STATE OF WEST VIRGINIA
Offices *of the* Insurance Commissioner
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Insurance Commissioner

Financial Requirement and QTL Template Instructions

The information requested in the accompanying worksheets will assist in determining a health insurance carrier's (Carrier) compliance with benefit classification requirements, quantitative treatment limitations (QTLs) and financial requirement (FR) testing outcomes required under the Mental Health Parity and Addiction Equity Act (MHPAEA). This document will provide illustrations of the various tabs and how best to complete the worksheets.

As an initial step, identification of all covered services, both medical/surgical and behavioral, mental health, and substance use disorder (MH/SUD), is critical for complete QTL and Nonquantitative Treatment Limits (NQTL) analyses. Classification of covered services must remain consistent across both types of analysis, thus must be established at the outset.

Covered Services Tab (FR and QTL Worksheet)

Step 1. Provide the requested Carrier 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	Provide Carrier 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.
- "Is there a tiered network?" If Yes, continue to the next question. If no, move to Step 3.
  - Tiered network refers to multiple levels of tiering with respect to contracted providers. Out-of-network is not considered a tier.
- "If yes, please select the number of tiers:" Select the appropriate number of tiers from the dropdown box.
- **NOTE: This template does not automatically separate multiple networks for purposes of analysis. If the Carrier choses 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 utilizing additional Worksheets if necessary.**

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 the Certificates of Coverage and Schedules of Benefits should be identifiable in the list of covered services.
- Covered services should have their own line based on network (in and out, as well as tiering if applicable), cost-sharing type, applicable visit or day limits, FR or QTL level, and classification.

Network: Include a separate covered service line for services that are covered in-network and out-of-network, e.g., one line for primary care physician (PCP) office visit-in network, and a separate line for PCP office visit-out of network.

Covered Services Tab Illustration I

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

Services should be separated by tier when there is more than one network tier, e.g., preferred specialist on one line, non-preferred specialist on a separate line.

Covered Services Tab Illustration II

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

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 line for reporting covered services.

Covered Services Tab Illustration III

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

Classification: For purposes of MHPAEA analysis, classification of benefits, 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 Tab Illustration IV

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 Tab Illustration V

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.
- Once defined as medical/surgical or MH/SUD, the Carrier's definition must remain consistent for all MHPAEA analyses within the product being analyzed, i.e., QTL and NQTL analyses. NOTE: Every medical/surgical service classification should have corresponding MH/SUD covered services

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.

- 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 are not 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 (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.
- 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 and Column G, 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

Covered Services Tab Illustration VI

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 in the Covered Services tab will auto-populate the corresponding classification tabs for purposes of reporting QTLs and Financial Requirements, e.g. All benefits listed under the Outpatient, In-network classification on the Covered Services tab will automatically populate on the Outpatient-INN tab.

For each tab, enter the corresponding cost-sharing and/or visit limit information in the lines with covered services. Where limits are not applied or the cost-sharing is $0, enter "N." Do not enter information in any other areas. Formulas in place will complete the calculations.

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

SubC-Outpatient-Office INN Tab Illustration

Service Categories within the Sub-Classification of: OPTION-OUTPATIENT, IN, OFFICE	COLUMN 1 EXPECTED CLAIM DOLLAR AMOUNT INSTRUCTIONS: List Claim Expected Allowed Dollar Amounts (Annual) for each service category listed.	COLUMN 2 COPAY APPLICATION 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.	COLUMN 3 COINSURANCE 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.	COLUMN 4 DEDUCTIBLE 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.	COLUMN 5 SESSION LIMITS 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: All MEDICAL/SURGICAL service categories provided within this sub-classification are listed below.					
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 prompted if the substantially all threshold is not met and which level is the predominant level, if applicable.