Mental Health and Substance Use Disorder (MHSUD)

Financial Requirement Parity Certification

*Required to be submitted with Plan Year (PY) 2026*

*ACA Individual and Small Group Market Rate Filings*

## Purpose

Issuers are required to comply with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations and guidance, such as Chapter 284-43 WAC Subchapter K, Mental Health and Substance Use Disorder. Financial requirements and treatment limitations applicable to mental health/substance use disorder (MHSUD) benefits cannot be more restrictive than those applicable to medical/surgical benefits.

This document focuses on financial parity requirements [MHPAEA and WAC 284-43-7040]. For quantitative treatment limitations (QTL) and non-quantitative treatment limitations (NQTL), see the checklist under the form filing instructions; for QTL and NQTL definitions, see MHPAEA and WAC 284-43-7010.

Financial requirements are defined in MHPAEA and WAC 284-43-7010 as cost sharing measures, such as deductibles, copayments, coinsurance, and out-of-pocket maximums; note that the definition explicitly excludes aggregate lifetime and annual dollar limits.

See WAC 284-43-7010 for additional relevant definitions (e.g., classification of benefits, medical/surgical benefits, mental health benefits, predominant level, substance use disorder benefits, and substantially all).

## Key Points

1. Required level of review

Attest/certify in section III below.

1. Parity review must be done separately by plan, for each type of financial requirement and each benefit classification.
2. Parity review also must be done separately by coverage unit, if a plan or issuer applies different levels of financial requirement (i.e., different cost shares) to different coverage units. [WAC 284-43-7020(6)(e), WAC 284-43-7040(2) and WAC 284-43-7040(4)]

WAC 284-43-7010 defines a coverage unit as the way in which a plan or issuer groups individuals for purposes of determining benefits, premiums, or contributions. For example, different coverage units could be self-only, family, or employee-plus-spouse.

1. Classifying Benefits

[Note especially WAC 284-43-7020.]

Attest/certify in section III below.

1. All medical/surgical and MHSUD benefits are subject to parity review. Each medical/surgical and MHSUD benefit must be assigned to a benefit classification.
2. Permitted classifications of benefits:
3. Inpatient, In-Network
4. Inpatient, Out-of-Network
5. Outpatient, In-Network

(3a) Outpatient, In-Network – Office Visits

(3b) Outpatient, In-Network – All Other Outpatient

1. Outpatient, Out-of-Network

(4a) Outpatient, Out-of-Network – Office Visits

(4b) Outpatient, Out-of-Network – All Other Outpatient

1. Emergency Care
2. Prescription Drugs

Per WAC 284-43-7020(6)(a), plans and issuers may split outpatient into “office visits” and “all other outpatient items and services.” A particular plan should address (3) **or** both (3a)+(3b), not all three; similarly, a particular plan should address (4) **or** both (4a)+(4b), not all three.

1. When classifying benefits, the same standards must apply to both medical/surgical and MHSUD benefits.

For example, assign covered intermediate MHSUD benefits (e.g., residential treatment, partial hospitalization, and intensive outpatient treatment) in the same way comparable intermediate medical/surgical benefits are assigned. Additionally, if home health care is classified as outpatient, then any covered MHSUD intensive outpatient services and partial hospitalizations must also be classified as outpatient. [WAC 284-43-7020(3)]

1. Financial requirement parity details

[Note especially WAC 284-43-7020, WAC 284-43-7020(4), and WAC 284-43-7040.]

Attest/certify in section III below.

1. Financial requirement parity analysis considers both type and level.
   1. Financial requirement cost share *types* include deductibles, copayments, coinsurance, and out-of-pocket maximums but not aggregate lifetime and annual dollar limits.
   2. A financial requirement cost share *level* is the amount of the financial requirement type. For example, coinsurance levels might include 20% and 25%; copayment levels might include $15 and $20; and deductible levels might include $250 and $500.
2. Financial requirement parity methodology:

Within each benefit classification [WAC 284-43-7020], a plan or issuer may not apply any financial requirement to MHSUD benefits that is more restrictive than the corresponding predominant level applied to medical/surgical benefits.

1. WAC 284-43-7010 indicates that a type of financial requirement is considered to apply to “*substantially all*” medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification as determined by WAC 284-43-7040(2)(a).
2. WAC 284-43-7010 indicates if a type of financial requirement applies to substantially all medical/surgical benefits in a classification, the “*predominant level*” is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement.
3. Review projected plan payments for medical/surgical benefits for the upcoming plan year.

Dollar amounts should be stated as allowed claim amounts (i.e., the amount the plan allows) before enrollee cost sharing because payments based on the allowed amounts cover the full scope of benefits being provided. A reasonable actuarial method must be used to project the dollar amounts. [WAC 284-43-7040(1)(c)]

1. Note that WAC 284-43-7040(1)(d) clarifies how to handle certain plan dollar thresholds.
2. Rate filing documentation of financial requirement parity:

In the rate filing, address the following for each plan, classification, and coverage unit (if applicable).

1. For medical/surgical benefits, show every different cost share type and level. Then, demonstrate what meets the “substantially all” requirements and what qualifies as the “predominant level.”
2. Compare MHSUD benefit cost shares to medical/surgical benefits’ substantially all and predominant level cost shares.
3. As noted under section B above, WAC 284-43-7020(6)(a) allows, but does not require, subclassifications within outpatient – (a) office visits versus (b) all other outpatient items and services.

For each plan, please indicate whether outpatient parity testing was conducted in aggregate (i.e., one outpatient benefit classification) or using the outpatient subclassifications. Provide information and results accordingly.

1. Actuarial memorandum discussion of projected plan dollar amounts:

In the Part III Actuarial Memorandum, please describe how the 2026 annual projected plan and benefit dollar amounts were determined.

Address the following:

1. Describe the underlying claims data source and characteristics as well as any adjustments made. Explain any differences versus the data used to project PY2026 claims and premium rates.
2. Ensure claim amounts reflect what the plan allows before reductions for enrollee cost sharing.
3. How does plan-level data compare to data for the book of business?

The underlying data set will *not* usually be your issuer’s entire projected book of business; additionally, the projections will reflect plan-level assumptions as opposed to product-level assumptions. For example, see the (\*) CMS FAQs listed below.

1. Certify that a reasonable actuarial method was used to project amounts for each plan in accordance with WAC 284-43-7040(1)(c)(ii) and applicable Actuarial Standards of Practice.
2. Provide additional requested data details on the ‘Data Information’ tab in your complementary Excel workbook of MHSUD financial requirement parity calculations.

(\*) CMS/CCIIO ACA FAQ 31; April 20, 2016; Q8. CMS/CCIIO ACA FAQ 34; October 27, 2016; Q3.

1. Cumulative financial requirements

[Note especially WAC 284-43-7040(3).]

Attest/certify in section III below.

A plan or issuer may not apply cumulative financial requirements (e.g., deductibles and out-of-pocket maximums) for MHSUD benefits in a classification that accumulate separately from any cumulative requirement established for medical/surgical benefits in the same classification. Note that cumulative requirements must also satisfy the quantitative parity analysis.

1. Prohibited exclusions

[Note especially WAC 284-43-7080.]

Attest/certify in section III below.

A plan may not exclude MHSUD treatments or services for any of the reasons documented in WAC 284-43-7080.

## Documentation & Attestation

| **General Information** | |
| --- | --- |
| Issuer Name: | <<Enter Issuer Name>> |
| Applicable Market: | <<Enter Market (e.g., Individual or Small Group)>> |
| Plan Year: | 2026 |

1. Please complete and submit one set of MHSUD financial requirement parity certification documents for each rate filing.
   * Certification: PDF version of this certification document.
   * Calculations: Excel file (and its corresponding PDF file) demonstrating financial requirement parity testing results. See below for details.
2. For the calculations, use the OIC-developed Excel template found on our website ([Certification - Rates - 2026 Mental Health and Substance Use Disorder Financial Req Parity Calculations](https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts)).
3. Review instructions on the first worksheet tab.
4. Create and populate a separate detailed worksheet for each plan.
5. After fully populating the Excel file, create a PDF version of the file. In SERFF, submit both the Excel and PDF file formats. Remember the Excel and PDF file contents and file names should exactly match with the only exception being that the Excel file name will end in “DUPLICATE.”
6. Actuarial certification:
   1. Complete the actuarial certification below.
   2. Enter requested information, as needed.
   3. Check attestation boxes, where appropriate, to indicate your agreement.
   4. Then, complete the signature block.
   5. Create a PDF version of the file, and upload the PDF version to SERFF.
7. List below the names of the supporting files:

|  |
| --- |
| <<enter Excel & PDF file name(s)>> |

**Actuarial Certification**

**of MHSUD Financial Requirement Parity**

**for the PY2026 ACA Rate Filing:**

I, <<insert *name of actuary including the actuary’s credentials*>>, certify the following:

I am an employee of <<insert company name>> or

I am a consultant associated with the firm of <<insert name of consulting firm>>;

I am a qualified actuary as outlined in Chapter 284-05 WAC. I am a member of the American Academy of Actuaries, and I am acting within the scope of my training, experience, and qualifications.

Level of review:

I attest to conducting MHSUD financial requirement parity analysis at the appropriate level, as noted below:

Parity review was done separately by plan, for each type of financial requirement and each benefit classification. Parity analysis does not vary by coverage unit because financial requirements do not vary by coverage unit.

Parity review was done separately by plan and coverage unit, for each type of financial requirement and each benefit classification. Parity analysis varies by coverage unit because financial requirements vary by coverage unit.

Benefit classifications:

I attest that all medical/surgical and MHSUD benefits were assigned to benefit classifications.

I attest that the issuer (1) has criteria documented as to how medical/surgical benefits were assigned to each permitted classification and (2) the same standards apply for both medical/surgical and MHSUD benefits.

Upon request, the documentation can be made available to the Washington OIC within 10 business days.

Cost-share accuracy:

For the 2026 plan year, I certify the accuracy of the cost shares for both medical/surgical and MHSUD benefits that are used to evaluate parity of MHSUD financial requirements as loaded into the calculation workbook (*<<insert the name of your MHSUD Financial Requirement Parity Workbook>>*)and as otherwise discussed in this rate filing.

Projected plan dollar amounts:

I attest to the following related to dollar amounts used to test MHSUD financial requirement parity:

Projected dollar amounts are consistent with plan-specific projected allowed amounts used elsewhere in this rate filing, or

Projected dollar amounts differ from plan-specific projected allowed amounts used elsewhere in this rate filing as explained in the Part III actuarial memorandum.

Projected dollar amounts reflect what the plan allows before reductions for enrollee cost sharing.

Plan-level dollar amounts do not reflect aggregate data for the book of business.

A reasonable actuarial method was used to project amounts for each plan in accordance with WAC 284-43-7040(1)(c)(ii) and applicable Actuarial Standards of Practice (ASOPs).

Additional data details are available on the ‘Data Information’ tab in the Excel workbook of MHSUD financial requirement parity calculations.

Financial requirement parity:

I attest to parity between MHSUD benefits and medical/surgical benefits in

Financial requirements as outlined in Chapter 284-43 WAC Subchapter K Mental Health and Substance Use Disorder and

Financial accumulators, such as deductibles and out-of-pocket maximums, by plan and classification. [Note especially WAC 284-43-7040(3).]

Substantially all and predominance:

I certify that each plan submitted in this rate filing meets the “substantially all” and “predominant” / ”predominant level” financial requirement parity testing requirements under MHPAEA and Chapter 284-43 WAC, Subchapter K Mental Health and Substance Use Disorder.

Type: I attest that for each plan, the type of financial requirement imposed upon MHSUD benefits in each classification (or applicable subclassification) applies to at least two-thirds of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification).

Level: I attest that for each plan, the level of financial requirement imposed upon MHSUD benefits in each classification (or applicable subclassification) is no more restrictive than the level of financial requirement imposed upon more than one-half of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification).

I attest that if a single financial requirement did not meet the one-half threshold for a particular plan and classification (or applicable subclassification), then the level of financial requirement imposed upon MHSUD benefits was determined after combining levels until the combination of levels covered more than one-half of projected allowed amounts for medical/surgical benefits within that classification (or applicable subclassification), as described in WAC 284-43-7040(2)(b)(ii) and (iii).

I attest that the above statements are supported by details in the complementary MHSUD financial requirement calculation workbook (cited above) and submitted as part of this rate filing.

Parity across tiers:

* WAC 284-43-7020(5)(a): A plan or issuer must treat the least restrictive level of the financial requirement that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to MHSUD benefits in the same classification.

I certify that this does not apply to any plans in this rate filing. The plans do not use provider tiers, or the financial requirements do not vary by provider tier.

This situation applies to at least one plan in this rate filing, and I certify that the requirements were met. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

* WAC 284-43-7020(5)(b): If a plan or issuer classifies providers into tiers and varies cost-sharing by tier, the criteria for classification must be applied to generalists and specialists providing MHSUD services no more restrictively than such criteria are applied to medical/surgical benefit providers.

I certify that this does not apply to any plans in this rate filing. The plans do not use provider tiers, or the cost-sharing does not vary by provider tier.

This situation applies to at least one plan in this rate filing, and I certify that the requirements were met. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

* WAC 284-43-7020(6)(b): A plan or issuer may divide its benefits furnished on an in-network basis into subclassifications that reflect network tiers if the tiering is based on reasonable factors and without regard to whether a provider is an MHSUD provider or a medical/surgical provider.

I certify that this does not apply to plans in this rate filing. The plans do not use network tiers.

This situation applies to at least one plan in this rate filing, and I certify that the requirements were met. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

* WAC 284-43-7020(6)(c): After network tiers are established, the plan or issuer may not impose any financial requirement on MHSUD benefits in any tier that is more restrictive than the predominant financial requirement that applies to substantially all medical/surgical benefits in that tier.

I certify that this does not apply to any plans in this rate filing. The plans do not use network tiers.

This situation applies to at least one plan in this rate filing, and I certify that the requirements were addressed. See this related file for additional documentation and explanation: *<<enter name of file(s)>>*.

* WAC 284-43-7020(6)(d): If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to MHSUD benefits, the plan satisfies the parity requirements with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

I certify that none of the plans in this rate filing use prohibited prescription drug tiers. Prescription drug tiers are based only on the reasonable factors listed above and without regard to whether a drug is prescribed for medical/surgical or MHSUD benefits.

No prohibited exclusions:

WAC 284-43-7080 (*including rule updates effective January 1, 2022, for gender affirming treatment*): A plan may not exclude MHSUD treatments or services for any of the reasons documented in WAC 284-43-7080.

I certify that none of the plans in this rate filing apply exclusions prohibited by WAC 284-43-7080.

I attest that, to the best of my knowledge, each of the plans otherwise satisfy the requirements under MHPAEA and Chapter 284-43 WAC, Subchapter K.

Actuary’s Name & Designations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Attestation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_