Due Dates for 2018 Filings

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* Per Guidance 1163:4, insurers are encouraged to submit preliminary rate information on these dates.

I. Overview and New for 2018

- **Discontinuation Notices**: The deadline for submitting discontinuation notices is August 1. Consumers renewing on January 1, 2018 must receive discontinuation notices by October 3, 2017. CIC §§ 10273.4(e), 10273.6(e). Please submit notices in a separate filing and reference the associated form filing on the General Information tab.

- **Prescription Drug Formularies**: Please submit 2018 formularies in your form filing(s) no later than June 1, 2017. Due to A.B. 339, the Department must review 2018 formularies and cannot accept 2017 formularies. If you anticipate having difficulty meeting the submission deadline, please contact Jessica.Ryan@insurance.ca.gov.

- **Summaries of Benefits and Coverage (SBCs)**:
  - Template: Individual market products must use the new SBC template (April 2017 edition) for the 2018 policy year. Small group products continue using the new template.
  - SBC web links: As with last year, please ensure that all SBCs include direct links to associated policy forms, provider directories, drug formularies, and the uniform glossary. 45 C.F.R. § 147.200(a)(2)(i)(J), (K), (L), and (M); for further guidance see 2017 Letter to Issuers in the Federally-facilitated Marketplaces at page 84.

- **SERFF Binders**: Please submit the Network ID Template, Essential Community Providers/Network Adequacy Template, Service Area Template, Plans and Benefits Template, and Prescription Drug Template. The Prescription Drug Template is not required in dental binders.

NOTE
The information in these filing instructions is provided to assist filers in submitting a complete file. No insurer or individual may rely on this information as a defense against disapproval of a policy form or network filing or an enforcement action taken by the Department.
• **Small Group Deductible Limit:** In 2018, the maximum deductible in platinum, gold, and silver plans (including any separate prescription drug deductible) is $2,300 for individual (self-only) coverage and $4,600 for family coverage. CIC § 10112.29.

• **Actuarial Value De Minimis Range:** In the 2018 payment notice, CMS finalized a change to the upper de minimis AV limit for bronze plans that cover at least one non-preventive major service before the deductible or meet the requirements for a HDHP. 45 CFR § 156.140(c). In addition, in the Market Stabilization proposed rule, CMS proposed changing the lower de minimis AV limit for plans at all levels of coverage to -4%. However, state law provides that “[a]ctuarial value shall not vary by more than plus or minus 2 percent.” CIC §§ 10112.295(b)(1), 10112.297(b)(1). Therefore, the AV of 2018 plans may not fall outside of the +/-2% de minimis AV range required by CIC §§ 10112.295 and 10112.297. The Department will provide additional guidance on this topic if state law is changed this year.

• **Plans and Modifications Workbook:** As with last year, this Excel workbook must be submitted on the Supporting Documentation tab in each non-standard filing (include only one product per workbook). **New for this year is that a workbook must be submitted in standard filings if any changes are made to product network type, benefits, limits, or out-of-network cost sharing; or if replacing a standard plan with another standard plan at the same level of coverage.**
  o For existing 2017 plans, please indicate your intentions for each plan in 2018 in the “List of Plans Worksheet” as follows: (a) continue the plan without modification, (b) modify the plan within the parameters of uniform modification of coverage (“UMC”) under 45 C.F.R. § 147.106(e), or (c) discontinue the plan. If there are any modifications to an existing plan, including to cost sharing, benefits, limits, or product network type, please specifically describe each and every modification in the “Plan Modification Worksheet.” Please do not submit incomplete information, as we cannot begin reviewing for UMC until all proposed modifications are identified.

• **Mental Health Parity Analysis Workbook and Supporting Documentation Template:** The compliance documentation requirements for federal mental health parity are described in Section V below. The Department provides two templates to assist filers with submitting complete documentation demonstrating compliance with mental health parity law, and to minimize common issues and deficiencies seen in insurers’ compliance documentation. The first is a Mental Health Parity Analysis Workbook containing Excel templates for the quantitative analysis components outlined in Section V, Part B. *Quantitative Analysis.* The second is a Mental Health Parity Supporting Documentation Template containing Word tables for all other components outlined in Section V, Part C. *Narrative Explanation of Methodology* and Part F. *Nonquantitative Treatment Limitations.* Please fill out the attached workbook and template for each filing according to the instructions and submit them on the Supporting Documentation tab in each form filing. Each workbook should only include analyses for the plans in that filing.

**NOTE:** Please visit the [HPAB Filing Instructions page](#) to download the latest copies of CDI’s form filing workbooks and templates.
II. General Information

- The Department will accept amendments to approved 2017 policies and certificates as long as the amendments are consistent with CIC § 10291.5(b)(1). However, the Department will not accept amendments to existing schedules of benefits. Please submit new schedules of benefits for all plans.

- Please file forms, networks, and rates in separate SERFF filings. Please include cross references to the state tracking number or SERFF tracking number of associated form/network/rate/binder filings on the General Information tab in all filings.

- Each filing should contain a single health insurance product. Please do not submit multiple products (multiple policies/certificates) in the same filing. Please submit all non-standard plans offered under a single product in the same filing. See generally the definitions of “product” and “plan” at 45 C.F.R. § 144.103.

- Please submit standard plans in a separate filing from non-standard plans/products. In non-standard filings, please include a cross reference to the state tracking number of your standard filing.

- Please indicate whether you intend to offer the product on the California Health Benefit Exchange in the “Include Exchange Intentions” field on the General Information tab.

III. Tips for the Review Process

- A form that has been disapproved may not be issued until the Department affirmatively approves (“issue authorized”) the form. CIC § 10291. The prior filing requirement for policy forms was extended from 30 days to 120 days. CIC § 10290 (as amended by Stats. 2015, ch. 691 (A.B. 387), § 3, eff. 1/1/16).

- Standard filings are reviewed before non-standard filings. CIC § 10112.3(e). At the end of the standard filing review process, we will instruct you to make conforming changes to your non-standard forms. Please keep a record of all changes made to the standard forms and make all of the applicable changes to the non-standard forms. We will begin review of non-standard filings after all conforming changes have been made. We will ask you to provide a redline comparison of the standard and non-standard forms for verification. Non-standard filings cannot be approved before standard filings are approved. CIC § 10112.3(e).

- Do not make changes to your forms without requesting and receiving permission from your reviewer. In active filings, we generally prefer that all changes are submitted with a response to a disapproval letter. Your reviewer will authorize exceptions to this policy as appropriate.

- In all resubmissions, you must disclose unsolicited changes (changes that have not been made in response to an objection) and the reason for each change in your response document. Simply redlining the change does not constitute sufficient disclosure.

- Provide substantive responses to objections with page numbers where the requested changes appear. If a requested change is not made, provide a legal justification.

- A statement of variables (SOV) is required if any forms contain bracketed variable text. The statement of variables must contain an index to all brackets in the forms and fully
explain the purpose for the variable text. It must also disclose the text that will be inserted into the brackets or explain under what circumstances the bracketed text will either be included or removed in its entirety. 10 CCR §§ 2213, 2594.6(b), 2594.7(b). Essential health benefits and cost sharing values may not be bracketed. 10 CCR §§ 2594.6(b)(1), 2594.7(b)(1). Please remove all unnecessary or stray brackets from your forms.

- If the Department approved an application (and enrollment form if applicable) for use in a prior year, and you intend to continue using it in 2018, include the form number and state tracking number of the file containing the application on the General Information tab in your 2018 filings. 10 CCR § 2209. Otherwise, please file an application (and enrollment form if applicable) on the Form Schedule tab in your standard filing.

IV. New Legal Requirements

- Standard and Non-Standard Health Insurance Filings: Please ensure your forms reflect required changes due to recently enacted law.
  - CIC § 10112.8 (added by Stats. 2016, ch. 492 (A.B. 72), § 4, operative 7/1/17): Please ensure that A.B. 72 disclosures are incorporated into your 2018 forms. Please redline the language even if the Department approved it in an amendment.
  - CIC § 10123.196(f) (amended by Stats. 2016, ch. 499 (S.B. 999), § 4, effective 1/1/17): Disclose coverage for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an insured by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.
    - Please ensure any quantity limits for contraceptives in prescription drug formularies are revised to comply with subdivision (f)(4).
    - Please also ensure contraceptive coverage and any utilization management restrictions in formularies comply with CIC § 10123.196(b)(1)(A) and (b)(3).
  - CIC § 10133.53 (added by Stats. 2016, ch. 500 (S.B. 1135), § 2, effective 1/1/17): Disclose standards for timely access to care and access to oral interpretation services. Applicable standards are located at 10 CCR §§ 2240.15(b), 2240.16(b), 2538.6(a).

  - Please thoroughly review your schedules of benefits against the 2018 PCBPD, including the endnotes, and make required changes.
• **Exchange Dental Filings**
  
  o The [2018 Dental Benefit Plan Designs](#) were also approved at the March 14 Covered California Board meeting. With the exception of changes to endnote 13, there were no changes to the coinsurance plan designs for 2018.
  
  o CIC § 10133.53 (added by Stats. 2016, ch. 500 (S.B. 1135), § 2, effective 1/1/17): Disclose standards for timely access to care and access to oral interpretation services. Applicable standards are located at 10 CCR §§ 2240.16(b), 2538.6(a).

V. **Mental Health Parity Compliance Documentation**

Cost sharing for mental health and substance use disorder benefits must comply with the quantitative parity requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and its implementing regulations and guidance. CIC § 10112.27(a)(2)(D); 45 C.F.R. § 146.136(c)(2); see 42 U.S.C. § 300gg-26; 78 Fed. Reg. 68,240 (Nov. 13, 2013).

Under MHPAEA, any financial requirement or treatment limitation applied to mental health or substance use disorder (MH/SUD) benefits must not be more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/ surgical benefits in the same classification. 45 C.F.R. § 146.136(c)(2)(i). A plan that provides more generous MH/SUD benefits, such as through lower (or no) cost sharing or less restrictive treatment limitations than for medical/surgical benefits, is compliant with MHPAEA.

To demonstrate compliance with federal parity law, all non-grandfathered individual and small group health insurance form filings should include the following:

1. A quantitative parity analysis, prepared pursuant to the methodology described in § 146.136(c)(3);

2. An explanation of methodology as described below, demonstrating that the quantitative analysis was prepared in compliance with § 146.136(c)(3) and implementing federal guidance; and

3. A list of all MH/SUD benefits subject to nonquantitative treatment limitations (NQTLs), as well as medical necessity criteria and utilization review policies and procedures applicable to the inpatient hospital services described in Part F below. § 146.136(c)(4).

This applies to both standard and non-standard filings. CIC § 10112.27(a)(2)(D).

Please submit all mental health parity analyses and documentation under the Supporting Documentation tab in SERFF.

A. **New for 2018 Filings**

• Updated Mental Health Parity Analysis Workbook and Supporting Documentation Template: The Department has updated the mental health parity templates for plan year 2018. These templates are provided to assist filers with submitting quantitative analyses and other information that sufficiently demonstrate compliance with MHPAEA. The
Mental Health Parity Analysis Workbook consists of Excel worksheets for the quantitative analysis components outlined in Part B below. The Mental Health Parity Supporting Documentation Template consists of Word tables for the components outlined in Parts C and F below. Please carefully review the instructions of each template.

- Data requirements: Please note the data and methodology requirements described in recent federal guidance. ACA FAQ 31, Q8 (Apr. 20, 2016) and ACA FAQ 34, Q3 (Oct. 27, 2016). If the total payment data used in the analysis is not based on plan-specific projected payments, please submit an actuarial certification pursuant to ACA FAQ 34, Q3. The actuarial certification should address: (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.

B. Quantitative Analysis

*Note: This component may be provided using the Excel templates in the Department’s Mental Health Parity Analysis workbook.*

- Quantitative analyses are required for any financial requirements, as defined in § 146.136(a) and (c)(1)(ii), applicable to medical/surgical or MH/SUD benefits in a plan. Please submit analyses in Excel format (.xlsx or .xls). We recommend using the Department’s Mental Health Parity Analysis template to minimize issues during review.

- Please provide a separate analysis for each plan in a filing. The analysis should only pertain to the plans in that filing; it should not include analyses for plans from other filings.

- The analysis should address each type of financial requirement present in the plan for each classification, as described below.

- Analyses should be provided for each classification, as defined in § 146.136(c)(2)(ii)(A), as follows:
  1. Inpatient (in-network)
  2. Outpatient (in-network); for all standard plans, and for any non-standard plans that sub-classify outpatient MH/SUD benefits, please also provide analyses of the outpatient sub-classifications specified in § 146.136(c)(3)(iii)(C):
     - Outpatient office visits
     - All other outpatient items and services
  3. Inpatient (out-of-network)
  4. Outpatient (out-of-network); or, if the plan sub-classifies out-of-network outpatient MH/SUD benefits, analyses of the outpatient sub-classifications.

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1 Quantitative treatment limitations (QTLs) are not applicable in non-grandfathered individual and small group health products because mental health and substance use disorder (MH/SUD) benefits are essential health benefits and the base benchmark plan does not impose any treatment limitations on MH/SUD benefits. CIC § 10112.27(b).

2 Because the 2018 PCBPD sub-classifies outpatient MH/SUD benefits, all standard plans must include analyses at the outpatient sub-classification level. CIC §§10112.3(e), 10112.27(a)(2)(D); 45 C.F.R. § 143.136(c)(2)(3).
5. If a plan imposes different financial requirements for benefits under the following classifications based on whether they are medical/surgical or MH/SUD in nature, the analysis should also address:

- Emergency care
- Prescription drugs (see special rule, § 146.136(c)(3)(iii)(A))

- Please list each covered medical/surgical benefit within each classification (and sub-classification, if applicable), and for each benefit, list the applicable type\(^3\) and level\(^4\) of financial requirement, and the total expected payments\(^5\) for the applicable plan year. Please express total expected payments in absolute values (such as total dollar amounts) instead of relative values (such as a percentage of total spend within a classification).

- Each plan’s quantitative analysis should show the result of the analysis for each financial requirement within each classification (and sub-classification, if applicable) by clearly indicating the following:
  - The percentage (based on total expected payments) of medical/surgical benefits subject to each type of financial requirement.
  - Which type of financial requirement, if any, meets the “substantially all” test. § 146.136(c)(3)(i)(A).
  - For each type of financial requirement that meets the “substantially all” test, what level of financial requirement meets the “predominant” test, and the percentage of medical/surgical benefits subject to that level (among the medical/surgical benefits subject to that type). § 146.136(c)(3)(i)(B).

- **Tips for Quantitative Analyses:** Please keep in mind the following guidelines when preparing your quantitative analyses to minimize or avoid objections pertaining to your analyses:
  - Ensure all covered medical/surgical benefits are included in the quantitative analysis. The quantitative analysis should not include: (1) any MH/SUD benefits; or (2) any benefits that are not covered by the plan.
  - Assign benefits to the correct classification or sub-classification. Avoid overlapping classifications (listing the same or similar benefits in two different categories). All classifications and sub-classifications should reasonably fit within the meanings and intent of the federal rule. § 146.136(c)(2)(i)(A), (c)(3)(iii)(C). For example, outpatient prescription drug benefits should be classified under the Prescription Drugs classification, not in the Outpatient classification or one of its sub-classifications. Similarly, all benefits relating to emergency services, such as emergency room and

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\(^3\) Different “types” of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. § 146.136(c)(1)(ii).

\(^4\) “Level” refers to the magnitude of the type of financial requirement. § 146.136(c)(1)(iii).

\(^5\) The analysis must be “based on the dollar amount of all plan payments for medical/surgical benefits in the classification [and sub-classification, if applicable] expected to be paid under the plan for the plan year.” § 146.136(c)(3)(i)(C). “Plan payments” means the allowed amount under the plan (before enrollee cost sharing); it is not limited to the portion of benefits paid by the plan. 78 Fed. Reg. at 68,243.
emergency ambulance benefits, should be classified in the Emergency Care classifica
tion rather than in the Outpatient classification or sub-classifications.

- Use correct cost sharing in your analytical model. The cost sharing type and level
(amount) reflected for each medical/surgical benefit in your quantitative analysis
must match the cost sharing in the policy forms (or PCBPD in standard plans).
Because the cost sharing type and level for each benefit affects the outcome of the
analysis in each classification, they must be correct in the quantitative analysis.

C. Explanation of Methodology

Note: This component may be provided using Part II (Explanation of Methodology) and
Part III (Classification of Benefits) of the Department’s Mental Health Parity Supporting
Documentation Template.

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

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

  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.

  2. The quantitative analysis for each classification and sub-classification accounts
     for all expected payments (total allowed amounts) for all covered medical/surgical
     benefits under the plan. § 146.136(c)(3)(i)(C).

  3. A “reasonable method” was used to determine the expected payment amounts.
     § 146.136(c)(3)(i)(E).

  4. The data and methodology used in the analyses comply with the requirements
     described in recent federal guidance. ACA FAQ 31, Q8 (Apr. 20, 2016) and ACA
     FAQ 34, Q3 (Oct. 27, 2106). NOTE: If the total payment data used in the
     analysis is not based on plan-specific projected payments, please submit an
     actuarial certification pursuant to ACA FAQ 34, Q3.

- A description of the methodology used to perform the quantitative mental health parity
analysis for each type of financial requirement.

- Classification/sub-classification of benefits:

  o Please describe the standards that were applied in assigning medical/surgical and
    MH/SUD benefits to each classification and, if applicable, sub-classification.
    § 146.136(c)(2)(ii)(A).
o Provide a table showing the classification (and sub-classification, if applicable) to which each covered benefit is assigned. This should be done for all covered medical/surgical and MH/SUD benefits in all classifications, even those which may not raise a parity issue, to demonstrate that the quantitative analyses account for all relevant benefits, and benefits have been classified in a consistent manner. § 146.136(c)(2)(ii)(A); 78 Fed. Reg. at 68,246-68,247.

o Please ensure the sub-classification standards and table are consistent with Endnote 15 of the 2018 PCBPD, as discussed below.

D. MHPAEA Cost Sharing Compliance in Standard Plans

- If an insurer’s quantitative analysis for a standard plan indicates that the PCBPD’s cost sharing for any MH/SUD classification or sub-classification would not be permissible under MHPAEA, the insurer must revise the MH/SUD cost sharing to the extent necessary to achieve compliance with MHPAEA.

- MH/SUD cost sharing in standard plans “may be different but not more than” that specified in the PCBPD. 2018 PCBPD, Endnote 21. Therefore, achieving MHPAEA compliance in a standard plan should not result in higher cost sharing than that specified in the PCBPD. CIC § 10112.3. The PCBPD provides the upper limit for MH/SUD cost sharing in standard plans.

- Example. The PCBPD for the Individual Silver plan provides a $35 copay for “all other outpatient items and services” MH/SUD benefits. An insurer’s analysis indicates that in this plan, 20% coinsurance meets the substantially all and predominance tests in the “all other outpatient items and services” sub-classification. The insurer must revise the cost sharing in the Individual Silver Plan for “all other outpatient items and services” MH/SUD benefits as follows:
  - If insurer can implement a capped coinsurance: 20% coinsurance not to exceed $35
  - If insurer cannot implement a capped coinsurance: No charge

- Sub-classification of outpatient benefits: Endnote 15 of the 2018 PCBPD Endnotes specifies the MH/SUD benefits that must be included in the “all other outpatient items and services” sub-classification. 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.

Endnote 15 has the following implications for quantitative analyses and policy forms:

- In standard plans, the assignment of benefits to the outpatient MH/SUD sub-classifications must conform to Endnote 15. CIC § 10112.3(e).
Insurers must also revise their sub-classification standards for medical/surgical benefits accordingly so that outpatient medical/surgical benefits similar to those in Endnote 15 are also assigned to the “all other outpatient items and services” sub-classification. This ensures that medical/surgical and MH/SUD benefits are sub-classified using the same standards. § 146.136(c)(2)(ii)(A).

The sub-classification of medical/surgical benefits used in the quantitative analysis must conform to points above. § 146.136(c)(2)(ii)(A).

The definition of the “all other outpatient items and services” sub-classification in the policy form (including any summary descriptions in the schedules) for MH/SUD benefits must be revised to conform to Endnote 15. The permissible cost sharing for MH/SUD benefits is determined by the results of the plan’s quantitative analysis in each classification and sub-classification. § 146.136(c)(2)(i), (c)(3). Therefore, policy forms must sub-classify MH/SUD benefits in accordance with the standards used in the quantitative analysis.

E. Other MHPAEA Implications for Health Policy Forms

If a plan sub-classifies outpatient MH/SUD benefits for purposes of its mental health parity analysis pursuant to 45 C.F.R. § 146.136(c)(3)(iii)(C), please ensure your form filing addresses the issues identified below. As the 2018 PCBPD sub-classifies outpatient MH/SUD benefits, this also applies to all standard filings.

- The policy/certificate and the schedule(s) of benefits should state which MH/SUD benefits fall under each outpatient sub-classification to clarify the applicable cost sharing and any other coverage requirements for each covered MH/SUD benefit.
- The SBCs should be revised to reflect cost sharing and other coverage differences for each outpatient MH/SUD sub-classification. This primarily affects the MH/SUD section of the Common Medical Event chart.

F. Nonquantitative Treatment Limitations

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).

The Department is reviewing NQTLs on MH/SUD benefits for compliance with parity requirements under § 146.136(c)(4). CIC § 10112.27(a)(2)(D). 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.
• Please provide the following information concerning NQTLs.  
  Note: This component may be provided using Part I (Nonquantitative Treatment Limitations) in the Mental Health Parity Supporting Documentation Template.
  
  o Please provide a list of all MH/SUD benefits subject to NQTLs, as defined in § 146.136(c)(4). Please group the listed benefits by classification.
  
  o Please list all NQTLs applicable to each listed MH/SUD benefit.
  
  o Please provide the page numbers in the policy/cert where the NQTLs are described, including the list of benefits subject to utilization review procedures and the description of those procedures, as applicable.
  
  o Please submit documentation of the medical necessity criteria and utilization review policies and procedures applicable to the services listed below. § 146.136(d)(1); CIC § 10123.135(f).
    - Top three (3) inpatient in-network hospital medical/surgical services by frequency of request for authorization* in calendar years 2015-2016 at the product level.
    - Top three (3) inpatient in-network mental health services (including both hospital and residential settings of care) by frequency of request for authorization* in calendar years 2015-2016 at the product level.
    - Top three (3) inpatient in-network substance use disorder services (including both hospital and residential settings of care) by frequency of request for authorization* in calendar years 2015-2016 at the product level.

*Frequency of request for authorization means by frequency of requests for prior authorization and/or continued stay/concurrent review for an inpatient service, and not total claims volume.

• Upon review of the information submitted in each filing, the Department may request further information regarding NQTLs, including but not limited to the insurer’s processes, strategies, evidentiary standards, or other factors used in applying any NQTLs to medical/surgical and MH/SUD benefits. CIC § 10112.27(a)(2)(D); 45 C.F.R. § 146.136(c)(4)(i); see also ACA FAQ 31, Q9 (Apr. 20, 2016). Any additional information requests will be communicated to filers during the review process.

VI. Submission Requirements for Standard Health Insurance Filings

Each of the following documents must be submitted.6

• A policy/certificate or an amendment to an approved 2017 policy/certificate.
  
  o If you submit an amendment, please submit the approved 2017 policy/certificate to be amended on the Supporting Documentation tab.

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6 The following forms must be submitted on the Form Schedule tab (unless otherwise instructed in this document): certificate, policy, summary of benefits and coverage (SBC), schedule of benefits, statement of variables, application, and enrollment form. Other requested documents, including redline comparisons, should be submitted on the Supporting Documentation tab.
If you do not submit an amendment, please submit a redline comparison of the 2018 policy/certificate against your approved 2017 standard policy/certificate on the Supporting Documentation tab.

- A schedule of benefits for each plan specifying cost sharing prescribed by the Patient-Centered Benefit Plan Designs for all benefits. 10 CCR §§ 2594.6(a)(1).
- Redlines of the schedules of benefits compared with your approved 2017 standard schedules of benefits.
- A list of all changes, including changes to the forms due to new legal requirements listed in Section IV above, as well as any other changes, with page numbers and explanations of the changes. Cost sharing changes that must be made pursuant to the 2018 PCBPD may be omitted from the list.
- The prescription drug formulary associated with the product. 10 CCR § 2594.4(b)(3).
- Mental health parity compliance documentation as described in Section V above. CIC § 10112.27(a)(2)(D).
- An SOV containing an index to, and fully explaining, all variable text in the forms, as described in Section III above. 10 CCR §§ 2213, 2594.6(b).
- An SBC for each plan. CIC § 10603(a)(2).
- An attestation of compliance with 28 CCR § 1300.67.24. 10 CCR § 2594.4(b)(4).
- A list of plans currently in force identified by form number and state tracking number. CIC §§ 10753.17(a), 10753.05(a).
- A Plans and Modifications Workbook only if there are changes to product network type, benefits, limits, or out-of-network cost sharing; or if replacing a standard plan with another standard plan at the same level of coverage (such as a non-HSA compatible plan with an HSA compatible plan or vice versa).
- For new products/forms only, the 2018 Individual and Small Group Health Policy Component Location List.

VII. Submission Requirements for Non-Standard Health Insurance Filings

Each of the following documents must be submitted:

- If you use the same policy/certificate for the standard filing and the non-standard filing:
  - After the standard filing is approved, submit the approved standard policy, certificate and, if applicable, any amendments on the Supporting Documentation tab in the non-standard filing. The form numbers may remain the same.
- If you do not use the same policy/certificate for the standard filing and the non-standard filing, please make all applicable conforming changes to your non-standard forms after the standard filing is approved.
If you submit an amendment to an approved 2017 non-standard policy/certificate, please submit the approved 2017 policy/certificate to be amended, as well as a redline comparison of the amendment with the amendment approved in your 2018 standard filing, on the Supporting Documentation tab.

If you do not submit an amendment, please submit a redline comparison of the policy/certificate against your approved 2018 standard policy/certificate on the Supporting Documentation tab.

- A schedule of benefits for each plan specifying cost sharing for all benefits. 10 CCR § 2594.6(a)(1).
- Redlines of the schedules of benefits compared with your approved 2017 non-standard schedules of benefits.
- A completed Plans and Modifications Workbook.
- A list of all changes, including changes to the forms due to new legal requirements listed in Section IV above, as well as any other changes, with page numbers and explanations of the changes. You may refer to the Plans and Modifications Workbook for any changes specifically described therein.
- The prescription drug formulary associated with the product. 10 CCR § 2594.4(b)(3).
- Mental health parity compliance documentation as described in Section V above. CIC § 10112.27(a)(2)(D).
- Verification of actuarial value: Depending on compatibility with the AV calculator, submit either legible screenshots of 2018 AV calculator worksheet outputs for each plan or, where any aspect of a plan’s design is incompatible with the AV calculator, an actuarial certification. Actuarial certification is required for all plans that assign different cost sharing to outpatient mental health and substance use disorder office visits and all other outpatient items and services. 10 CCR § 2594.6(a)(2), (c).
- An SOV containing an index to, and fully explaining, all variable text in the forms, as described in Section III above. 10 CCR §§ 2213, 2594.6(b).
- An SBC for each plan. CIC § 10603(a)(2).
- An attestation of compliance with 28 CCR § 1300.67.24. 10 CCR § 2594.4(b)(4).
- For new products/forms only, the 2018 Individual and Small Group Health Policy Component Location List.

VIII. Submission Requirements for Exchange Dental Filings
Each of the following documents must be submitted:

- A policy/certificate or an amendment to an approved 2017 policy/certificate.
  - If you submit an amendment, please submit the approved policy/certificate to be amended on the Supporting Documentation tab.
If you do not submit an amendment, please submit a redline comparison of the 2018 policy/certificate against your approved 2017 policy/certificate on the Supporting Documentation tab.

- A schedule of benefits for each plan specifying cost sharing prescribed by the Dental Benefit Plan Designs for all benefits. 10 CCR §§ 2594.7(a)(1). For coinsurance plans offered in 2017, submission of schedules or an amendment to schedules for 2018 is only necessary if changes must be made due to the revisions to endnote 13. If changes are unnecessary, submit the approved 2017 schedules on the Supporting Documentation tab.

- Redlines of the schedules of benefits compared with your approved 2017 schedules of benefits (only if any changes are made).

- A list of all changes, including changes to the forms due to new legal requirements listed in Section IV above, as well as any other changes, with page numbers and explanations of the changes. Cost sharing changes that must be made pursuant to the 2018 Dental Benefit Plan Designs may be omitted from the list.

- An SOV containing an index to, and fully explaining, all variable text in the forms, as described in Section III above. 10 CCR §§ 2213, 2594.7(b).

- Rate tables or factors pursuant to CIC § 10290 (actuarial memorandum not required).

- A cross-reference to the most recently filed Medical Loss Ratio Annual Report. CIC § 10112.26.

- In individual market filings only, an actuarial attestation that the rates satisfy the lifetime anticipated loss ratio required under 10 CCR § 2222.12(c).