QTL/Financial Requirement Template Instructions

The information requested in this template will assist in determining a plan's[1] compliance with benefit classification requirements and Quantitative Treatment Limitation and Financial Requirement (QTL) testing outcomes required under the Mental Health Parity and Addiction Equity Act (MHPAEA). As an initial step, identification of all covered services, both medical/surgical and MH/SUD, is critical for complete QTL and Nonquantitative Treatment Limitation (NQTL) analyses. Classification of covered services must remain consistent across both types of analysis, thus must be established at the outset.

The level of detail included in this template supplements the Data Collection Tool for Mental Health Parity Analysis found in Chapter 24B of the *2020 Market Regulation Handbook*.

Covered Services Tab

Step 1. Provide the requested Company Name, Plan Name/ID, Plan Year, and Coverage Type (i.e., HMO, PPO, EPO, POS, etc.), and select the appropriate dropdown box (large group, small group, or individual) for the Plan Market information.

Cell	Notes on Response
C2	Company Name
C3	Plan Name/ID (e.g., HIOS #)
C4	Plan Year
E4	Select from Dropdown (Small, Large, Individual)
F4	Provide Coverage type

Step 2. Answer the following questions by selecting either Yes or No in the appropriate dropdown box:

- **Are outpatient services sub-classified into "office visit" and "other"?**
  - This question must be answered in order to populate the classification cells in column E. Answering yes will populate a drop-down menu with subclassification options; answering no will populate a drop-down menu with the six listed classifications.
- **Is there a tiered network?** If Yes, continue to the next question. If no, move to Step 3.
- **If yes, please select the number of tiers:** Select the appropriate number of tiers from the dropdown box.
  - **NOTE: "Tiered network" refers to multiple levels of tiering with respect to contracted providers. Out-of-network is not considered a tier.**
- **NOTE: This template does not automatically separate multiple networks for purposes of analysis.**
  - **Any covered services that allow for use of multiple provider tiers should be separated out into separate rows and each tier identified (see example below).**
  - **If the company chose to subclassify based on networks (pursuant to 45 C.F.R. §146.136(c)(3)(iii)(B)), the analysis will have to be completed manually as described below.**

[1] Note that an issuer must perform this analysis separately for each plan within a product, as those terms are defined in 45 CFR §144.103.

Cell	Notes on Response
E6	Select from Dropdown: Yes or No regarding outpatient sub-classification
E7	Select from Dropdown: Yes or No regarding tiering
E8	If Yes above, select number of tiers (excluding out-of-network)

Step 3. List all Covered Services in Column B

Cell	Notes on Response
Beginning with B10	List all Covered Services

- All services included in Certificates of Coverage and Schedules of Benefits should be identifiable in the list of covered services.
- Covered services should have their own row based on classification, network (in and out, as well as tiering if applicable), cost-sharing type, applicable FR or QTL (i.e., cost sharing and visit or day limits), and FR or QTL level.
- Covered services that match in benefit type (MH/SUD or Med/Surg), classification/sub-classification, FR type and level, and QTL type and level can be rolled into a single line.

Example 1 - Network: Include a separate covered service row for services that are covered in- network and out-of-network, e.g., one row for PCP office visit-in network, and a separate row for PCP office visit-out of network.

Covered Services	Medical/Surgical or MH/SUD	Expected Claim Dollar Amount	Classification
PCP Office Visit, In-network	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
Specialist Office Visit, In-network	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
PCP Office Visit, Out-of-network	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office
Specialist Office Visit, Out-of-network	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office

Example 2 - Network: Services should be separated by tier when there is more than one network tier, e.g., preferred specialist on one row, non-preferred specialist in a separate row. (See Ch.24B, Q6 (p. 819) re: NQTL considerations for network tiering).

Covered Services	Medical/Surgical or MH/SUD	Expected Claim Dollar Amount	Classification
PCP Office Visit, Preferred Tier	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
PCP Office Visit, Non-preferred Tier	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
PCP Office Visit, Out-of-network	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office

Example 3 - Cost-Sharing: Include a separate covered service line for services that have different cost sharing that is dependent upon site of service or diagnostic vs. preventive. For example, CDC-recommended immunizations are $0 cost-sharing but may be provided in a PCP's office or at a pharmacy, while other immunizations (e.g., for travel) may be provided by a PCP but may have cost-sharing applied. Each instance would need to have its own row for reporting covered services.

Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification
Immunizations - ACA preventive - PCP office	Med/Surg	$xx,xxx,xxx	OutPt, IN-Office
Immunizations - non-ACA preventive - PCP office	Med/Surg	$xx,xxx,xxx	OutPt, IN-Office
Immunizations - ACA preventive - non-PCP	Med/Surg	$xx,xxx,xxx	OutPt, IN-Other

Example 4 - Classification: For purposes of MHPAEA analysis, classification of benefits as MH/SUD or Med/Surg, and any corresponding limitations, should be based on the underlying diagnosis, regardless of site of service or the system through which claims are processed. For example, occupational therapy may be appropriate for both medical/surgical and MH/SUD diagnoses, and processed through a medical claims system. For purposes of the analysis, however, the occupational therapy claims processed for underlying medical/surgical diagnoses should be classified as medical/surgical and occupational therapy processed for underlying MH/SUD (e.g., ADHD, Autism, as defined in product information) should be classified as MH/SUD.

Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification
Occupational Therapy - office	Med/Surg	$xxx,xxx,xxx	OutPt, IN-Office
Occupational Therapy - ADHD office	MH/SUD		OutPt, IN-Office
Occupational Therapy - ASD office	MH/SUD		OutPt, IN-Office
Occupational Therapy - ASD community	MH/SUD		OutPt, IN-Other

and

Covered Services	Medical/Surgical or MH/SUD	Expected Claim Dollar Amount	Classification
Speech therapy, ASD	MH/SUD		OutPt, IN-Office
Speech therapy, Medical/Surgical	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
Speech therapy, ASD	MH/SUD		OutPt, OON-Office
Speech therapy, Medical/Surgical	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office

Step 4. Designate whether each covered service is Medical/Surgical or MH/SUD in Column C, **taking the following into consideration:**

- Services must be identified as medical/surgical or MH/SUD as defined under the terms of the plan and in accordance with applicable state and federal law. Any condition defined by the plan as being medical/surgical or MH/SUD must be consistent with generally recognized independent standards of current medical practice (e.g., the most current version of the ICD or State guidelines). For example, state law defines bipolar disorder, major depressive disorder, and anorexia nervosa as a mental illness, thus covered services used in the treatment of those diagnoses must be identified as MH/SUD in the MHPAEA analysis. (See Ch.24B, Q3 (pg. 818) re: generally recognized independent standards of current medical practice).
- Once defined as medical/surgical or MH/SUD, the Company's definition must remain consistent for all MHPAEA analyses for each plan within the product being analyzed, i.e., QTL and NQTL analyses.
- NOTE: Every medical/surgical service classification must have MH/SUD covered services **in that same classification** (45 C.F.R. § 146.136(c)(2)(ii)(A)). See Ch.24B, Q4 (pg. 818), Data Collection Tool, rows 1, 2, 3 (pg. 823)

Cell	Notes on Response
Beginning with C10	Select from Dropdown: Medical/surgical or MH/SUD for each Covered Service listed in Column B

Step 5. Enter Expected Claim Dollar Amounts in Column D for each listed covered service that is identified as medical/surgical. The template auto-fills the cells for Expected Claim Dollar Amounts for MH/SUD services with red, as those dollar amounts are not necessary.

- All covered medical/surgical services, including those services with zero-dollar cost sharing for members, must have an associated expected plan claim dollar amount listed. Also, expected claim dollar amounts must be based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year; expected claim dollar amounts do not include cost sharing amounts paid by members.

Cell	Notes on Response
Beginning with D10	List expected claim dollar amount for each Covered Service listed in Column B

Step 6. Choose the appropriate Classification or Sub-Classification in Column E **by selecting the appropriate responses in the dropdown boxes.**

- Services should be classified consistently regardless of ACA requirements, e.g., Mammography (preventive/screening) and Mammography (diagnostic or non-screening) should be included in the same classification since the service is the same regardless of whether it is an ACA covered preventive mammogram or a diagnostic mammogram. They would require separate rows, however, due to the difference in cost-sharing.
- For outpatient services, location of service may be a permissible distinction, e.g., immunizations in PCP's office may be placed in the outpatient, office visit subclassification while immunizations in a pharmacy may be placed in the outpatient, all other subclassification.
- Similar services should be classified together unless the location or other distinction can be identified, e.g., breastfeeding supplies and diabetic supplies may be in the same classification unless diabetic supplies are covered under pharmacy benefits and breastfeeding supplies are considered DME.

Cell	Notes on Response
Beginning with E10	Select classification or sub-classification from dropdown for each Covered Service listed in Column B

Step 7. In Column F through Column J, list the copay, coinsurance, deductible, session limit, and/or day limit information for each of the benefits listed in the covered services tab, including both MH/SUD and Med/Surg benefits.

- Instructions are provided for each FR or QTL type
  - If the FR or QTL type is not applied to that benefit, put "N"
  - If the FR or QTL type is applicable to that benefit, put the numeric value only (except deductible, please indicate "Y" per instructions)

Example 5.

INSTRUCTIONS: Is a copay applied to this service category? If yes, list the copay dollar amount applied to the Service Category. If no, put a "N" for every Service Category where there is no copay application.	INSTRUCTIONS: Is a coinsurance applied to this service category? If yes, list coinsurance Percentage Amount Applied to the Service Category. If no, put a "N" for every Service Category where there is no coinsurance application.	INSTRUCTIONS: Is a deductible applied to this service category? If yes, put a "Y" for every Service Category with a deductible application. If no, put a "N" for every Service Category where there is no deductible application.	INSTRUCTIONS: Is a session limit applied to this service category? If yes, put the session limit for every Service Category. If no, put a "N" for every Service Category where there is no session limit application.	INSTRUCTIONS: Is a day limit applied to this service category? If yes, put the day limit for every Service Category. If no, put a "N" for every Service Category where there is no day limit application.
COPAY APPLICATION	**COINSURANCE APPLICATION**	**DEDUCTIBLE APPLICATION (Y or N)**	**SESSION LIMITS APPLICATION**	**DAY LIMITS APPLICATION**
25	10	Y	30	N

Step 8. In Column K and Column L, provide citations in the form of page numbers and sections in both the Certificate of Coverage and Schedule of Benefits where the services included in each line of the listed Covered Services can be found.

- This information will allow examiners to determine the specific services from Certificates of Coverage and Schedules of Benefits that are included in each line of Covered Services.

Cell	Notes on Response
Beginning with F10	List COC page number related to each Covered Service listed in Column B
Beginning with G10	List SOB page number related to each Covered Service listed in Column B

Example 6.

COC Cites:	SOB Cites:
pg. 14, Section III	pg. 3, Section II
pg. 25, Section V	pg. 4, Section III

Analysis Tabs

Data entered in columns B through G will auto-populate the corresponding tabs for purposes of reporting QTLs and Financial Requirements.

For each tab, enter the corresponding cost-sharing or visit limit information in the lines with covered services. Where limits are not applied or the cost-sharing is $0, enter "N." **Please note: This should be the same information provided on the covered services tab in columns F through J, therefore the information provided within the analysis tabs should match the covered services tab for Med/Surg benefits.**

- Note that only medical/surgical services carry over to the calculation tabs.

Service Categories within the Sub-Classification of: OPTION-OUTPATIENT, IN, OFFICE	COLUMN 1 EXPECTED CLAIM DOLLAR AMOUNT	COLUMN 2 COPAY APPLICATION	COLUMN 3 COINSURANCE APPLICATION	COLUMN 4 DEDUCTIBLE APPLICATION	COLUMN 5 SESSION LIMITS APPLICATION
INSTRUCTIONS: All MEDICAL/SURGICAL service categories provided within this sub-classification are listed below.	INSTRUCTIONS: List Claim Expected Allowed Dollar Amounts (Annual) for each service category listed.	INSTRUCTIONS: Is a copay applied to this service category? If yes, list the copay dollar amount applied to the Service Category. If no, put a "N" for every Service Category where there is no copay application.	INSTRUCTIONS: Is a coinsurance applied to this service category? If yes, list coinsurance Percentage Amount Applied to the Service Category. If no, put a "N" for every Service Category where there is no coinsurance application.	INSTRUCTIONS: Is a deductible applied to this service category? If yes, put a "Y" for every Service Category with a deductible application. If no, put a "N" for every Service Category where there is no deductible application.	INSTRUCTIONS: Is a session limit applied to this service category? If yes, put the session limit for every Service Category. If no, put a "N" for every Service Category where there is no session limit application.
Occupational Therapy - office	$45,545,522.00	$40.00	N	N	N
Speech Therapy - office	$48,552,679.00	$40.00	N	N	N
Immunization- ACA - PCP office	$1,525,588.00	N	N	N	N
Immunization - Travel - PCP office	$544,899.00	$25.00	N	N	N

When Columns 2-6 (D-H) are filled out, formulas will auto-calculate the substantially all and predominant level tests. The user will be alerted if the substantially all threshold is not met and which level is the predominant level, if applicable. See Ch.24B, Q8 (pg. 819).

In the example below, the substantially all test was not met for day limits, resulting in the message "Threshold Not Met". Since the day limits applied to Med/Surg benefits did not meet the substantially all test, day limits cannot be applied to MH/SUD benefits in the benefit classification and there is no need to proceed to the predominant level test.

AGGREGATE TOTAL OF MEDICAL AND SURGICAL BENEFITS EXPECTED CLAIM DOLLAR AMOUNT WITHIN THIS CLASSIFICATION	$2,047,172.79	For every row in **COLUMN 2** with an amount listed, **ADD** the expected claim dollar amounts (COLUMN 1) for the service category listed within that row.	For every row in **COLUMN 3** with an amount listed, **ADD** the expected claim dollar amounts (COLUMN 1) for the service category listed within that row.	For every row in **COLUMN 4** with a **Y**, **ADD** the expected claim dollar amounts (COLUMN 1) for the service category listed within that row.	For every row in **COLUMN 5** with an amount listed, **ADD** the expected claim dollar amounts (COLUMN 1) for the service category listed within that row.	For every row in **COLUMN 6** with a amount listed, **ADD** the expected claim dollar amounts (COLUMN 1) for the service category listed with that row.
	AGGREGATE TOTALS	$0.00	$2,047,172.79	$2,047,172.79	$0.00	$19,358.00
		DIVIDE the AGGREGATE TOTAL of all rows with COPAY listed (COLUMN 2), indicating copay is applied, by the **AGGREGATE TOTAL** of **COLUMN 1.**	**DIVIDE the AGGREGATE TOTAL of all rows with COINSURANCE listed** (COLUMN 3), indicating coinsurance is applied, by the **AGGREGATE TOTAL** of **COLUMN 1.**	**DIVIDE the AGGREGATE TOTAL of all rows with a Y** (COLUMN 4), indicating deductible is applied, by the **AGGREGATE TOTAL** of **COLUMN 1.**	**DIVIDE the AGGREGATE TOTAL of all rows with SESSION LIMITS listed** (COLUMN 5), indicating session limits are applied, by the **AGGREGATE TOTAL** of **COLUMN 1.**	**DIVIDE the AGGREGATE TOTAL of a rows with DAY LIMITS listed** (COLUMN 6), indicating day limits are applied, by the **AGGREGATE TOTAL** of **COLUMN 1.**
	If the amount listed within this row is not greater than or equal to 2/3, or 66.67%, the QTL cannot be applied for this plan design.	0.00%	100.00%	100.00%	0.00%	0.95%
						Threshold Not Met

In the example below, the substantially all test was met for application of coinsurance, so the user is alerted to the level of coinsurance that meets the predominant level test.

LEVELS OF COINSURANCE, LOWEST TO HIGHEST	TOTAL EXPECTED CLAIM DOLLARS APPLIED AT THIS COINSURANCE LEVEL	PERCENT (%) OF CLASSIFICATION APPLIED AT THIS LEVEL [LEVEL $ AMOUNT DIVIDED BY ***TOTAL B*** $]	START HERE, MOVE DOWNWARD ONE LEVEL UNTIL AGGREGATE TOTAL OF LEVELS REACH OVER 50.01%; STOP. THAT IS THE PREDOMINANT LEVEL, AND THE HIGHEST LEVEL THAT CAN BE APPLIED TO MH/SUD BENEFITS.	*NOTE: If any of the levels individually reach over 50.01%, that level may be applied to MH/SUD benefits. Otherwise, use chart to determine appropriate level.*
20%	$758,299.90	37.04%	37.04%	
30%	$1,288,872.89	62.96%	100.00%	Predominant Level Met
			0.00%	
			0.00%	
			0.00%	
			0.00%	
TOTAL B:	$ 2,047,172.79			