California Department of Insurance
Form Filing Instructions for Plan Year 2027

Non-Grandfathered
Individual and Small Group Health Insurance and Exchange Dental Products

Deadlines for 2027 Filings

Filing Requirement	Deadline
Individual and Small Group Standard Health Insurance Form Filings (on-Exchange only)	May 15, 2026
Individual and Small Group Non-Standard Health Insurance Form Filings (off-Exchange only)	May 29, 2026
Exchange Dental Form Filings and Rate and Loss Ratio Information	May 29, 2026
Prescription Drug Formulary Filing and Prescription Drugs Template	June 26, 2026
Small Group Rate Filings	TBD
Discontinuation Notices	July 24, 2026
Network Filings	June 1, 2026
Provider Directory Policies and Procedures	July 1, 2026

I. Overview and New for 2027

- **PLEASE NOTE: The Plans and Benefits Template, Transparency in Coverage Template, and Prescription Drugs Template are no longer required to be submitted to the Department.**
- **Discontinuation Notices**: The deadline for submitting discontinuation notices is July 24, 2026. Consumers renewing on January 1, 2027 must receive discontinuation notices by October 3, 2026. CIC §§ 10273.4(e), 10273.6(e). Submit notices in a separate filing and reference the associated plan year 2026 and 2027 form filings on the General Information tab.
- **Prescription Drug Benefits**: By June 26, 2026, submit a prescription drug formulary, either currently in effect or with prospective 2027 benefits, in a separate filing from your forms.
- **Summaries of Benefits and Coverage (SBCs) web links**: Please ensure that before submission all SBCs include direct links to a location where the following information will be posted on approval or is currently posted: associated policy forms, provider directory, drug formulary, and the uniform glossary. 45 CFR § 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.
- **Small Group Deductible Limit**: In 2027, the maximum deductible in platinum, gold, and silver plans, including any separate prescription drug deductible, is $3,750 for individual (self-only) coverage and $7,500 for family coverage.[1] 45 CFR § 156.130; CIC § 10112.29. Please note, this represents an approximately 14 percent **increase** from the 2026 maximum deductible of $3,300 for individual coverage and $6,600 for family coverage.
- **Actuarial Value Documentation**: Actuarial value documentation must be submitted for all non-standard plans. A plan that sub-classifies outpatient mental health and substance use disorder

[1] The small group deductible limit was calculated using the premium adjustment percentage in the 2027 PAPI Parameters Guidance dated January 29, 2026 for 2027 Benefit Year (1.8916224814). 45 CFR § 156.130(e).

benefits into office visits and all other items and services is incompatible with the AV calculator (AVC). Submit an actuarial certification addressing all aspects of plan designs that are incompatible with the AVC. 10 CCR § 2594.6(a), (c); 45 CFR § 156.135(b).

- **Plans and Modifications Workbook**: Submit this Excel workbook on the Supporting Documentation tab in each non-standard filing. Include only one product per workbook.
    - A workbook must be submitted in standard filings only 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 (such as a non-HSA compatible plan with an HDHP or vice versa).
    - Please closely follow the instructions for reporting AVs in the List of Plans Worksheet. The AV that must be reported in column D is the AV of the 2026 plan in the 2027 AVC. The result indicates whether modifications to the 2026 plan are necessary to maintain a compliant AV in 2027.
    - For existing 2026 plans, indicate your intentions for each plan in 2027 in the List of Plans Worksheet as follows: (1) continue the plan without modification; (2) modify the plan within the parameters of uniform modification of coverage (UMC) under 45 CFR § 147.106(e); or (3) discontinue the plan. If there are any modifications to an existing plan, including to cost sharing, benefits, limits, or product network type, specifically describe each modification in the Plan Modification Worksheet. Do not submit incomplete information, as review for UMC cannot begin 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 now provides three templates to assist filers with submitting complete documentation demonstrating compliance with mental health parity law, and to minimize common issues and deficiencies identified in insurers' compliance documentation. Fill out the designated workbook and templates 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. The three templates are:
    - Mental Health Parity Analysis Workbook, which consists of Excel templates for the quantitative analysis components outlined in Section V, Part B. *Quantitative Analysis*.
    - Mental Health Parity Supporting Documentation Template, which contains Word tables for all other components outlined in Section V, Part C., *Explanation of Methodology*, and Part F. *Nonquantitative Treatment Limitations*.
    - Nonquantitative Treatment Limitation (NQTL) Comparative Analysis Submission Form, which provides a model for documenting comparative analyses of the design and application of NQTLs, as described in Section V, Part F. *Nonquantitative Treatment Limitations*.
- **Network Filings**: Updated instructions for 2026 network adequacy filings were released separately and posted on SERFF for California LAH.

- **Provider Directory Policies and Procedures**: Filing instructions for the provider directory policies and procedures that must be submitted pursuant to CIC § 10133.15(m)(1) are released separately and will be posted on SERFF for California LAH.
- **Resources**: Visit the SERFF General Instructions page for California LAH to download the latest versions of CDI's form filing workbooks and templates. You may also contact Ethan Lavelle at Ethan.Lavelle@insurance.ca.gov or Christopher Citko at Christopher.Citko@insurance.ca.gov for answers to questions or to obtain workbooks and templates not located in SERFF.

II. General Information

- The Department will accept amendments to approved policies and certificates if the amendments are consistent with CIC § 10291.5(b)(1). However, the Department will not accept amendments to schedules of benefits. Please submit new schedules of benefits for all plans.
- Please submit forms, networks, and rates in separate SERFF filings. Please include cross-references to the state or SERFF tracking number of associated forms, network, and rate filings on the General Information tab in each filing.
- Each filing should contain a single health insurance product. Please do not submit multiple products (multiple policies/certificates) in the same filing. See generally the definitions of "product" and "plan" at 45 CFR § 144.103.
- Please submit standard plans in a separate filing from non-standard plans/products.
- Please submit all non-standard plans offered under a single product in the same filing. In non-standard filings, please cross-reference 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

- Forms may not be issued until they are approved ("issue authorized") or 120 calendar days expire without disapproval. CIC § 10290. A form that has been disapproved may not be issued until the Department affirmatively approves the form. CIC § 10291.
- With some exceptions,[2] standard filings are reviewed before non-standard filings. Please keep a record of all changes made to the standard forms and make all the applicable changes to the non-standard forms at the end of the standard filing review process. We will begin review of non-standard filings after all conforming changes have been made. You must 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.

[2] For example, in non-standard filings, cost sharing, uniform modification of coverage, and actuarial value may be reviewed while the review of standard filings is ongoing.

- Unsolicited changes are changes that have not been made in response to an objection. In all submissions and resubmissions, you must disclose all unsolicited changes, and the reason for each change, in your response document. Simply redlining the change does not constitute sufficient disclosure.
- Provide substantive responses to objections, and include page numbers where the requested changes appear. If a requested change is not made, you must provide an explanation that includes sufficient legal justification for not making the change.
- A statement of variables (SOV) is required if any forms contain bracketed variable text. The SOV 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 between the brackets or explain the circumstances under which 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 variable. 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 the approved form without change for the upcoming plan year, include the form number and state tracking number of the filing containing the application on the General Information tab. 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**: Ensure your forms reflect required changes due to recently enacted laws. Some bills noted below are for informational purposes and do not necessarily require language to be added to forms. However, any preexisting form language that conflicts with a new law must be revised for consistency. Please note this is not a comprehensive list of new legislation that may be applicable. Please note also that additional legislation that takes effect on or before January 1, 2027 may be chaptered after the issuance of these instructions. Each insurer should undertake its own review to ensure its policy forms are compliant with all new legal requirements.
    - CIC § 10123.195 [amended by Stats. 2025, Ch. 136 (A.B. 260), Sec. 19, effective 9/26/2025]: Effective immediately, insurers that cover prescription drugs (directly or indirectly) must cover brand name or generic mifepristone, even if the drug has not been approved by the FDA for abortion.
    - CIC § 10133.641 [amended by Stats. 2025, Ch. 136 (A.B. 260), Sec. 20, effective 9/26/2025]: Effective immediately, insurers may not discriminate against providers, and provider contracts may not contain any term that would result in termination or nonrenewal of the contract or otherwise penalize the provider, for manufacture, transport, distribution, delivery, receipt, acquisition, sale, possession, furnishment, dispensation, repackaging, or storage of brand name or generic mifepristone or any drug used for medication abortion that is lawful under the laws of the state.
    - CIC § 10176.61 [amended by Stats. 2025, Ch. 680 (A.B. 40), Sec. 1, effective 1/1/2026]:
        - Insurers must cover at least one insulin prescription drug in each drug type (as defined in the statute) without step therapy.
        - For policies issued, amended, or renewed on and after January 1, 2027,

insurers may not impose any cost sharing on insulin that exceeds $35 for a 30-day supply. If the policy maintains a drug formulary grouped into tiers, this cost-sharing cap only applies to insulin in Tier 1 and Tier 2. Insurers must include at least one insulin for a given drug type in all forms and concentrations on Tier 1 or Tier 2. If there is no Tier 1 or Tier 2 insulin that is clinically appropriate for an insured, the insurer must limit the cost sharing for a higher tier drug to no more than $35 for a 30-day supply.

- CIC § 10112.27 [amended by Stats. 2025, Ch. 84 (A.B. 224), Sec. 2, effective 1/1/2026]: Commencing January 1, 2027, if approved by the United States Department of Health and Human Services, the following will be included in the state EHB benchmark plan, as specified in the statute:
  - Services to evaluate, diagnose, and treat infertility;
  - Durable medical equipment;
  - An annual hearing exam; and
  - One hearing aid per ear every three years.
- CIC § 10144.51 [amended by Stats. 2025, Ch. 84 (A.B. 951), Sec. 2, effective 1/1/2026; Stats. 2025, Ch. 413 (S.B. 402), Sec. 8.5, effective 1/1/2026]: Insurers may not require an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a rediagnosis (as defined in the statute) to maintain coverage for behavioral health treatment for pervasive developmental disorder or autism. Also, insurers may not discontinue or delay existing treatment while waiting for a rediagnosis to be completed. Utilization review (as defined in the statute) is not prohibited.
- CIC § 10123.2045 [added by Stats. 2025, Ch. 605 (S.B. 41), Sec. 16, effective 1/1/2026]: Insurers may not calculate an insured's cost sharing for a prescription drug at an amount that exceeds the actual rate paid by the insurer for the drug. That means, e.g., if the policy requires an insured to pay a coinsurance calculated as a percentage of an allowed amount, the allowed amount may be no more than the actual amount paid by the insurer. Also, spread pricing is prohibited in contracts between an insurer and a pharmacy benefit manager (PBM), meaning a PBM may not charge an insurer more than the actual amount paid by the PBM to the pharmacist or pharmacy.
- CIC § 10125.2 [amended by Stats. 2025, Ch. 605 (S.B. 41), Sec. 17, effective 1/1/2026]:
  - Contracts between an insurer and a PBM must specify the PBM's responsibilities, including that the PBM must comply with the Insurance Code, and the insurer must monitor the PBM to ensure compliance.
  - Contracts between an insurer and a PBM issued, amended, or renewed on and after January 1, 2027 (or a later date established by the Department of Managed Health Care (DMHC)) must require the PBM to be licensed and in good standing with the DMHC.
- CIC § 10123.146 [added by Stats. 2025, Ch. 219 (S.B. 386), Sec. 2, effective 4/1/2026]: Insurers covering dental services that provide payment directly, or through a contracted vendor, to a dental provider must have a non-fee-based default method of payment, and must obtain a dental provider's affirmative consent to issue payments using a fee-based payment method. Insurer must also remit or associate with each payment the claims and claim details associated with payment.

- **Standard Health Insurance Filings**: The 2027 Patient-Centered Benefit Plan Designs (PCBPD) and endnotes approved by the Covered California Board on April 16, 2026, are available at: https://board.coveredca.com/meetings/2026/april/.

- **Exchange Dental Filings:** The 2027 Dental Benefit Plan Designs approved by the Covered California Board on April 16, 2026 are available at available at the link above.

V. Mental Health Parity Compliance Documentation

Cost sharing for mental health and substance use disorder (MH/SUD) 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) & 10144.4; 45 CFR § 146.136(c)(2); see 42 USC § 300gg-26; 78 Fed. Reg. 68,240 (Nov. 13, 2013). Please note, this includes all benefits for gender-affirming care (e.g., hormone therapy, inpatient and outpatient services, surgical procedures, etc.).

Under MHPAEA, any financial requirement or treatment limitation applied to 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 CFR § 146.136(c)(2)(i). A plan that provides more generous MH/SUD benefits, such as lower cost sharing or less restrictive treatment limitations than 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 45 CFR § 146.136(c)(3);
2. An explanation of methodology as described below, demonstrating that the quantitative analysis was prepared in compliance with 45 CFR § 146.136(c)(3) and implementing federal guidance; and
3. A list of all MH/SUD benefits subject to nonquantitative treatment limitations (NQTLs).

This applies to both standard and non-standard filings. CIC §§ 10112.27(a)(2)(D), 10144.4. Please submit all MHPAEA-related compliance documentation under the Supporting Documentation tab in SERFF.

A. Reminders for Plan Year 2027 Filings

- **Templates**: The Mental Health Parity Analysis Workbook and Mental Health Parity Supporting Documentation Template are unchanged from last year; the Department's Nonquantitative Treatment Limitation (NQTL) Comparative Analysis Submission Form has been updated consistent with the new and revised requirements in 45 CFR §§ 146.136 and 146.137 (this will be provided to insurers if a comparative analysis is requested, as described in Section F on Nonquantitative Treatment Limitations). These templates are provided to assist filers with submitting quantitative analyses, comparative 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**: As a reminder, please note the data and methodology requirements described in 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 45 CFR § 146.136(a)(2) and (c)(1)(ii), applicable to medical/surgical or MH/SUD benefits in a plan.[3] Please submit analyses in Excel format (.xlsx or .xls). We recommend using the Department's Mental Health Parity Analysis Workbook to minimize issues during review.
- Please provide a separate analysis for each plan in a filing. The analyses should only pertain to the plans in that filing; the filing should not include analyses for plans from other filings. If using the Mental Health Parity Analysis Workbook, the filing should include a workbook for each plan.
- 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 45 CFR § 146.136(c)(2)(ii)(A), as follows:
    1. *Inpatient (in-network)*
    2. *Outpatient (in-network)*; for all standard plans,[4] and for any non-standard plans that sub-classify outpatient MH/SUD benefits, please also provide analyses of the outpatient sub-classifications specified in 45 CFR § 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)*; if the plan sub-classifies out-of-network outpatient MH/SUD benefits, also provide analyses of the outpatient sub-classifications.
    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, 45 CFR § 146.136(c)(3)(iii)(A))
- Separately list each covered medical/surgical benefit in each classification and, if applicable, sub-classification. For each benefit, list the applicable type and level of financial requirement,[5] and the

[3] Quantitative treatment limitations (QTLs) are not applicable in non-grandfathered individual and small group health products because MH/SUD benefits are essential health benefits, and the base benchmark plan does not impose any QTLs on MH/SUD benefits. CIC § 10112.27(b). Further, QTLs are impermissible under SB 855.
[4] Because the PCBPD sub-classifies outpatient MH/SUD benefits, all standard plans must include analyses at the outpatient sub-classification level. CIC § 10112.3(e); 45 CFR § 146.136(c)(2)-(3).
[5] Different "types" of financial requirements include deductibles, copayments, and coinsurance; "level" refers to the magnitude of the type of financial requirement. 45 CFR § 146.136(c)(1)(ii), (iii).

total expected payments[6] for the applicable plan year. Express total expected payments in absolute values (such as total dollar amounts) instead of relative values (such as percentage of total spend).

- 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. 45 CFR § 146.136(c)(3)(i)(A).
    - For each type of financial requirement that meets the "substantially all" test, what level meets the "predominance" test, and the percentage of medical/surgical benefits subject to that level (among the medical/surgical benefits subject to that type). 45 CFR § 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, and that benefits are listed separately. 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. 45 CFR § 146.136(c)(2)(ii)(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 emergency ambulance benefits, should be classified in the Emergency Care classification 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 (and 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 as

[6] 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." 45 CFR § 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.

described in 45 CFR § 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 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 insurer), projected for the applicable plan year. 45 CFR § 146.136(c)(3)(i)(C); 78 Fed. Reg. at 68,243.
    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. 45 CFR § 146.136(c)(3)(i)(C).
    3. A "reasonable method" was used to determine the expected payment amounts. 45 CFR § 146.136(c)(3)(i)(E).
    4. The data and methodology used in the analyses comply with the requirements described in 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:
    - Please describe the standards that were applied in assigning medical/surgical and MH/SUD benefits to each classification and, if applicable, each outpatient sub-classification. 45 CFR § 146.136(c)(2)(ii)(A).
    - 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 covered medical/surgical benefits, and benefits have been classified in a consistent manner. 45 CFR § 146.136(c)(2)(ii)(A); 78 Fed. Reg. at 68,246-68,247.
    - In standard plans, please ensure the sub-classification standards and table are consistent with Endnote 15 of the 2027 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 deviate from the PCBPD if necessary to comply with the California Mental Health Parity Act or MHPAEA. 2027 PCBPD, Endnote 21. In that case, cost sharing may be different, but not more than, that specified in the PCBPD. The PCBPD provides the upper limit for MH/SUD cost sharing in standard plans.

- *Example*. The PCBPD for the Individual Silver plan provides a $40 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 $40.
  - If insurer cannot implement a capped coinsurance: No charge.

- **Sub-classification of outpatient benefits**: Endnote 15 of the 2027 PCBPD 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. 45 CFR § 146.136(c)(2)(ii)(A).
  - The sub-classification of medical/surgical benefits used in the quantitative analysis must conform to points above. 45 CFR § 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 insurer's quantitative analysis in each classification and sub-classification. 45 CFR § 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 CFR § 146.136(c)(3)(iii)(C), please ensure your form filing addresses the issues identified below. As the 2027 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 if the insurer fails to meet the requirements of paragraph 45 CFR § 146.136(c)(4)(i) or (iii). 45 CFR § 146.136(c)(4).

- Requirements related to design and application of a nonquantitative treatment limitation (45 CFR § 146.136(c)(4)(i)):
    - 45 CFR § 146.136(c)(4)(i) provides that a plan may not impose a NQTL 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 designing and 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 designing and applying the NQTL with respect to medical/surgical benefits in the classification. 45 CFR § 146.136(c)(4)(i)(A).
    - Also, a plan may not rely upon discriminatory factors or evidentiary standards to design a NQTL to be imposed on MH/SUD benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against MH/SUD benefits as compared to medical/surgical benefits. 45 CFR § 146.136(c)(4)(i)(B). Specifically, insurers may not rely on:
        - Information, evidence, sources, or standards that systematically disfavor access or are specifically designed to disfavor access to MH/SUD benefits as compared to medical/surgical benefits. 45 CFR § 146.136(c)(4)(i)(B)(1).
        - Historical plan data or other historical information from a time when the plan or coverage was not subject to MHPAEA or was not in compliance with MHPAEA (unless the insurer has taken the steps necessary to correct, cure, or supplement the data or information). 45 CFR § 146.136(c)(4)(i)(B)(2).
- Required use of outcomes data (45 CFR § 146.136(c)(4)(iii))
    - 45 CFR § 146.136(c)(4)(iii) requires insurers to collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTLs on relevant outcomes related to access to MH/SUD benefits and medical/surgical benefits and carefully consider the impact as part of the plan's or issuer's evaluation. 45 CFR § 146.136(c)(4)(iii)(A).
    - To the extent the relevant data evaluated suggest that the NQTL contributes to material differences in access to MH/SUD benefits as compared to medical/surgical benefits in a classification, such differences will be considered a strong indicator that the plan or issuer violates MHPAEA. In that case, insurers must take reasonable action to address the material differences to ensure compliance, and must document the actions that

have been or are being taken to address material differences in access to MH/SUD benefits, as compared to medical/surgical benefits. 45 CFR § 146.136(c)(4)(iii)(B).

- See special rule for use of outcomes data for NQTLs related to network composition. 45 CFR § 146.136(c)(4)(iii)(C).

Insurers that impose NQTLs on MH/SUD benefits must perform and document their comparative analyses of the design and application of NQTLs, including:

- The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification;
- The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits;
- The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical or surgical benefits;
- The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and
- The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

Insurers must make these comparative analyses and other information available to the Department upon request. 42 U.S.C.A. § 300gg-26(a)(8)(A); 45 C.F.R. § 146.137; see also ACA FAQ 45 (April 2, 2021).

The Department reviews NQTLs on MH/SUD benefits for compliance with parity requirements under 42 U.S.C.A. § 300gg-26(a)(8)(A) and 45 CFR §§ 146.136(c)(4) and 146.137. CIC §§ 10112.27(a)(2)(D), 10144.4. 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 CFR § 146.136(a)(2); 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.
  - Provide a list of all MH/SUD benefits subject to NQTLs, as defined in 45 CFR § 146.136(a)(2) and (c)(4). Please group the listed benefits by classification.
  - List all NQTLs applicable to each listed MH/SUD benefit.
  - Note the page numbers in the policy/cert where the NQTLs are described, including the list of benefits that are subject to utilization review procedures and the description of those procedures, as applicable.

Upon review of the information submitted in each filing, the Department may request further information regarding NQTLs, including but not limited to a comparative analysis for any NQTLs (*Note: This component may be provided using the Nonquantitative Treatment Limitation (NQTL) Comparative Analysis Submission Form*) or other information related to the insurer's design and application of any NQTLs to medical/surgical and MH/SUD benefits. 45 CFR §§ 146.136(c)(4), 146.137; see also ACA FAQ 31, Q9 (Apr. 20, 2016) and 2020 MHPAEA Self-Compliance Tool, Section F on Nonquantitative Treatment Limitations. Any additional information requests will be communicated to filers during the review process.

Please note that, while the Nonquantitative Treatment Limitation (NQTL) Comparative Analysis Submission Form is based on the updated federal law and guidance, any NQTLs that are imposed in connection with policies issued in California, and the analyses performed with respect thereto, must also be consistent with applicable requirements under state law, including but not limited to:

- The coverage mandate for all medically necessary treatment of MH/SUD (CIC § 10144.5(a)(1));
- All applicable definitions related to MH/SUD, such as the definitions of "mental health and substance use disorders" and "medically necessary treatment of a mental health or substance use disorder," which establish the conditions that are considered MH/SUD, when services must be considered MH/SUD for the purpose of the analysis, and the appropriate medical necessity standard for MH/SUD (CIC § 10144.5(a)(2), (3));
- Requirements related to medical necessity determinations and utilization review for MH/SUD (CIC § 10144.52); and
- Prohibitions on discrimination based on health conditions (e.g., CIC §§ 10140, 10753.05(h)(3) [small group], 10965.5(a)(3) [individual]; 10 CCR § 2594.2(g)(2) [ind/SG]).

NOTE: If the Department determines that an insurer has failed to meet the requirements of 45 CFR § 146.136(c)(4)(i) or (iii) or that the insurer is not in compliance with the requirements of 42 U.S.C.A. § 300gg-26(a)(8) or 45 CFR § 146.137 with respect to a NQTL, the insurer is prohibited from imposing the NQTL with respect to MH/SUD benefits in the relevant classification. 45 CFR § 146.136(c)(4), (c)(4)(v).

If a NQTL is approved for use based on the Department's review of an insurer's comparative analysis, whether submitted using the Nonquantitative Treatment Limitation (NQTL) Comparative Analysis Submission Form or otherwise, the comparative analysis documents will be made publicly available.

VI. Submission Requirements for Standard Health Insurance Filings

Each of the following documents must be submitted:[7]

- A policy/certificate or an amendment to an approved policy/certificate.
    - If you submit an amendment, please submit the approved policy/certificate to be amended and any prior amendments on the Supporting Documentation tab.

[7] 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 2027 policy/certificate against your approved 2026 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 (PCBPD) for all benefits. 10 CCR §§ 2594.6(a)(1).
- Redlines of the schedules of benefits compared with your approved 2026 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 2027 PCBPD may be omitted from the list.
- Mental health parity compliance documentation as described in Section V above. CIC §§ 10112.27(a)(2)(D), 10144.4.
- 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 §§ 10753.05(a), 10753.17(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 HDHP or vice versa).

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 non-standard policy/certificate, please submit the approved policy/certificate to be amended and any prior amendments, as well as a redline comparison of the amendment with the amendment approved in your 2026 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 2026 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 2026 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.
- Mental health parity compliance documentation as described in Section V above. CIC §§ 10112.27(a)(2)(D), 10144.4.
- Verification of actuarial value: Depending on compatibility with the AV calculator, submit either legible screenshots of 2027 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 and any accompanying AV calculator worksheet outputs. An actuarial certification is required for all plans that subclassify outpatient benefits and 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).

VIII. Submission Requirements for Exchange Dental Filings

Each of the following documents must be submitted:

- If it is unnecessary to make changes to forms for 2027, submit the last approved forms on the Supporting Documentation tab.
- Only if changes are necessary for 2027: Submit a policy/certificate or an amendment to an approved policy/certificate.
  - If you submit an amendment, please submit the approved policy/certificate to be amended and any prior amendments on the Supporting Documentation tab.
  - If you do not submit an amendment, please submit a redline comparison of the 2027 policy/certificate against the policy/certificate that was last approved on the Supporting Documentation tab.
- Only if changes are necessary for 2027: 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).
- Only if changes are necessary for 2027: Redlines of the schedules of benefits compared with your last approved schedules of benefits.

- Only if changes are necessary for 2027: 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.
- Only if changes are necessary for 2027: 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. An actuarial memorandum is 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).

NOTE

The Department is providing these instructions to assist insurers in submitting a complete filing and expedite review and authorization. Insurers and individuals are advised to review all applicable legal requirements and may not rely upon this information as legal authority or as a defense against disapproval of a filing or regulatory enforcement by the Department.