

Instructions for the Federal Mental Health Parity and Addiction Equity Act Compliance Filing

Purpose

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) requires that the Department of Managed Health Care verify full service health plan compliance with the MHPAEA and its regulations (45 CFR § 146.136). MHPAEA applies to all full service health plans that offer medical/surgical (M/S) benefits and mental health (MH) and/or substance use disorder (SUD) benefits. *Each full service health plan is responsible for ensuring compliance, whether MH/SUD services are provided directly by the health plan, or are carved out to a behavioral health plan, or delegated to a provider entity.*

General Instructions

The MHPAEA Compliance Filing requires full service health plans offering commercial health plan coverage to submit detailed information on how the financial requirements, quantitative treatment limitations, and nonquantitative treatment limitations in Benefit Plan Designs comply with the MHPAEA. The Department has narrowed the number of Benefit Plan Designs to be analyzed for compliance in 2014 to 15 plan designs; see subsection 2, below. Health plans are required to:

- Complete five (5) tables (Tables 1 through 5) for each of the up to 15 Benefit Plan Designs that the health plan will offer in 2015;
- Complete one (1) List of Exhibits table (Table 6) that lists all the supporting documents for the up to 15 Benefit Plan Designs. Include:
 - Methodologies, evidences of coverage, policies and procedures, and other documents that clarify and support the data recorded in the tables; and
 - An attestation executed by a health plan officer that the analyses of the financial requirements and quantitative treatment limitations in Tables 3 and 4 have been calculated in accordance with the MHPAEA regulations;
- Submit each required table, supporting document, and attestation for the filing as the eFiling exhibit letter/number specified in Table 6; and
- Submit public, redacted versions of any document for which the plan is submitting a confidential, unredacted version of the same document, along with a Request for Confidentiality, as required under California Code of Regulations, title 28, section 1007.

1. DESCRIPTION OF THE TABLES

A. *Tables 1-4:* The tables in the Excel workbook concern financial requirements (FRs) and quantitative treatment limitations (QTLs). They include:

- i) An Index;
- ii) Table 1: FRs-Deductibles;
- iii) Table 2: FR-Out-of-Pocket Maximums;
- iv) Table 3: FR-Copayments/Coinsurance; and
- v) Table 4: QTLs.

The health plan must complete Tables 1-4 within the workbook for each Benefit Plan Design.

B. *Table 5:* This table concerns non-quantitative treatment limitations (NQTLs). Table 5: NQTLs is a Word document. The health plan must complete a separate Table 5 for each Benefit Plan Design *unless* the NQTLs are the same for all the Benefit Plan Designs. See the instructions for Table 5.

C. *Table 6:* This table, List of Exhibits to be Filed and Supporting Documentation, is a single Excel spreadsheet on which the health plan must list all documentation that it is submitting to support Tables 1-5. This documentation includes a written description of the methodology that the health plan used to estimate the annual health plan payment volume¹ for each benefit that has an FR and/or a QTL and how the predominant and significant FR and QTLs were calculated for each of the benefit classifications/subclassifications.

The health plan must submit one Table 6 that contains references to the documentation for all of the Benefit Plan Designs that it submits. Table 6 assigns a unique eFiling exhibit letter/number to each document in the filing.

2. The health plan must submit Tables 1-5 for the following benefit designs, as applicable to the health plan's offering of individual, small group, or large group contracts in 2015.

A. *Individual Plan Coverage (Non-grandfathered)*

Health plans participating in the non-grandfathered individual plan market in 2015 must submit the six (6) standard Benefit Plan Designs listed below—either their on-Exchange standard Benefit Plan Designs or, if not participating in the Exchange, their mirrored off-Exchange standard Benefit Plan Designs. Health plans offering one or more off-Exchange alternative designs in 2015 should also submit one of those alternative designs. If the health plan offers both coinsurance and copay benefit designs, the health plan must include at least one with coinsurance and one with copays among the six (6) standard Benefit Plan

¹ See 45 CFR §146.136(c)(3)(i)(E) for a discussion on determining the dollar amount of plan payments.

Designs they submit. Health plans offering standard Benefit Plan Designs through more than one type of network—HMO, EPO, PPO, or POS—should also ensure that their selection of six (6) standard designs includes all network types that they offer.

- i) Platinum 90 HMO (or PPO, EPO, or POS), Coinsurance or Copay
- ii) Gold 80 HMO (or PPO, EPO, or POS), Coinsurance or Copay
- iii) Silver 70 HMO (or PPO, EPO, or POS), Coinsurance or Copay
- iv) Silver 73 HMO (or PPO, EPO, or POS), Coinsurance or Copay, 200%-250% FPL
- v) Bronze 60 HMO (or PPO, EPO, or POS, but not the HSA)
- vi) Minimum Coverage (Catastrophic)
- vii) The Most Popular Alternative Plan Design—if the health plan will offer alternative designs off-Exchange to individuals in 2015, then it should submit the 2015 design that is the same or the most like the 2014 design that it offered off-Exchange that has the largest number of enrollees. If the health plan is new to offering alternative designs in 2015, it should submit one of those designs.

B. Small Group Coverage (Non-grandfathered)

Health plans participating in the non-grandfathered small group market in 2015 must submit the four (4) standard Benefit Plan Designs listed below (either the on-Exchange Designs or the mirrored off-Exchange Designs), plus one (1) alternative Benefit Plan Design if the health plan will offer one or more alternative designs off-Exchange in 2015. If the health plan offers both coinsurance and copay benefit designs, the health plan must include at least one with coinsurance and one with copays among the four (4) designs it submits. Health plans offering standard Benefit Plan Designs through more than one type of network—HMO, EPO, PPO, or POS—should also ensure that their selection of four (4) standard designs includes all the network types that they offer.

- i) Platinum 90 HMO (or PPO, EPO, or POS) w/ (or w/o) Child Dental, Coinsurance or Copay
- ii) Gold 80 HMO (or PPO, EPO, or POS) w/ (or w/o) Child Dental, Coinsurance or Copay
- iii) Silver 70 HMO (or PPO, EPO, or POS) w/ (or w/o) Child Dental, Coinsurance or Copay
- iv) Bronze 60 HMO (or PPO, EPO, or POS) Plan w (or w/o) Child Dental
- v) Most Popular Alternative Plan Design—if the health plan will offer alternative plan designs off-Exchange to small groups in 2015, then it should submit the 2015 Benefit Plan Design that is the same or the most like the 2014 design that it offered off-Exchange that has the largest number of enrollees. If the health plan is new to offering alternative plan designs in 2015, it should select and submit one of those designs.

C. *Large Group Coverage (Non-grandfathered or Grandfathered)*

- i) Established Health Plan—submit three (3) Benefit Plan Designs that the health plan will offer in 2015 that have the largest numbers of enrollees in 2014, including both non-grandfathered and grandfathered plan(s) that meet this criterion. Health plans offering both HMO and PPO network designs should ensure that the 3 Benefit Plan Designs they submit include both HMO and PPO designs, even if that would mean one of the designs is not among the three (3) with the most enrollees.
- ii) Health Plan that is new to the large group market in 2015—select and submit three (3) differing benefit designs that the health plan will offer; e.g., an HMO copay plan with no deductible, an EPO copay plan with deductible, a PPO coinsurance plan, an HSA-HDHP plan.
- iii) Health plans offering only IHSS or PASC-SEIU coverage – submit the Benefit Plan Design that the health plan will offer in 2015

Financial Requirements and Quantitative Treatment Limitations Excel Workbook—Index and Tables 1 through 4

1. OVERVIEW

This workbook contains 16 spreadsheets. The first spreadsheet is an index to the Benefit Plan Designs to be analyzed in the remaining 15 spreadsheets. The 15 spreadsheets are identical, with each containing Tables 1 through 4. Complete one spreadsheet for each of the applicable Benefit Plan Designs listed in General Instructions, 2, above. Do not renumber or delete any of the spreadsheets. If a spreadsheet is not applicable, mark it as NA.

2. INDEX SPREADSHEET

- A. *Plan Name:* Record the name of the health plan.
- B. *Contact Name:* Record the name of the person to contact if there are questions about the submission.
- C. *Telephone:* Record the telephone number of the contact person.
- D. *E-mail:* Record the e-mail address of the contact person.
- E. *Index Spreadsheet Columns*
 - i) Column B, Benefit Plan Identifier: On lines 9 through 24, record the identifiers (names) of the Benefit Plan Design for each of the spreadsheets the health plan is submitting.
 - ii) Column C, Effective Date: On lines 9 through 24, record the effective dates of the Benefit Plan Design for each of the spreadsheets the health plan is submitting.
 - iii) Columns D through G, Line of Business: On lines 9 through 24, put an X in the applicable Line of Business column.

3. BENEFIT PLAN DESIGN SPREADSHEETS 1-15

A. *Table 1: Financial Requirements—Deductibles*

i) Section A: Indicate whether this Benefit Plan Design has any deductibles.

ii) Section B: Indicate the amount of any deductible.

(1) If there is a single deductible applicable to all benefits, record the deductible amount.

(a) If there are different deductibles for different coverage units (e.g., self-only, family, and employee-plus-spouse) record the deductible amount for each coverage unit.

(b) List the benefits to which the deductible does not apply.

(2) If there are deductibles applicable to specific benefits, such as prescription drugs (or brand-name drugs), pediatric dental benefits, or fertility benefits, in addition to an overall deductible, add rows on the spreadsheet and record all the deductible amounts and the benefits to which they apply.

(a) If there are different deductibles for different coverage units (e.g., self-only, family, and employee-plus-spouse) record the deductible amount for each coverage unit.

(b) List the benefits to which the deductibles do not apply.

iii) Section C. Indicate whether the deductible or deductibles apply to “substantially all” medical/surgical benefits within *each* classification/subclassification. See 45 CFR § 146.136(c)(3)(v)(B) Example 4.

iv) ***Documentation Required***

(1) Submit the Evidence of Coverage (and Cost-Sharing Summary, if separate from EOC) for this Benefit Plan Design that shows the information about the deductible(s). List the name of the document(s) and the pertinent page numbers on Table 6.

(2) Submit a document that describes the methodology the health plan used to determine whether the deductible or deductibles apply to “substantially all” medical/surgical benefits within each classification/subclassification to which the deductible applies. This can be part of the document that describes the methodology that the health plan used to determine whether the “predominant” financial requirement is applicable to “substantially” all medical/surgical benefits in each classification/subclassification in Table 3 below and the methodology that the health plan used to determine the “predominant” quantitative treatment limitation is applicable to “substantially” all medical/surgical benefits in each classification/subclassification in Table 4 below. List the name of the document and the pertinent page numbers on Table 6.

B. *Table 2: Financial Requirements—Out-of-Pocket Maximums*

- i) Section A: Indicate whether this Benefit Plan Design has any out-of-pocket maximums.
- ii) Section B: If an out-of-pocket maximum applies, record the amount.

(1) If there are different out-of-pocket maximums for different coverage units (e.g., self-only, family, and employee-plus-spouse) record the out-of-pocket maximum for each coverage unit.

- iii) Section C: Identify any benefits that are not subject to the out-of-pocket maximum.

iv) **Documentation Required:**

Submit the Evidence of Coverage (and Cost-Sharing Summary, if separate from EOC) for this Benefit Plan Design that shows the out-of-pocket maximum amount(s) and the benefits to which the out-of-pocket maximum amount(s) applies. List the name of the document(s) and the pertinent page numbers on Table 6.

C. *Table 3: Financial Requirements—Copayments and Coinsurance*

In this Table, the health plan must demonstrate that this Benefit Plan Design meets the MHPAEA financial parity requirement for benefit copayments and coinsurance. This Table and Table 4 are also used to evaluate the health plan's classification of benefits.

- i) Classifications/Subclassifications of Benefits

Both medical/surgical and mental health/substance abuse disorder benefits must be listed in the classifications/subclassifications specified in the MHPAEA regulations [45 CFR § 146.136(c)(2)(ii)(A)(1)-(6); (c)(3)(iii)], which are shown below:

(1) Inpatient, In-Network

(2) Inpatient, Out-of-Network

(3) Outpatient, In-Network: Office Visits

(4) Outpatient, In-Network: Other Outpatient Items and Services (the health plan can choose to combine this with (3) Outpatient, In-Network: Office Visits)

(5) Outpatient, Out-of-Network: Office Visits

(6) Outpatient, Out-of-Network: Other Outpatient Items and Services (the plan can choose to combine this with (5) Outpatient, Out-of-Network: Office Visits)

(7) Emergency

(8) Prescription Drugs (the health plan should use only those tiers applicable to each Benefit Plan Design):

- Tier 1
- Tier 2
- Tier 3
- Tier 4

A health plan that has subtiers based on mail order vs. pharmacy pick-up should add these subtiers to the Prescription Drugs portion of Tables 3 and 4. See the example for Table 3 below.

H. Prescription Drugs	List Copayment/Coinsurance for Each Benefit
Tier One: Generic Medications	
Pharmacy Pick-up	
Mail Order	
Tier Two: Preferred Brand Medications	
Pharmacy Pick-up	
Mail Order	
Tier Three: Non-preferred Brand Medications	
Pharmacy Pick-up	
Mail Order	
Tier Four: Specialty Medications	
Pharmacy Pick-up	
Mail Order	

(9) A health plan that has multiple network tiers may subclassify its in-network benefits to reflect that benefit structure. To subclassify, the health plan must duplicate the subtables for in-network benefits, appropriately label the tiers, and then list the covered benefits and the corresponding financial requirements or quantitative treatment limitations.

For example, a POS product that offers benefits through: 1) HMO providers, 2) PPO providers, and 3) out-of-network providers may use the following classifications and subclassifications:

Medical/Surgical	Mental Health/Substance Use Disorders
Inpatient, In-Network – HMO Tier	Inpatient, In-Network – HMO Tier
Inpatient, In-Network – PPO Tier	Inpatient, In-Network – PPO Tier

Inpatient, Out-of-Network	Inpatient, Out-of-Network
Outpatient Office Visits, In-Network – HMO Tier	Outpatient Office Visits, In-Network – HMO Tier
Outpatient Office Visits, In-Network – PPO Tier	Outpatient Office Visits, In-Network – PPO Tier
Outpatient Office Visits, Out-of-Network	Outpatient Office Visits, Out-of-Network
Outpatient Other, In-Network – HMO Tier	Outpatient Other, In-Network – HMO Tier
Outpatient Other, In-Network – PPO Tier	Outpatient Other, In-Network – PPO Tier
Outpatient Other, Out-of-Network	Outpatient Other, Out-of-Network
Emergency Services	Emergency Services
Prescription Drugs	Prescription Drugs

A health plan must include all tiers that are part of the Benefit Design Plan, including those tiers that are overseen by the California Department of Insurance.

If the health plan has an uneven number of tiers between medical/surgical and mental health/substance use disorder benefits (e.g., three medical/surgical tiers and two mental health/substance use disorder tiers), the health plan may satisfy MHPAEA requirements by complying with federal guidance provided at 78 Fed.Reg. 68243.

- ii) Where to Classify Benefits: 45 CFR § 146.136(c)(2)(ii)(A) states “If a plan (or health insurance coverage) provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits.”
- iii) Intermediate Services: The Preamble to the final MHPAEA regulations states “This general rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must assign covered intermediate mental health and substance use disorder benefits to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance

use disorder services and partial hospitalization must be considered outpatient benefits as well.” [78 Fed. Reg. 68247 (Nov. 13, 2013)]

- iv) A suggested list of benefits to be listed on Table 3, if available under the Benefit Plan Design, is shown below. For Benefit Plan Designs requiring compliance with essential health benefits (EHB), note that pediatric dental and pediatric vision benefits are included in the list below as medical/surgical benefits. Also note that this list is provided as an example and is not intended to suggest how plans choose to categorize their benefits within the six MHPAEA benefits classifications.

Suggested Benefits for Table 3		
Primary care or non-specialist practitioner visit	Home health care	SUD outpatient services
Specialist visit	Outpatient habilitation services	SUD individual and group evaluation
Preventive care/screening/immunization	Outpatient rehabilitation services	SUD individual and group treatment
Laboratory tests	Skilled nursing care	SUD individual and group chemical dependency counseling
X-rays and diagnostic imaging	Durable medical equipment	SUD day treatment programs
Imaging (CT/PET scans, MRIs)	Hospice services	SUD intensive outpatient programs
Pharmacy (list tiers with brief description)	MH inpatient psychiatric hospitalization	SUD medication treatment for withdrawal
Outpatient surgery facility services	MH outpatient services	SUD inpatient detoxification
Outpatient surgery physician/surgeon services	MH individual and group evaluation	SUD transitional residential recovery services in a non-medical residential recovery setting
Emergency room services	MH individual and group treatment	Child eye care: Eye exam

Suggested Benefits for Table 3		
Emergency medical transportation	MH psychological testing	Child eye care: One pair glasses per year or contact lenses in lieu of glasses.
Urgent care	MH outpatient monitoring of drug therapy	Child dental care: diagnostic and preventive services (oral exam, preventive cleaning, preventive x-rays, sealants per tooth, topical fluoride application, space maintainers-fixed)
Hospital inpatient facility services	MH partial hospitalization	Child dental care: Child orthodontics – when medically necessary
Hospital inpatient physician/surgeon services	MH psychiatric observation	Child dental care: Amalgam fill-one surface
Preconception visits and prenatal care	MH crisis residential program	Child dental care: Root canal-molar
Maternity and newborn hospital services	MH multidisciplinary treatment in an intensive outpatient psychiatric treatment program	Child dental care: Gingivectomy per quad
Labor and delivery professional services	SUD inpatient services	Child dental care: Extraction—single tooth exposed root or complete bony
		Child dental care: Porcelain with metal crown

v) Table 3, Columns A and B

On each line in each classification/subclassification, record the Benefit Plan Design medical/surgical benefits for that classification/subclassification in Column A and the related copayment or coinsurance for that benefit in Column B. If there is no copayment or coinsurance, record “0.”

vi) Table 3, Column C

For each classification/subclassification, except the Prescription Drugs classification, calculate the “predominant” financial requirement applicable to “substantially all” the medical/surgical benefits in the classification/subclassification according to the directions in 45 CFR §146.136(c)(3) and record the result in Column C.

Prescription Drugs. The federal regulations contain a special rule for multi-tiered prescription drug benefits. If the health plan imposes different levels of financial requirements on different tiers of prescription drugs based on reasonable factors (such as cost, efficacy, generic vs. brand, and mail order vs. pharmacy pick-up), without regard to whether a drug is generally prescribed for medical/surgical or mental health/substance use disorder benefits, then the health plan satisfies the requirements of 45 U.S.C. § 146.136(c). The health plan should list all applicable copayment or coinsurance requirements for each prescription drug tier on separate lines in columns A, B, D, and E.

vii) Table 3, Columns D and E

- (1) On each line in each classification/subclassification, record the Benefit Plan Design mental health/substance use disorder benefits for that classification/subclassification in Column D and the related copayment or coinsurance for that benefit in Column E. If there is no copayment or coinsurance, record “0.”
- (2) If there are analogous medical/surgical and mental health/substance use disorder benefits, such as inpatient hospital services, list those benefits in the same row in their respective columns.

Prescription Drugs. The federal regulations contain a special rule for multi-tiered prescription drug benefits. If the health plan imposes different levels of financial requirements on different tiers of prescription drugs based on reasonable factors (such as cost, efficacy, generic vs. brand, and mail order vs. pharmacy pick-up), without regard to whether a drug is generally prescribed for medical/surgical or mental health/substance use disorder benefits, then the health plan satisfies the requirements of 45 U.S.C. § 146.136(c). The health plan should list all applicable copayment or coinsurance requirements for each prescription drug tier on separate lines columns A, B, D, and E.

viii) ***Documentation Required***

- (1) Submit the Evidence of Coverage (and Cost-Sharing Summary, if separate from EOC) for this Benefit Plan Design that shows the medical/surgical benefits and related copayments and coinsurance and the mental health/substance use disorder benefits and related copayments and coinsurance. List the name of the document(s) and the pertinent page numbers on Table 6.
- (2) Submit a document that describes the logic that the health plan used to assign benefits to the classifications in Table 3. Include the discussion of the assignment of all of the “intermediate” mental health/substance use disorder services in this

Benefit Plan Design. List the name of the document and the pertinent page numbers on Table 6.

- (3) Submit a document that describes the methodology the health plan used to determine the “predominant” coinsurance or copayments applicable to “substantially all” medical/surgical benefits within each classification/subclassification.

The description of methodology requested in subsection 3, above, can be part of the document that describes the methodology that the health plan used to determine that the deductible or deductibles apply to “substantially all” medical/surgical benefits within each classification/subclassification to which the deductible applies for Table 1 above. List the name of the document and the pertinent page numbers on Table 6.

D. Table 4: Quantitative Treatment Limitations

In this Table, the health plan must demonstrate that this Benefit Plan Design meets the MHPAEA quantitative treatment limits (QTLs) requirements, including, but not limited to, annual, episode, and lifetime day and visit limits.

- i) Table 4, Column A

Copy the benefits listed in Table 3, Column A to Table 4, Column A.

- ii) Table 4, Column B

Record the QTLs associated with each benefit listed in Table 4, Column A. If there are no QTLs associated with a benefit, record “0.”

- iii) Table 4, Column C

For each classification/subclassification, except the Prescription Drugs classification, calculate the “predominant” quantitative treatment limitation applicable to “substantially all” the medical/surgical benefits in the classification/subclassification according to the directions in 45 CFR § 146.136(c)(3) and record the result in Column C.

- iv) Table 4, Column D

Copy the benefits listed in Table 3, Column D to Table 4, Column D.

- v) Table 4, Column E

Record the quantitative treatment limitation(s) associated with each benefit listed in Table 4, Column D. If there are no quantitative treatment limitations associated with a benefit, record “0.”

Prescription Drugs. The federal regulations contain a special rule for multi-tiered prescription drug benefits. If the health plan imposes different levels of financial

requirements on different tiers of prescription drugs based on reasonable factors (such as cost, efficacy, generic vs. brand, and mail order vs. pharmacy pick-up), without regard to whether a drug is generally prescribed for medical/surgical or mental health/substance use disorder benefits, then the health plan satisfies the requirements of 45 U.S.C. § 146.136(c). The health plan should list all applicable quantitative limitations on prescription drug benefits (e.g., quantity or refill limitations) for each prescription drug tier on separate lines in columns A, B, D, and E.

vi) **Documentation Required**

- (1) Submit the Evidence of Coverage (and Cost-Sharing Summary, if separate from EOC) for this Benefit Plan Design that shows the medical/surgical benefits and related QTLs and the mental health/substance use disorder benefits and QTLs. List the name of the document and the pertinent page numbers on Table 6.
- (2) Submit a document that describes the methodology the health plan used to determine the “predominant” QTLs applicable to “substantially all” medical/surgical benefits within each classification/subclassification.

This can be part of a document that describes the methodology that the health plan used to determine that the deductible or deductibles and the copayments and coinsurance apply to “substantially all” medical/surgical benefits within each classification/subclassification to which the deductible applies for Tables 1 and 3 above. List the name of the document and the pertinent page numbers on Table 6.

Non-Quantitative Treatment Limitations—Table 5

1. OVERVIEW

- A. As required by 45 CFR § 146.136(c)(4), the health plan must ensure parity between non-quantitative treatment limitations (NQTLs) applied to medical/surgical benefits and mental health/substance use disorder benefits. Table 5 is a Word document that identifies a list of frequently utilized methods for controlling access, duration and intensity of services for benefits in each of the classifications in a health plan’s Benefit Plan Design. This is not an all-inclusive list and the health plan must list any other NQTLs that are relevant to each of the Benefit Plan Designs.
- B. Responses must describe all the NQTLs used by the health plan and the contracted entities to which the health plan delegates the management of mental health and substance abuse disorder benefits, including, but not limited to, behavioral health plan(s), medical groups and behavioral health groups, if applicable.

Documentation must include both the health plan’s policies and procedures related to NQTLs and those of its behavioral health delegates.

Note: For this initial submission, the Department is requiring the health plan to submit NQTL information in Table 5 and supporting documentation for the health plan’s NQTL policies, procedures, processes, evidentiary standards, etc., and those of its behavioral

health delegates. The Department is not requiring the health plan to submit the NQTL policies, procedures, processes, evidentiary standards, etc., of its medical/surgical delegates. Nonetheless, the health plan remains responsible for assuring that its delegates' policies, procedures and processes maintain parity between the provision of medical/surgical benefits and the provision of mental health/substance use disorder benefits.

- C. Complete one Table 5 for each Benefit Plan Design listed on the Index spreadsheet in the Excel workbook containing the Index and Tables 1-4.
- D. Note: If all the **Medical/Surgical NQTLs and Mental Health/Substance Use Disorder NQTLs** are the same for a product line (e.g., HMO, EPO, POS, PPO,), the health plan may submit one Table 5 for each product line and an attestation that all NQTLs are the same for all Plan Benefit Designs in that product line. If the NQTLs are the same for all product lines, the health plan may submit one Table 5.

2. PLAN INFORMATION

- A. *Plan Name:* Record the name of the health plan.
- B. *Date:* Record the date that Table 5 was completed.
- C. *Contact Name:* Record the name of the person to contact if there are questions about the submission.
- D. *Telephone:* Record the telephone number of the contact person.
- E. *E-mail:* Record the e-mail address of the contact person.
- F. *Line of Business:* Indicate whether this Benefit Plan Design is for an HMO, EPO, POS, or PPO product.
- G. *Contract Type:* Indicate whether this Benefit Plan Design is for a large group, a small group, or individual plan contract.
- H. *Benefit Plan Design Effective Date:* Record the effective date of this Benefit Plan Design
- I. *Benefit Plan Design Identifier:* Record the Benefit Plan Design identifier (name) that was listed on the Index spreadsheet for this Benefit Plan Design. If submitting one Table 5 for each product line, list all the Benefit Plan Design identifiers to which the Table 5 applies.
- J. *Document Header:* Record the following:
 - i) The Plan Name;
 - ii) The Benefit Plan Design Identifier; and
 - iii) The Benefit Plan Design Effective Date

3. NQTL TABLE

A. Columns:

i) *Medical/Surgical Benefits*

In this column summarize the health plan's and any delegated entity's/entities' NQTLs for medical/surgical benefits that are applicable to the topic listed in the Area column. Include any variations by benefit.

ii) *Mental Health/Substance Use Disorder Benefits*

In this column summarize the health plan's and any delegated entity's (including contracted behavioral health plan's) NQTLs for mental health/substance use disorder benefits that are applicable to the topic listed in the Area column. Include any variations by benefit.

iii) *Explanation*

In this column describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). This description can be provided in a separate written document that is submitted as an exhibit that is listed on Table 6.

iv) *Documentation Required*

Provide the relevant pages of the documents in which the NQTLs are described and list this documentation on Table 6. This should include, but is not limited to, relevant pages of the Evidence of Coverage, utilization management, care management, and care coordination policies and procedures, utilization management guidelines.

List of Exhibits to be Filed and Supporting Documentation—Table 6

1. OVERVIEW

- A. Because the MHPAEA compliance filings will include many documents, health plans should label each document with the exact Exhibit J letters and numbers assigned to that document on Table 6.
- B. Submit the Excel workbook containing the Index and the spreadsheets containing Tables 1-4 for each Benefit Plan Design submitted as an Exhibit J-11-A.
- C. Submit Table 5 for each Benefit Plan Design submitted in Exhibit J-11-A as the first attachment (i.e.; J-11 Att. 1-a; J-11 Att. 2-a; J-11 Att. 3-a, etc.)
- D. The first supporting document for each Benefit Plan Design (i.e., J-11 Att. 1-b; J-11 Att. 2-b; J-11 Att.3-b, etc.) must be a description of the methodology used to calculate the "predominant" financial requirement and quantitative treatment limitations applicable to "substantially all" medical/surgical benefits in each classification/subclassification on Tables 1, 3 and 4, as required by 45 CFR § 146.136(c)(2). The description must include the

methodology used to estimate annual health plan payments for each of the deductibles in Table 1 and the benefits that have financial requirements in Table 3 and QTLs in Table 4. It must also describe how the health plan determined the financial requirements and quantitative treatment limitations that were applicable to substantially all medical/surgical benefits and how it determined the predominant financial requirement and QTL.

- E. The second supporting document for each Benefit Plan Design (i.e., J-11 Att. 1-c; J-11 Att. 2-c; J-11 Att.3-c) is the proposed 2015 Evidence of Coverage for the Benefit Plan Design.

The health plan must submit the entire Evidence of Coverage (and Cost-Sharing Summary, if separate from EOC) applicable to each of the Benefit Plan Designs. For other documents, such as policies, procedures, utilization management guidelines, etc., the health plan can submit the relevant pages, rather than the whole document, together with a cover sheet listing the relevant pages and the name of the source document.

- F. Health plans should skip (not use) an Exhibit J letter/number if it is assigned to a document for a Benefit Plan Design that the health plan will not offer in 2015, and, therefore, is not included in the filing. For example, health plans that offer only group coverage will not submit any documents as Exhibits J-11 Att. 1, J-11 Att. 2, J-11 Att. 3, J-11 Att. 4, J-11 Att. 5, J-11 Att. 6, or J-11 Att. 7, because those exhibit letters/numbers are assigned to individual Benefit Plan Designs.
- G. Do not submit more than one copy of a supporting document that pertains to more than one Benefit Plan Design. For example, if the Utilization Management, Care Coordination Policies and Procedures submitted as Exhibit J-11 Att. 1-e for Benefit Plan Design #1 Individual Platinum 90 HMO also applies to all individual Benefit Plan Designs (i.e., Benefit Plan Designs #2 through #7) describe the document and pertinent pages once for J-11 Att. 1-e. For Benefit Plan Designs #2 through #7 record "See Benefit Plan Design #1, J-11 Att. 1-e."
- H. Include a comprehensive list of all exhibits submitted in the compliance filing by exhibit letter/number and by name within Exhibit E-1.
- I. When submitting an electronic (Adobe PDF) version of a printed document, reference the Adobe PDF page numbers, not the page numbers in the printed document.

2. PLAN INFORMATION

- A. *Plan Name:* Record the name of the health plan.
- B. *Date Submitted:* Record the date Table 6 is submitted.
- C. *Contact Name:* Record the name of the person to contact if there are questions about the submission.
- D. *Telephone:* Record the telephone number of the contact person.
- E. *E-mail:* Record the e-mail address of the contact person.

3. LIST OF EXHIBITS FILED AND SUPPORTING DOCUMENTATION

A. Columns

- i) *Benefit Plan Design*: Complete the rows only for those Benefit Plan Designs for which the health plan completed Tables 1-5. Record NA for Benefit Plan Designs that are not applicable. Do not renumber the Benefit Plan Designs.
- ii) *Documents to be Filed*: Label all the documents supporting the information in Tables 1-5 as indicated; e.g., for health plans submitting information for 15 Benefit Plan Designs, the EOCs are labeled J-11 Att. 1-c through J-11 Att. 15-c.
- iii) *Document Name(s) and Applicable Pages*: List the name of the document and the relevant page numbers if only part of the document is applicable. Add rows as needed for additional documents and continue the numbering scheme. For example, the next exhibit number for Benefit Plan Design #1 would be J-11 Att. 1-g.

Attestation to Compliance with 45 CFR § 146.136 in Calculating the Financial Requirements and the Quantitative Treatment Limitations

1. File an Exhibit J-12 that contains a signed and dated attestation from a health plan officer attesting to the health plan's compliance with the requirements of 45 CFR § 146.136 when calculating the financial requirements and quantitative treatment limitations reported in the health plan's MHPAEA Compliance Filing worksheets.
2. If applicable, include a signed and dated attestation from a health plan officer attesting that the non-quantitative treatment limitation documentation listed on Table 5 and Table 6 as applying to all Benefit Plan Designs within a product line is accurate.