

**WEST VIRGINIA
SECRETARY OF STATE
NATALIE E. TENNANT
ADMINISTRATIVE LAW DIVISION**

Form #7

Do not mark in this box
Filing Date

FILED

2009 JUL 31 PM 3:37

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE Effective Date

NOTICE OF AN EMERGENCY RULE

AGENCY: Offices of the Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY W.Va. Code §§33-2-10 and 33-16-3a

EMERGENCY AMENDMENT TO AN EXISTING RULE: YES NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 64

TITLE OF RULE BEING AMENDED: Mental Health Parity

IF NO, SERIES NUMBER OF RULE BEING FILED AS AN EMERGENCY: _____

TITLE OF RULE BEING AMENDED: _____

THE ABOVE RULE IS BEING FILED AS AN EMERGENCY RULE TO BECOME EFFECTIVE AFTER APPROVAL BY SECRETARY OF STATE OR 42ND DAY AFTER FILING, WHICHEVER OCCURS FIRST.

THE FACTS AND CIRCUMSTANCES CONSTITUTING THE EMERGENCY ARE AS FOLLOWS:



Virgil T. Helton
Cabinet Secretary
West Virginia Department of Revenue

Insurance Commissioner
Emergency Rule
Title 114, Series 64

MENTAL HEALTH PARITY

TITLE 114, SERIES 64

BRIEF SUMMARY OF EMERGENCY RULE

The 2009 WV legislature enacted HB 3288 (effective 8/25/09) to meet new federal requirements regarding mental health parity (MHP). Parity applies to copays, lifetime limits, etc. Under the federal law, whenever MH benefits are included in any group policy covering more than 50 persons, parity is required, but a state's MHP laws are not preempted if they provide at least as much consumer protection as the federal law. WV's MHP laws are already considerably stronger than even the new federal requirements, the changes in HB3288 were relatively minimal and only amended the method used to measure the cost of the MH benefits used to determine if the carrier could get relief from the parity requirements.

Relief from the parity requirements is permitted under federal and WV law when MH costs reach a certain level relative to the total benefits paid by a carrier. The relief permitted in the federal and WV statutes differ considerably.

-First, the federal law provides for a one year *exemption* from the parity requirements if the cost cap is exceeded (that is, the insurer can offer MH benefits at any level for one year without regard to the effect on parity), whereas in WV, the mandate to offer MH benefits is always in effect and the only relief (if the cost cap is exceeded) is to permit the insurer to request to impose cost containment measures to bring the costs below the cap.

-Second, the federal cost-cap is 2% for the first year and 1% thereafter, whereas in WV the cap remains at 2% (prior to HB 3288, groups under 25 persons were subject to a 1% cost-cap; the bill imposes a 2% cost-cap on all groups, including the under 51 groups to which the federal law does not apply).

The only change to the WV statute in response to this federal law was to mirror the manner in which costs are measured. State law previously looked to an insurer's *anticipated* costs of compliance with the state mandates; if an insurer could show that its anticipated costs would exceed the 2% cap, it could then ask for the cost containment measures going forward. The new federal law, however, requires use of *actual* costs. HB 3288 simply amended WVC §33-16-31 to require an "actual cost" test for groups

of more than 50 (the only groups covered by the federal law; groups under 51 would be subject to the anticipated costs test). Everything else in state law remained the same - mandate for all groups large and small, constant 2% cost-cap, request for cost containment measures (rather than an exemption). The changes being made to this rule more specifically implement these changes and are necessary to complete the state's compliance with the federal changes.

Department of Revenue
Agency Questionnaire

Re: Emergency Rule to be Filed

MENTAL HEALTH PARITY

TITLE 114, SERIES 64

Question 1: Are regulations required?

Yes, federal legislation in 2008 requires parity in two areas of every state's mental health laws, treatment limits and financial limitations.

Question 2: Is the rule you are proposing controversial? If yes, what are the pros and the cons?

The rule is not controversial.

Question 3: Is the rule you are proposing a copy of another state's rule? A model rule? Custom-drafted?

This rule is custom drafted, due to the need to mesh new federal requirements with existing state parity laws.

Question 4: What are the really important things you think the Secretary of the Department of Revenue should know about this rule and the issues that surround it?

In discussions with Centers for Medicare and Medicaid Services, OIC asserted that it would handle certain aspects of compliance with the new federal mandate through rule. The deadline for having a rule in place is October 3, 2009.

Mental Health Parity
(Title 114, Series 64)
EMERGENCY RULE

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE:

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER
ATTN: Legal Division
1124 Smith Street
Post Office Box 50540
Charleston, West Virginia 25305-0540

EMERGENCY RULE TITLE: Mental Health Parity (Title 114, Series 64)

1. Date of Filing:

2. Statutory authority for promulgating emergency rule:

W.Va. Code §§33-2-10 and 33-16-3a

3. Date of filing of proposed legislative rule:

May 29, 2009

4. Does the emergency rule adopt new language or does it amend or repeal a current legislative rule?

The emergency rule amends a current legislative rule, §114CSR64

5. Has the same or similar emergency rule previously been filed and expired?

No, this emergency rule has not been previously filed.

Mental Health Parity
(Title 114, Series 64)
EMERGENCY RULE

6. State, with particularity, those facts and circumstances which make the emergency rule necessary for the immediate preservation of public peace, health, safety and welfare.

N/A

7. If the emergency rule was promulgated in order to comply with a time limit established by the Code or federal statute or regulation, cite the Code provision, federal statute or regulation and time limit established therein.

N/A

8. State, with particularity, those facts and circumstances which make the emergency rule necessary to prevent substantial harm to public interest.

Federal legislation enacted in October 2008 requires that large group health plans (50+) that offer mental health benefits to provide parity between such benefits and medical/surgical benefits with respect to treatment limits (same limits on number of inpatient and outpatient visits) and financial limitations (same deductibles, copays and other cost sharing). The law does not preempt state laws, and it permits stronger state laws to continue in effect. Overall, West Virginia's mental health parity law is considerably stronger than the new federal law; however, until the 2009 amendment to the state parity statute, West Virginia's method of measuring the overall cost of parity (MH benefits can be reduced if the MH benefits cost exceeds 2%) was different than the new federally-prescribed method (WV used "anticipated costs" rather than the federal "actual cost" measure). The proposed amendments are also necessary to reflect this recent state-law change, as well as to flush out some of the other aspects of the federal law (parity in use of out of network providers, actuarial certification of the costs and record retention). The amendment to the state parity statute (HB3288) becomes effective August 25, 2009 with an internal effective date of October 3, 2009 and the emergency rule will need to be in place by October 3 in order to comply with the newly amended statute and with federal law.

Offices of the Insurance Commissioner
Emergency Rule
Title 114, Series 64

MENTAL HEALTH PARITY

TITLE 114, SERIES 64

STATEMENT OF CIRCUMSTANCES

Federal legislation enacted in October 2008 requires that large group health plans (50+) that offer mental health benefits must provide parity between such benefits and medical/surgical benefits with respect to treatment limits (same limits on number of inpatient and outpatient visits) and financial limitations (same deductibles, copays and other cost sharing). The law does not preempt state laws, and it permits stronger state laws to continue in effect. Overall, West Virginia's mental health parity law is considerably stronger than the new federal law; however, until the 2009 amendment to the state parity statute, West Virginia's method of measuring the overall cost of parity (MH benefits can be reduced if the MH benefits cost exceeds 2%) was different than the new federally-prescribed method (WV used "anticipated costs" rather than the federal "actual cost" measure). The proposed amendments are necessary to reflect this recent state-law change, as well as to address more specifically some of the other aspects of the federal law (parity in use of out of network providers, actuarial certification of the costs and record retention).

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Mental Health Parity (Series 64)

Type of Rule: Legislative Interpretive Procedural Emergency

Agency: Offices of the Insurance Commissioner

Address: Post Office Box 50540
1124 Smith Street, Greenbrooke Building
Charleston, West Virginia 25305-0540

Phone Number: (304) 558-0401 Email: _____

Fiscal Note Summary

Summarize in a clear and concise manner what impact this measure will have on costs and revenues of state government.

The rule will have no additional fiscal impact upon state government.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

FISCAL YEAR			
Effect of Proposal	Current Increase/Decrease (use "-")	Next Increase/Decrease (use "-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	N/A	N/A	N/A
Personal Services	N/A	N/A	N/A
Current Expenses	N/A	N/A	N/A
Repairs & Alterations	N/A	N/A	N/A
Assets	N/A	N/A	N/A
Equipment	N/A	N/A	N/A
Other	N/A	N/A	N/A
2. Estimated Total Revenues	N/A	N/A	N/A

Rule Title: Mental Health Parity (Series 64)

- 3. Explanation of above estimates (including long-range effect):**
Please include any increase or decrease in fees in your estimated total revenues.

N/A

MEMORANDUM

Please identify any areas of vagueness, technical defects, reasons the proposed emergency rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

N/A

Date: _____

Signature of Agency Head or Authorized Representative

Timothy R. Murphy, Associate Counsel

**TITLE 114
EMERGENCY RULE
INSURANCE COMMISSIONER**

**SERIES 64
MENTAL HEALTH PARITY**

Section

- 114-64-1. General.
 - 114-64-2. Definitions.
 - 114-64-3. Providing Benefits for Serious Mental Illness.
 - 114-64-4. Allowance of ~~Additional~~ Cost Containment Measures.
 - 114-64-5. Calculation for Application of ~~Additional~~ Cost Containment Measures.
 - 114-64-6. Aggregate Lifetime Limits.
 - 114-64-7. Annual Limits.
 - 114-64-8. Rates and Forms Filings.
 - 114-64-9. Record Retention Requirements.
- ~~Appendix A — Mental Health Parity Cost Containment Measures Application~~

TITLE 114
EMERGENCY RULE
INSURANCE COMMISSIONER

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SERIES 64
MENTAL HEALTH PARITY

OFFICE WEST VIRGINIA
SECRETARY OF STATE

§114-64-1. General.

1.1. Scope. -- a. The purposes of this rule are to:

1. Create a legal framework within which insurers can develop an environment of parity between mental health and medical-surgical benefits;

2. Provide for parity in the application of aggregate lifetime limits and annual limits between mental health benefits and medical-surgical benefits;

3. Provide for parity with respect to treatment limits and financial limitations that meet or exceed the requirements of the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008;

4. Define standards by which health care professionals shall implement parity;

4 5. Minimize the possibilities of confusion and interruption of patient care; and

5 6. Ensure that cost containment measures not applicable to medical-surgical benefits are also not applicable to mental health benefits until demonstrated to be actuarially necessary.

b. This rule applies to:

1. Group health benefit plans issued by any and all insurers transacting the business of insurance under W. Va. Code §§33-16-1 *et seq.* and 33-25A-1 *et seq.*, or who are otherwise subject to W. Va. Code §33-16-3a.

2. Individual subscribers and members and to all group members of a health benefit plan.

3. Group health benefit plans which begin ~~on or after the first day of January, 2003~~ October 3, 2009.

c. This rule does not apply to any policy of individual accident and sickness

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insurance issued in accordance with article fifteen of chapter thirty-three of the W. Va. Code. (W. Va. Code §§33-15-1 *et seq.*).

1.2. Authority. -- W. Va. Code §§33-2-10 and 33-16-3a.

1.3. Filing Date. -- ~~April 29, 2008.~~

1.4. Effective Date. -- ~~April 29, 2008.~~

§114-64-2. Definitions.

2.1. ~~“Additional cost~~ Cost containment measures” means ~~relief provided to a group health plan after it has actuarially demonstrated to the commissioner that its total anticipated costs for the first year, or the total costs for every year thereafter for treatment of mental illness for any plan will exceed or will have exceeded two percent or one percent for any group with twenty-five members or less~~ changes to cost-sharing requirements and/or treatments limits in a policy that are designed to lower the cost of providing mental health benefits relative to the cost of medical-surgical benefits.

2.2. “Commissioner” means the West Virginia insurance commissioner.

2.3. ~~“Base~~ Experience period” means the period used to calculate whether the insurer may claim the two percent ~~or one percent~~ increased cost exemption. The ~~base~~ experience period must be twelve consecutive calendar months ending on or about sixty days preceding the next filing of the application.

2.4. “Claims” means requests for reimbursement for payment of services made by or on behalf of an insured to an insurer or a provider to an insurer, or its intermediary, administrator or representative.

2.5. “Diagnostic codes” means a numerical identifier as set forth in the current American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, as periodically revised.

2.6. “Diagnostic related groups” means a numerical code method of determining financing to reimburse various providers for services performed. A diagnostic related group is associated with a method of classifying inpatient hospital services published in the Federal Register.

2.7. “Group members” means beneficiaries or members receiving health care coverage through a group health benefit plan.

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2.8. "Group health plan" means an employee welfare benefit plan, including a church plan or a governmental plan, all as defined in section three of the Employee Retirement Income Security Act of 1974, 29 U. S. C. §1002, to the extent that the plan provides medical care.

~~2-8~~ 2.9. "Health benefit plan" means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate, hospital, medical or health service corporation contract, health maintenance organization contract, or plan provided by a multiple-employer trust or multiple-employer welfare arrangement. "Health benefit plan" does not include excepted benefits as defined by W. Va. Code §33-16-1a (f).

~~2-9~~ 2.10. "Incurred expenditures" means costs associated with mental health benefits and medical-surgical benefits. Incurred expenditures include actual claims paid and that percentage of per member per month case management expenses, administrative expenses, utilization review and capitation paid associated with mental health benefits during the base period. The allowable percentage is to be calculated by comparing actual amounts paid to providers per the terms of the health benefit plan or provider agreement for mental illness with the actual amounts paid to providers per the terms of the health benefit plan or provider agreement for all claims. Incurred expenses do not include premiums.

~~2-10~~ 2.11. "Individual subscribers and members" means a single participant in a group health benefit plan.

~~2-11~~ 2.12. "Insurer" means an insurer licensed to transact accident and sickness insurance in this state, and a health maintenance organization to whom a certificate of authority has been issued by the ~~West Virginia Insurance~~ Commissioner under the provisions of W. Va. Code §§33-16-1 *et seq.* and 33-25a-1 *et seq.*, or who are otherwise subject to W. Va. Code §33-16-3a.

~~2-12~~ 2.13. "Mental illness" means any illness or treatment that is specified as related to mental health in the form of diagnostic related groups, diagnostic codes, pharmaceutical and/or therapeutic classes.

~~2-13~~ 2.14. "Pharmaceutical classes" means a numerical identifier of pharmaceuticals as set forth in the current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, under the following classifications, as periodically revised: antianxiety and sedative-hypnotic drugs, antimania drugs, antidepressants, antipsychotics, CNS stimulants, alcohol antagonists and antimentia drugs.

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~~2.14~~ 2.15. “Plan” means filings consisting of each form offered for any group with more than ~~twenty-five~~ fifty members. For groups with ~~twenty-five~~ fifty members or less, filings may consist of each form offered or of that form offered as a group plan of ~~twenty-five~~ fifty members or less.

~~2.15~~ 2.16. “Serious mental illness” means an illness included in the current American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, as periodically revised, under the diagnostic categories or subclassifications of: (i) Schizophrenia and other psychotic disorders; (ii) bipolar disorders; (iii) depressive disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine-related disorders; and (vi) anorexia and bulimia.

~~2.16~~ 2.17. “Therapeutic classes” means a numerical identifier of therapeutic treatments as set forth in the current American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, as periodically revised.

~~2.17~~ 2.18. “Total anticipated costs” means all costs anticipated to be associated with implementing mental health parity, including actual claims paid and that percentage of per member per month case management expenses, administrative expenses, utilization review and capitation paid associated with mental health benefits during the base period. The allowable percentage is to be calculated by comparing actual amounts paid to providers per the terms of the health benefit plan or provider agreement for mental illness with the actual amounts paid to providers per the terms of the health benefit plan or provider agreement for all claims.

2.19. “Total actual costs” means all incurred actual costs associated with providing mental health benefits, including actual paid claims and that percentage of per member per month case management expenses, administrative expenses, utilization review and capitation incurred during an experience period.

~~2.18~~ 2.20. “Total costs” means all costs associated with implementing and transacting a health benefit plan, including both mental health benefits and medical-surgical benefits, including actual claims paid, and that percentage of per member per month case management expenses, administrative expenses, utilization review and capitation paid associated with mental health benefits during the base period. The allowable percentage is to be calculated by comparing actual amounts paid to providers per the terms of the health benefit plan or provider agreement for mental illness with the actual amounts paid to providers per the terms of the health benefit plan or provider agreement for all claims.

§114-64-3. Providing Benefits for Serious Mental Illness.

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3.1. Each health benefit plan issued by an insurer shall provide benefits to all individual subscribers and members and to all group members for expenses arising from the treatment of serious mental illness. The expenses shall not include custodial care, residential care or schooling.

3.2. An insurer shall not apply cost-sharing requirements (e.g. deductibles, copayments, coinsurance) and treatment limits (e.g. limitations on frequency of treatment and number of visits) to mental health benefits that are more restrictive than those applied to medical and surgical benefits or otherwise discriminate between medical-surgical benefits and mental health benefits in the administration of its plan.

3.3. An insurer may make determinations of medical necessity and appropriateness, and, subject to the nondiscrimination requirements of subsection 3.2 of this section, may use health care quality and management tools, which may include but are not limited to utilization review, use of provider networks, implementation of cost containment measures, pre-authorization for certain treatments, setting coverage levels, including the number of visits in a given time period, using capitated benefit arrangements, using fee for service arrangements and using third party administrators and using patient cost sharing in the form of copayments, deductibles and coinsurance.

§114-64-4. Allowance of ~~Additional~~ Cost Containment Measures.

4.1. An Except as provided in subsection 4.2 of this section, an insurer may apply ~~additional~~ cost containment measures, upon approval of the ~~commissioner~~ Commissioner, if the insurer submits actuarially certified information to the ~~commissioner~~ Commissioner demonstrating that its total anticipated costs for ~~the first year of implementation for treatment of mental illness for any plan will exceed two percent, or one percent for any group with twenty-five members or less of the total costs for the plan.~~ Each In order to continue cost containment measures in each year thereafter, the insurer submits shall submit actuarially certified information to the ~~commissioner~~ Commissioner demonstrating its total costs for treatment of mental illness will exceed or have exceeded two percent, ~~or one percent for any group with twenty-five members or less, for the plan in the base period.~~

4.2. For any plan year beginning after October 3, 2009 with respect to any "group health plan" covering a group with an average of more than fifty employees on business days during the preceding calendar year, the insurer may request approval to apply cost containment measures if it is determined that the application of mental health benefits for the plan year involved resulted in an increase of the actual costs of coverage with respect to medical-surgical benefits and mental health benefits under the plan by more than two percent; such increase is to be calculated by comparing actual incurred amounts paid to providers for mental illness with the actual incurred amounts paid to providers for all incurred claims. The determination of increases in

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actual costs must be made in a written report prepared by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. The Commissioner may approve the use of cost containment measures for the following plan year only.

4.3. a. Whether a treatment is, for purposes of this rule, a treatment for mental illness will be determined by inclusion of the treatment in the diagnostic response groups, diagnostic codes, pharmaceutical classes or therapeutic classes related to mental illness as determined by the current American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, as periodically revised.

b. If a treatment is included in one or more diagnostic related groups, diagnostic codes, pharmaceutical and/or therapeutic classes, it shall be included in the insurer's calculations and actuarial assessment for total anticipated costs.

4.2 4.4. The total ~~anticipated~~ costs must be based on actual claims data, and may not be based on an increase in insurance premiums.

§114-6-5. Calculation for Application of Additional Cost Containment Measures.

5.1. If an insurer ~~anticipates~~ demonstrates that its total costs for treatment of mental illness for any plan ~~will exceed or have exceeded two percent, or one percent for any group with twenty-five members or less,~~ of the total costs for such plan in any base period, the following calculation shall be used as part of an application to implement cost containment measures intended by the insurer to maintain costs below the two percent ~~or one percent~~ of total costs threshold:

a. Total ~~anticipated~~ costs during the base experience period, for that plan, divided by

b. Total costs during the base experience period for that plan.

§114-6-6. Aggregate Lifetime Limits.

6.1. An average aggregate lifetime limit may be imposed if the benefit categories to which separate limits apply account for at least one-third of the dollar amount of all plan payments for medical-surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third of the dollar amount of all plan payments for medical-surgical benefits.

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§114-64-7. Annual Limits.

7.1. An average annual limit may be imposed if the benefit categories to which separate limits apply account for at least one-third of the dollar amount of all plan payments for medical-surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third of the dollar amount of all plan payments for medical-surgical benefits.

§114-64-8. Rates and Forms Filings.

8.1. In order to qualify for mental health parity cost containment measures, an insurer that anticipates total costs exceeding two percent, or exceeding one percent for groups of twenty-five members or less, shall complete and file the form attached to this rule as Appendix A with the Rates and Forms Division, Offices of the Insurance Commissioner must request approval in the manner prescribed by the Commissioner on the forms available on the Offices of the Insurance Commissioner's website.

8.2. The actuarially certified application shall be filed no less than sixty days before the anticipated effective date or renewal date of the plan.

8.3. The ~~commissioner~~ Commissioner shall have sixty days within which to approve or disapprove the use of cost containment measures.

8.4. The approval of ~~additional~~ cost containment measures shall be on an annual basis and may result in a directive to add or delete cost containment measures.

§114-64-9. Record Retention Requirements.

9.1. Any report submitted pursuant to subsection 4.2 of this rule and all underlying documents relied upon by the actuary in preparing the report, shall be retained by the insurer for six years following notification of the Commissioner's decision regarding the request to institute cost containment measures.

Appendix A

OFFICES OF THE WEST VIRGINIA INSURANCE COMMISSIONER

MENTAL HEALTH PARITY COST CONTAINMENT MEASURES APPLICATION

INSTRUCTIONS: This form is to be completed when applying for cost containment measures as outlined in 114 CSR 64. All questions must be answered; if no answer is applicable, enter the reason for such determination.

Company Name: _____

NAIC Code: _____

Part of Group: _____

Date Applied: _____

Proposed Effective Date: _____

I. General Information:

1. Base Period: From _____ to _____
(must be 12 consecutive months ending on or about 60 days preceding the next filing of the application)

2. Are there [] 25 members or less [] more than 25 members?

3. If this is the first application, please provide the total anticipated costs for the first year for treatment of mental illness for any plan that will exceed 2% or 1% for any group with 25 members or less: _____

4. If this is beyond the first year, please provide total costs for each year thereafter for treatment of mental illness for any plan that will exceed 2% or 1% for any group with 25 members or less: _____

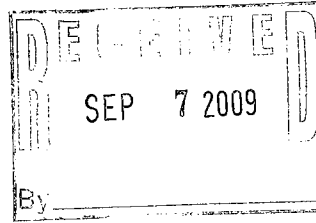
Please provide four years of data by year (include data prior to implementation of mental health parity):

	Base Period	Total Expenditures Incurred for Mental Health Benefits	Total Expenditures Incurred for all Benefits
a) actual claims incurred			
b) case management expenses			
c) administrative expenses			
d) utilization review paid			
e) capitation paid associated with mental health benefits			

H.

1. What Cost Containment measures do you plan to implement?
2. What is the anticipated reduction in cost for mental health benefits by implementing these cost containment measures?
3. What is the total anticipated cost of mental health benefits after implementation of cost containment measures for Mental Health Parity?
4. What is the total anticipated cost of all benefits after the implementation of cost containment for Mental Health Parity?

III. This application must be actuarially certified. Please attach the appropriate certification to this form.



Toll Free: 1-800-598-884
Phone: (304) 345-7312
Fax: (304) 342-6090
<http://www.wvmhca.org>

September 01, 2009

Natalie Tenant
Secretary of State
Bldg. 1, Suite 157-K
1900 Kanawha Blvd. East
Charleston, WV 25305-0770

Secretary Tennant,
Thank you for the opportunity to review and comment on the proposed emergency rules for the Mental Health Parity legislation (HB 3288) that recently passed in the West Virginia legislature.

We believe the Insurance Commission's assessment of the scope of the proposed rules and legislation is accurate. The legislation essentially amended the method by which the insurance carriers could calculate relief from parity if costs for mental healthcare exceeded 2% of the costs for the entire healthcare plan. Requiring carriers to present actual costs for a cap request as opposed to anticipated costs is a good move and brings WV in compliance with recent changes in federal law. Also, cost containment measures can only be approved for one year at a time preventing a carrier from receiving permanent relief for what maybe a temporary rise in cost. House Bill 3288 also changed covered entities in state law from 25 or more employees to 50 or more which is what the federal law requires. This change was unnecessary since a more stringent state law would have superseded the federal law in that regard, however it was a compromise agreed to during negotiations with the legislature and insurance commission.

We realize that the forms utilized to request cost containment will be changing considerably which is why they have been struck as an appendix accompanying the original rule. Even though we have not had the opportunity to review proposed forms requesting cost containment, we have confidence that the Insurance Commission will develop appropriate forms complying with federal and state law accurately reflecting the provisions prescribed in the emergency rule. Mental health parity is very important to ensure equitable treatment of physical and psychiatric health. Mental health is essential to your overall health, and healthcare should reflect self direction and choice as well as responsibility. We will continue to review the proposed rule and submit comments as needed.

If you have any questions or concerns please contact me.

Respectfully,

A handwritten signature in cursive script that reads "Debbie Toler".

Debbie Toler
Executive Director
WVMHCA

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2009 SEP -8 PM 2:15
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

WVMHCA
713 Bigley Avenue, Charleston, West Virginia 25302