California Department of Insurance Updated 4/5/2019

Mental Health Parity Supporting Documentation

NOTE: Instructions for this template are available at <https://www.insurance.ca.gov/0250-insurers/0300-insurers/0100-applications/hpab/index.cfm>.

# Nonquantitative Treatment Limitations

Nonquantitative treatment limitations (NQTLs) on mental health and substance use disorder (MH/SUD) benefits are reviewed for compliance with federal mental health parity requirements. Ins. Code §§ 10112.27(a)(2)(D) & 10144.4; 45 C.F.R. § 146.136(c)(4). Please complete the tables below and submit the requested documentation to enable the Department to determine NQTL parity compliance in each plan. 45 C.F.R. § 146.136(d)(1); Ins. Code § 10123.135(f).

## A. MH/SUD NQTL List

* **Benefit/Service Column:** Please list all MH/SUD benefits in each classification that are subject to NQTLs as defined in § 146.136(a) and (c)(4)(ii).Ensure that the list of benefits is comprehensive and consistent with the policy. In each table, insert additional rows as needed and delete any unnecessary rows.
* **NQTL(s) Column:** For each listed MH/SUD benefit, describe all nonquantitative treatment limitations (e.g., prior authorization, step therapy, continued stay review) that apply to that benefit. Ensure that all applicable NQTLs are listed here.
  + Please only list the applicable NQTLs themselves. Do **not** include an explanation of the insurer’s processes, strategies, evidentiary standards, or other factors used in applying the NQTL (or in the insurer’s decision to impose the NQTL) in this document. The Department will request specific information regarding the insurer’s NQTL processes and factors separately through the form review process.
* **Policy Form/Page No. Column:** Indicate the form and page numbers on which each NQTL appears. If a NQTL is not stated in the policy forms, please write “N/A.”
* **Out-of-Network Tables:** If the product imposes the same NQTL requirements on in-network and out-of-network benefits in a given classification, you do not need to repeat the NQTL list; instead, in the out-of-network table please reference the in-network list and delete any unnecessary blank rows (e.g., “Inpatient OON: NQTL requirements for MH/SUD are identical to Inpatient INN”).

| **Table I.A.1.a. MH/SUD NQTL List: Inpatient, in-network** | | |
| --- | --- | --- |
| **Benefit/Service** | **NQTL(s)** | **Policy Form/Page No.** |
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| **Table I.A.1.b. NQTL List: Inpatient, out-of-network (if applicable)** | | |
| --- | --- | --- |
| **Benefit/Service** | **NQTL(s)** | **Policy Form/Page No.** |
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| **Table I.A.2.a. NQTL List: Outpatient, in-network** | | |
| --- | --- | --- |
| **Benefit/Service** | **NQTL(s)** | **Policy Form/Page No.** |
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| **Table I.A.2.b. NQTL List: Outpatient, out-of-network (if applicable)** | | |
| --- | --- | --- |
| **Benefit/Service** | **NQTL(s)** | **Policy Form/Page No.** |
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| **Table I.A.3. NQTL List: Emergency Care** | | |
| --- | --- | --- |
| **Benefit/Service** | **NQTL(s)** | **Policy Form/Page No.** |
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| **Table I.A.4. NQTL List: Prescription Drugs** | | |
| --- | --- | --- |
| **Benefit/Service** | **NQTL(s)** | **Policy Form/Page No.** |
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# Explanation of Methodology

Please provide an explanation of methodology demonstrating that the quantitative 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)(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:

* 1. 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);
  2. 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
  3. 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*](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf)*, 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 CFR 144.103, and must rely on such data if it is credible to perform the required projections.* [*ACA FAQ 34*](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-part-34_10-26-16_FINAL.PDF)*, 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*](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-part-34_10-26-16_FINAL.PDF)*, Q3 (Oct. 27, 2106).*

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

* + 1. 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.
    2. The time period of the claims data—e.g., calendar years 2016 and 2017.
    3. What adjustments, if any, were made to the data or payment projections.
    4. **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.

[INSERT NARRATIVE EXPLANATION HERE]

# Classification Chart

## A. Classification Standards

Classification standards are the factors and criteria an insurer uses in determining the classification in which a particular benefit belongs. Insurers must apply the same classification standards to medical/surgical and MH/SUD benefits. 45 C.F.R. § 146.136(c)(2)(ii)(A). Please provide the following information to enable the Department to review the classification standards for compliance with federal parity requirements. Ins. Code §§ 10112.27(a)(2)(D) & 10144.4.

| **Table III.A.1. Classification Standards: Inpatient (INN and OON)** |
| --- |
| **Describe the classification standards for the inpatient classification. Please provide specific factors, standards, and criteria used to determine which benefits belong in this classification.** |
| [insert response] |
| **For products with out-of-network coverage: If different classification standards are used for in-network and out-of-network inpatient benefits (other than the network status of the provider), please explain the difference between the in-network and out-of-network standards.** |
| [insert response] |

| **Table III.A.2. Classification and Sub-Classification Standards: Outpatient (INN and OON)** |
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| Note: For standardized plans, the All Other Outpatient sub-classification standards must conform to Endnote 15 of the 2020 PCBPD. § 10112.3. |
| **Describe the classification standards for the outpatient classification. Please provide specific factors, standards, and criteria used to determine which benefits belong in this classification.** |
| [insert response] |
| **If any plans in this product sub-classify outpatient MH/SUD benefits, describe the sub-classification standards for the outpatient office visit sub-classification. Please provide specific factors, standards, and criteria used to determine which benefits belong in this sub-classification.** |
| [insert response] |
| **If any plans in this product sub-classify outpatient MH/SUD benefits, describe the sub-classification standards for the all other outpatient items and services sub-classification. Please provide specific factors, standards, and criteria used to determine which benefits belong in this sub-classification.** |
| [insert response] |
| **For products with out-of-network coverage: If different classification or sub-classification standards are used for in-network and out-of-network outpatient benefits (other than the network status of the provider), please explain the difference between the in-network and out-of-network standards.** |
| [insert response] |

| **Table III.A.3. Classification Standards: Emergency Care** |
| --- |
| **Describe the classification standards for the emergency care classification. Please provide specific factors, standards, and criteria used to determine which benefits belong in this classification.** |
| [insert response] |

| **Table III.A.4. Classification Standards: Prescription Drugs** |
| --- |
| **Describe the classification standards for the prescription drugs classification. Please provide specific factors, standards, and criteria used to determine which benefits belong in this classification.** |
| [insert response] |

## B. Benefit Classification Tables

Please list all covered benefits in each classification/sub-classification. Ins. Code §§ 10112.27(a)(2)(D) & 10144.4; 45 C.F.R. § 146.136(c)(2)(ii)(A). Insert additional rows in each table as needed; please delete any unnecessary rows in each table.

| **Table III.B.1. Benefit Classification Table: Inpatient (INN and OON)** | |
| --- | --- |
| **Medical/Surgical Services** | **Mental Health/Substance Use Disorder Services** |
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| **Table III.B.2(a). Benefit Classification Table: Outpatient (INN and OON)**  If any plans in this product sub-classify outpatient MH/SUD benefits, please omit this table and complete the sub-classification tables I.B.2(b) and (c) instead. | |
| --- | --- |
| **Medical/Surgical Services** | **Mental Health/Substance Use Disorder Services** |
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| **Table III.B.2(b). Benefit Sub-Classification Table: Outpatient Office Visits (INN and OON)**  If no plans in this product sub-classify outpatient MH/SUD benefits, please omit this table and complete the outpatient classification table I.B.2(a) instead. | |
| --- | --- |
| **Medical/Surgical Services** | **Mental Health/Substance Use Disorder Services** |
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| **Table III.B.2(c). Benefit Sub-Classification Table: All Other Outpatient Items and Services(INN and OON)**  If no plans in this product sub-classify outpatient MH/SUD benefits, please omit this table and complete the outpatient classification table I.B.2(a) instead. | |
| --- | --- |
| **Medical/Surgical Services** | **Mental Health/Substance Use Disorder Services** |
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| **Table III.B.3. Benefit Classification Table: Emergency Care** | |
| --- | --- |
| **Medical/Surgical Services** | **Mental Health/Substance Use Disorder Services** |
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| **Table III.B.4. Benefit Classification Table: Prescription Drugs** | |
| --- | --- |
| **Medical/Surgical Services** | **Mental Health/Substance Use Disorder Services** |
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