

**NOTE:** Compliance with the disclosure requirements of MHPAEA is not determinative of compliance with any other provision of other applicable federal or state law. Be sure that the plan or issuer, in addition to these disclosure requirements, is disclosing all information relevant to medical/surgical, mental health, and substance use disorder benefits as required pursuant to other applicable provisions of law. For example, if a plan document states it covers benefits consistent with generally accepted standards of care (for both medical/surgical and MH/SUD benefits), and the plan has developed internal guidelines that are more restrictive than the generally accepted standards of care for both medical/surgical and MH/SUD benefits, the plan might comply with MHPAEA but fail to comply with Part 4 of ERISA, which requires that the plan be administered in accordance with its plan documents. Plans should be prepared to disclose their medical necessity criteria and should ensure that, to the extent the plan document specifies a specific treatment guideline, it follows that as well.

#### Compliance Tip

- Under ERISA, ERISA-covered plans must provide an SPD that describes plan provisions related to the use of network providers and describe the composition of the provider network (*i.e.*, a provider directory). The provider directory may be distributed as a separate document from the SPD and, in many circumstances, may be provided electronically. However, the provider directory must be up-to-date, accurate, and complete (using reasonable efforts). *See e.g.*, 29 CFR 2520.102-3; *FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q10*, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resourcecenter/faqs/aca-part-39-final.pdf>; ERISA Secs. 102, 104, and 404(a).

## **SECTION H. ESTABLISHING AN INTERNAL MHPAEA COMPLIANCE PLAN**

Although not required by MHPAEA, an internal compliance plan that promotes the prevention, detection, and resolution of potential MHPAEA violations can help plans and issuers improve compliance with the law. Compliance plans for group health plans or issuers may differ, but many successful compliance plans share the following characteristics:

1. **Conducting effective training and education.** Successful compliance programs provide ongoing training and education to all individuals responsible for ensuring MHPAEA compliance, including those who are responsible for making decisions related

to medical/surgical and MH/SUD benefits on behalf of the plan or issuer (such as claims reviewers). EBSA provides many educational materials, webcasts, and in-person compliance assistance events that may assist in these trainings and can also be made available to participants and beneficiaries to inform them of their parity protections under MHPAEA.<sup>2</sup>

2. **Ensuring retention of records and information.** ERISA Section 107 requires the retention of certain documents. These documents should be retained for at least six years after the Form 5500 for the relevant plan year has been filed.
3. **Conducting internal monitoring and compliance reviews on a regular basis.** A plan or issuer may monitor compliance on an ongoing basis by conducting internal reviews for potential non-compliance and identification of problem areas related to MHPAEA and by auditing samples of adverse benefit determinations to assess the application of medical necessity criteria, the level of detail provided to claimants, and the correctness of determinations. Plans and issuers may wish to establish an internal consumer ombudsmen program to assist participants and beneficiaries in navigating their benefits and for elevating complaints of noncompliance. Plans and issuers that delegate management of MH/SUD benefits to another entity should have clear protocols to ensure that the service providers for both medical/surgical and MH/SUD benefits provide documentation of the necessary information to the plan or issuer (and to the entity that adjudicates MH/SUD benefit claims, if necessary) to ensure that all combinations of benefits that a participant or beneficiary can elect comport with MHPAEA and to ensure that plans and issuers are able to comply with disclosure requirements.
4. **Responding promptly to detected offenses and developing corrective action.** If a plan or issuer discovers a violation of MHPAEA, it should take steps to correct the violation promptly, including providing retroactive relief and notice to potentially affected participants and beneficiaries. EBSA Benefits Advisors may be able to assist plans and issuers in voluntarily complying with MHPAEA. They can be contacted at (866) 444-3272.

**If a group health plan is audited by DOL investigators for MHPAEA compliance, DOL may ask for at least the following, among other items:**

1. Plan materials related to the plan's compliance with MHPAEA, including the following:
  - a) Information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the plan or coverage.

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<sup>2</sup> See <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorderparity>.

- b) Records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under state law. Such records may also be helpful to plans and issuers in responding to inquiries from participants, beneficiaries, enrollees, and dependents regarding benefits under the plan or coverage.
- c) Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer has relied upon as the basis for determining its compliance with the requirement that any NQTL applicable to MH/SUD benefits be comparable to and applied no more stringently than the NQTL as applied to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or issuer to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits. If the standards that are applied to MH/SUD benefits are more stringent than those in nationally recognized medical guidelines, but the standards that are applied to medical/surgical benefits are not, plans and issuers should include any applicable explanation of the reason(s) for the application of the more stringent standard for MH/SUD benefits.
- d) Samples of covered and denied MH/SUD and medical/surgical benefit claims.
- e) Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of MH/SUD benefits to another entity).
- f) Any applicable MHPAEA testing completed by the plan or the issuer for financial requirements or QTLs applied to MH/SUD benefits.

In addition to this Self-Compliance Tool, the National Association of Insurance Commissioners (NAIC) has developed tools (such as a Data Collection Tool, which includes a Non-Quantitative Treatment Limitations Chart) to assist issuers in evaluating MHPAEA compliance. For more information regarding NAIC compliance assistance efforts, please visit its website at <https://content.naic.org/>.

## **APPENDIX I: ADDITIONAL ILLUSTRATIONS**

**ILLUSTRATION 1:** A Plan covers neuropsychological testing but excludes such testing for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing, for example, clinical efficacy of such testing for different conditions and the degree

to which such testing is used for educational purposes with regard to different conditions. Does the plan rely on criteria and evidence from comparable sources with respect to medical/surgical and mental health conditions? Does the plan have documentation indicating the criteria used and evidence supporting the plan's determination of the diagnoses for which the plan will cover this service and the rationale for excluding certain diagnoses? The result may be that the plan permissibly covers neuropsychological testing for some medical/surgical or mental health conditions, but not for all.

**Conclusion:** This outcome may be permissible to the extent the plan has based the exclusion of this testing for certain conditions on clinical efficacy and/or other factors if the factors are designed and applied in a comparable manner with respect to the conditions for which testing is covered and those for which it is excluded.

**ILLUSTRATION 2:** A Plan uses diagnosis related group (DRG) codes in their standard utilization review process to actively manage hospitalization utilization. For all non-DRG hospitalizations (whether due to an underlying medical/surgical condition or a MH/SUD condition), the plan requires precertification for hospital admission and incremental concurrent review. The precertification and concurrent review processes review unique clinical presentation, condition severity, expected course of recovery, quality, and efficiency. The evidentiary standards and other factors used in the development of the concurrent review process are comparable across medical/surgical benefits and MH/SUD benefits, and are well documented. These evidentiary standards and other factors are available to participants and beneficiaries free of charge upon request.

**Conclusion:** In this example, it appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its precertification and concurrent review of hospitalizations are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

**ILLUSTRATION 3:** A Plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical conditions as inpatient benefits and likewise treats any covered care in residential treatment facilities for MH/SUD as an inpatient benefit. In addition, the plan treats home health care as an outpatient benefit and treats intensive outpatient and partial hospitalization for MH/SUD services as outpatient benefits.

**Conclusion:** In this example, the plan assigns covered intermediate MH/SUD benefits to the six classifications in the same way that it assigns comparable intermediate medical/surgical benefits to the classifications.

**ILLUSTRATION 4:** Master's degree training and state licensing requirements often vary among provider types. The plan consistently applies its standard that any provider must meet the most

stringent licensing requirement standard in the applicable state related to supervised clinical experience requirements in order to participate in the network. Therefore, the plan requires master's-level therapists to have post-degree, supervised clinical experience in order to join its provider network. There is no parallel requirement for master's-level general medical providers because their licensing requires supervised clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD level psychologists since their licensing already requires supervised training.

**Conclusion:** The requirement that master's-level therapists must have supervised clinical experience to join the network is permissible, as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers whose state licensing does not require this experience.

**ILLUSTRATION 5:** A patient with chronic depression has not responded to five different antidepressant medications and therefore was referred for outpatient treatment with repetitive transcranial magnetic stimulation (TMS). This specific treatment has been approved by the FDA and has been the subject of more than six randomized controlled trials published in peer reviewed journals. The plan denies the treatment as experimental. The plan states that it used the same criteria to deny TMS as it does to approve or deny any MH/SUD or medical/surgical benefits under the plan. The plan identifies its standard for both medical/surgical benefits and MH/SUD benefits as requiring that at least two randomized controlled trials showing efficacy of a treatment be published in peer reviewed journals for any new treatment. However, the plan indicates that while more than two randomized controlled trials regarding TMS have been published in peer reviewed journals, a committee of medical experts involved in plan utilization management reviews reviewed the journals and determined that only one of the articles provided sufficient evidence of efficacy. The plan did not identify what specific standards were used to assess whether a peer review had adequately evidenced efficacy and what the qualifications of the plan's experts are. Lastly, the plan does not impose this additional level of scrutiny with respect to reviewing medical/surgical treatments beyond the initial requirement that the treatment has been the subject of the requisite number and type of trials.

**Conclusion:** The plan's exclusion fails to comply with MHPAEA's NQTL requirements because, in practice, the plan applies an additional level of scrutiny with respect to MH/SUD benefits and therefore applies the NQTL more stringently to mental health benefits than to medical/surgical benefits without additional justification. To come into compliance, the plan could ensure that any additional levels of scrutiny are imposed on both medical/surgical and MH/SUD benefits comparably, including by establishing standards for when a peer review has adequately evidenced efficacy, and that the qualifications of the plan's experts are similar for both MH/SUD and medical/surgical benefits.

**ILLUSTRATION 6:** A plan imposes prior authorization for certain MH/SUD and medical/surgical services. The medical/surgical outpatient services that require prior authorization include habilitative and rehabilitative services such as physical therapy. Physical therapy services were selected for prior authorization because of findings that physical

therapists' documentation of medical necessity is often inadequate. In addition, there has been an increase in litigation regarding physical therapy claims. Prior authorization is conducted telephonically and authorization determinations are reviewed by a physician in consultation with a licensed physical therapist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of sessions authorized is tailored to the specific medical/surgical condition treated, consistent with generally accepted national clinical guidelines. Determinations to approve or deny coverage are made by physicians with consultation from a licensed physical therapist.

Psychological testing also requires prior authorization. Psychological testing was selected for prior authorization because of recent Medicare fraud schemes and consistent with the Medicare Improper Payment Reports, which found improper payments with respect to psychological testing claims because of inadequate documentation from psychologists. Prior authorization is conducted telephonically and reviewed by a licensed psychologist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of hours authorized for psychological testing are tailored to the age of the client and type of evaluation requested and range from two to five hours for an average evaluation (on the basis of the average number of hours for evaluation as included in generally accepted national clinical guidelines). Determinations to approve or deny coverage are made by licensed psychologists with at least five years of experience in psychological testing.

**Conclusion:** In this example, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its preauthorization requirements, particularly the use of prior authorization to detect fraud and abuse, are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

## **APPENDIX II: PROVIDER REIMBURSEMENT RATE WARNING SIGNS**

The Departments have noted that, while outcomes are not determinative of a MHPAEA violation, they can often serve as red flags or warning signs to alert the plan or issuer that a particular provision may warrant further review. With respect to provider reimbursement, comparing a plan or issuer's average reimbursement rates for both medical/surgical and MH/SUD providers against an external benchmark of reimbursement rates, such as Medicare, may help identify whether the underlying methodology used to determine the plan's or issuer's reimbursement rates warrants additional review for compliance with MHPAEA. Furthermore, evaluating how medical/surgical and MH/SUD providers are reimbursed for the same or similar services may also help a plan or issuer determine if the plan's or issuer's underlying methodology for provider reimbursement warrants further review.



Accordingly, the following framework for comparison may assist plans and issuers in identifying information they might consider when comparing reimbursement rates for certain MH/SUD and medical/surgical services based on Current Procedural Terminology (CPT) codes. This is not the only framework for analyzing provider reimbursement rates, and it is not determinative of compliance. This framework utilizes Medicare reimbursement rates as its benchmark for comparison. If a plan's or issuer's comparison of reimbursement rates indicates that the reimbursement rate is lower for MH/SUD providers, either as compared to medical/surgical providers or as compared to an external benchmark, such as Medicare, the plan or issuer should consider further review to ensure that the processes, strategies, evidentiary standards, and other factors used with respect to provider reimbursement for MH/SUD benefits are comparable to, and applied no more stringently than, those used with respect to provider reimbursement for medical/surgical benefits. Please see Section F. Nonquantitative Treatment Limitations for information on how to further evaluate provider reimbursement rates for compliance with MHPAEA.

Specialty	CPT Code	Average Plan rate for Georgia	Medicare rate for Georgia	Plan rate as a percentage of Medicare
Orthopedic Surgery	99203	\$ 189	\$ 113	167 %
	99213	\$ 128	\$ 92	140%
Cardiologists	99203	\$ 204	\$ 113	180%
	99213	\$ 130	\$ 92	141%
Internists MD	99203	\$ 156	\$ 113	138%
	99213	\$ 115	\$ 92	126%
Endocrinologists	99203	\$ 178	\$ 113	157%
	99213	\$ 130	\$ 92	142%
Gastroenterologist	99203	\$ 185	\$ 113	163%
	99213	\$ 124	\$ 92	135%
Neurologists	99203	\$ 170	\$ 113	150%
	99213	\$ 117	\$ 92	128%
Pediatrician	99203	\$ 197	\$ 113	174%
	99213	\$ 99	\$ 92	108%
Dermatologists	99203	\$ 174	\$ 113	154%
	99213	\$ 123	\$ 92	134%
Psychiatrists	99203	\$ 155	\$ 114	136%
	99213	\$ 80	\$ 92	87%
Psychologists	90832 (based on 1 hr)	\$ 78	\$ 78	100%
	90791 (based on ½ hour)	\$ 105	\$ 179	59%

Specialty	CPT Code	Average Plan rate for Georgia	Medicare rate for Georgia	Plan rate as a percentage of Medicare
LCSW	90832 (based on 1 hr) 90791 (based on ½ hour)	\$ 53 \$ 91	\$ 78 \$ 179	68% 51%
Podiatrists	99203 99213	\$ 183 \$ 126	\$ 113 \$ 92	161% 138%
Chiropractor	99203 99213	\$ 133 \$ 86	\$ 113 \$ 92	117% 93%
Occupational Therapy	97165 97166 97167 97168	\$ 89 \$ 112 \$ 120 \$ 68	\$ 103 \$ 103 \$ 103 \$ 71	86% 109% 117% 96%
Physical Therapy	97161 97162 97163 97164	\$ 110 \$ 87 \$ 70 \$ 52	\$ 102 \$ 102 \$ 102 \$ 70	108% 85% 69% 74%
Speech Therapy	Initial Office Visit Codes do not exist. Analysis of specific tests or follow- up may be useful to consider.			

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### **OON Reimbursement**

The Comparative Analysis for the NQTL for Network Admissions applied to MH/SUD services, and/or providers of such services, and to M/S services and/or providers of such services, was drafted and performed by Kevin Cummings, Managing Counsel who advised Cigna in preparation of the comparative analysis, and the other individuals who participated in the creation of the comparative analysis were: Michael Battistoni, Provider Contracting Senior Director; Jo-Ann Lebel, Provider Contracting Manager; Terri Cothron, Provider Contracting Director; Keith Jones, Business Analytics Senior Manager. Cigna's subject matter experts meet routinely throughout the year to review and discuss trends and issues impacting the out-of-network reimbursement program offered to, and administered for, clients.