California Department of Insurance
Mental Health Parity Supporting Documentation Instructions

The following provides instructions to the California Department of Insurance's Mental Health Parity Supporting Documentation Template. The template may be downloaded from the Department's website at https://www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/hpab/index.cfm.

Introduction

The California Department of Insurance has provided two templates to assist filers with submitting analyses and complete supporting documentation to demonstrate compliance of health insurance policy forms with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations and guidance. Cal. Ins. Code §§ 10112.27(a)(2)(D) & 10144.4; 42 U.S.C. § 300gg-26; 45 C.F.R. § 146.136.

1. The **Mental Health Parity Analysis Workbook** contains Excel templates for quantitative analyses of cost sharing, as outlined in the Department's 2019 Filing Instructions, Section V, Part B. *Quantitative Analysis*.
2. The **Mental Health Parity Supporting Documentation Template** corresponds with the methodology and NQTL parity requirements of 45 C.F.R. § 146.136(c) and related federal guidance, as outlined in in Section V, Part C. *Explanation of Methodology* and Part F. *Nonquantitative Treatment Limitations*.

These instructions are for the Mental Health Parity Supporting Documentation template. The Mental Health Parity Analysis Workbook and instructions are available on the Department's website.

NOTE: The Supporting Documentation template contains tables and other sections for filers to complete and submit as part of their health insurance policy form filings for plan years 2020 and later. Due to technical limitations, the Department is unable to post the template in SERFF as a Word file. Please download a Word copy of the template from the Department's website at https://www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/hpab/index.cfm.

Please submit **one** completed Supporting Documentation template in each filing. The completed template should reflect only the standards and treatment limitations applicable to the product and plans in that filing.

The Mental Health Parity Supporting Documentation template consists of the following parts. Please complete all sections before submitting the template in your filings:

Part I. Nonquantitative Treatment Limitations
- A. MH/SUD NQTL List

Part II. Explanation of Methodology

Part III. Classification of Benefits
- A. Classification Standards
- B. Benefit Classification Tables

Instructions

Header: Please double-click in the header and provide the insurer name, product name, and state tracking number (or if a state tracking number has not been assigned at the time of submitting this template, the SERFF tracking number) in the upper right corner.

Part I. Nonquantitative Treatment Limitations (NQTLs)

Federal law prohibits a plan from imposing nonquantitative treatment limitations (NQTLs) with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical/ surgical benefits in the classification. § 146.136(c)(4)(i). NQTLs are defined as non-numerical limitations on the scope or duration of benefits covered by a plan, such as medical management standards, preauthorization requirements, formulary design, or step therapy protocols. 45 C.F.R. § 146.136(a); see § 146.136(c)(4)(ii) for an illustrative list.

The Department reviews NQTLs on MH/SUD benefits for compliance with parity requirements under § 146.136(c)(4). Ins. Code §§ 10112.27(a)(2)(D) & 10144.4. The MH/SUD NQTL List worksheet will allow the Department to review the NQTLs for compliance with federal law.

1. MH/SUD NQTL List

- Please list all MH/SUD benefits that are subject to NQTLs as defined in § 146.136(a) and (c)(4)(ii).
- For each listed benefit, describe the applicable NQTLs. If the NQTL requirement is expressed in the policy form(s), please also provide the relevant form(s) and page number(s).
- MH/SUD Benefits should be listed by classification consistent with the assignment of benefits reflected in the Benefit Classification Tables.
- If a plan provides out-of-network coverage, please separately list the MH/SUD NQTLs applicable to in-network **and** out-of-network Inpatient and Outpatient classifications. § 146.136(c)(2)(ii)(A), (c)(4)(i). If the MH/SUD out-of-network coverage imposes the same NQTL requirements in-network and out-of-network for a given classification, you do not need to repeat the NQTL requirements in the out-of-network classification; instead, please refer to the in-network requirements (e.g., "Inpatient OON: Same NQTL requirements as Inpatient in-network.").
- Depending on the information provided, the Department may request additional information regarding the processes, strategies, evidentiary standards, and other factors the insurer uses to determine which benefits will be subject to NQTLs.

Part II. Explanation of Methodology

Please provide an explanation of methodology addressing each of the points outlined in Part II to demonstrate that the quantitative mental health parity analysis was prepared in compliance with the federal rule's methodological requirements. Ins. Code §§ 10112.27(a)(2)(D) & 10144.4; 45 C.F.R. § 146.136(c)(2)-(3). The explanation should address each of the following, in addition to any other relevant factors:

1. A description of the underlying data used to determine the total payments of each benefit in the quantitative analyses, such as the steps, data, and assumptions used to calculate/project expected payments. The description should clearly demonstrate that:

a. the quantitative analysis is based on the total allowed amounts (not limited to the portion paid by the plan), projected for the applicable plan year; 45 C.F.R. § 146.136(c)(3)(i)(C); 78 Fed. Reg. 68,240, 68,243 (Nov. 13, 2013);
b. the quantitative analysis for each classification and sub-classification accounts for all expected payments for all covered medical/surgical benefits under the plan; § 146.136(c)(3)(i)(C); and
c. a "reasonable method" was used to determine the expected payment amounts. § 146.136(c)(3)(i)(E). Please ensure that the data used to project total plan payments for each plan's quantitative analysis complies with the requirements described in recent federal guidance, as follows:

- Basing the analysis on an issuer's entire overall book of business expected or book of business in a specific region or State is not a reasonable method to determine the dollar amount of all plan payments under MHPAEA. ACA FAQ 31, Q8 (Apr. 20, 2016).
- For small group and individual market plans, an issuer must consider "plan"-level (as opposed to the "product"-level) claims data to perform the substantially all and predominant analyses, as such terms are defined in 45 C.F.R. § 144.103, and must rely on such data if it is credible to perform the required projections. ACA FAQ 34, Q3 (Oct. 27, 2106).
- If an actuary who is subject to and meets the qualification standards for the issuance of a statement of actuarial opinion in regard to health plans in the United States, including having the necessary education and experience to provide the actuarial opinion, determines that a group health plan or issuer does not have sufficient data at the plan or product level for a reasonable projection of future claims costs for the substantially all or predominant analyses, the issuer should utilize other reasonable claims data to make a reasonable projection to conduct actuarially-appropriate analyses. Data from other similarly-structured products or plans with similar demographics may be utilized for the analyses if actuarially appropriate. In addition, to the extent possible, the claims data should be customized to reflect the characteristics of the group health plan to which the substantially all and predominant analyses are being applied. As part of using a "reasonable method" to make these projections, plans and issuers should document the assumptions used in choosing a data set and making projections. ACA FAQ 34, Q3 (Oct. 27, 2106).

Accordingly, as part of component (1)(c), please clearly describe the following, in addition to any other relevant information:

i. The source of the claims data used to determine the expected payment amounts for each plan's analysis. Please identify the specific plan(s) or product(s) from which the data was sourced.
ii. The time period of the claims data—e.g., calendar years 2016 and 2017.
iii. What adjustments, if any, were made to the data or payment projections.
iv. ***NOTE:*** If data other than plan-level data was used for each plan's analysis, please submit a separate actuarial certification addressing: (1) the sufficiency and credibility of plan-level and product-level data; and (2) why the substitute dataset used for the analyses is reasonable and actuarially appropriate, including a description of any assumptions used in choosing the data and making projections.

2. A description of the methodology used to perform the quantitative mental health parity analysis of each cost sharing type.

Part III. Classification of Benefits

1. The classifications and sub-classifications of benefits in insurers' mental health parity analyses must comply with the requirements and definitions provided in 45 C.F.R. § 146.136(a), (c)(2)(ii)(A), and (c)(3)(iii)(C). Ins. Code §§ 10112.27(a)(2)(D) & 10144.4. All classifications and sub-classifications should reasonably fit within the meanings and intent of the federal rule. 45 C.F.R. § 146.136(c)(2)(ii)(A), (c)(3)(iii)(C).

2. Classification Standards: For each classification or sub-classification, please describe the insurer's standards for determining which benefits belong in that classification or sub-classification. § 146.136(c)(2)(ii)(A).

3. Benefit Classification Tables:

- The Benefit Classification Tables must reflect at least **all** of the covered benefits identified in the product's policy forms (including the policy/certificate and any schedules of benefits). Other covered services that are not separately identified in the insurer's policy forms may also be listed in the chart if desired or needed for clarity (e.g., to identify any items reflected in the quantitative analysis tables).
- Ensure the labels used for services/benefits in the chart are understandable and reasonably consistent with the terminology used in the product's policy form documents. Avoid acronyms and abbreviations unless they are defined in the first instance. Clear and consistent terminology will facilitate the Department's review of the filing for compliance with mental health parity and reduce the number of objections relating to the mental health parity analysis.
- Add more rows in the table for each classification or sub-classification as needed; delete any unneeded rows.
- We presume insurers use consistent classification standards for in-network (INN) and out-of-network (OON) benefits. Accordingly, please do not provide a separate chart of OON benefit classifications unless specifically requested by the Department.

4. Outpatient Classification and Sub-Classifications:

- If this template is being submitted for a product containing at least one plan that sub-classifies outpatient MH/SUD benefits, please: (1) describe sub-classification standards for the Office Visit sub-classification and All Other Outpatient Items and Services sub-classification; and (2) complete the Benefit Classification at the sub-classification level instead.
- **All Other Outpatient Items & Services Sub-Classification:** In standard plans, the assignment of benefits to the All Other Outpatient Items & Services sub-classification must comply with the requirements of Endnote 15 of the 2020 Patient Centered Benefit Plan Designs (PCBPD) adopted by the Covered California Board on March 14, 2019. Ins. Code § 10112.3. This applies both to mental health and substance use disorder (MH/SUD) benefits, and to corresponding medical/surgical (med/surg) benefits. Ins. Code §§ 10112.27(a)(2)(D) & 10144.4; 45 C.F.R. § 146.136(c)(2)(ii)(A). Endnote 15 provides:

> *Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.*

5. Prescription Drugs Classification: Please note the federal mental health parity regulation's special rule regarding multi-tiered prescription drug benefits. 45 C.F.R. § 146.136(c)(3)(iii)(A). If a product's prescription drug benefit tiers comply with this special rule, please list the appropriate prescription drug benefits under the med/surg column; under the MH/SUD column, indicate separate MH/SUD benefits are inapplicable per § 146.136(c)(3)(iii)(A), and leave the remainder of that column blank for this classification.