WEST VIRGINIA
SECRETARY OF STATE
BETTY IRELAND
ADMINISTRATIVE LAW DIVISION

Form #3

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

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

AMENDMENT TO AN EXISTING RULE: YES X 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 PROPOSED: _____

TITLE OF RULE BEING PROPOSED: _____

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Virgil T. Helton
Cabinet Secretary
West Virginia Department of Revenue

#5.80

Insurance Commissioner
Legislative Rule
Title 114, Series 64

MENTAL HEALTH PARITY

TITLE 114, SERIES 64

BRIEF SUMMARY OF RULE

[The following numbered paragraphs are from an NAIC summary of the "The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act," which was included as a provision in the Emergency Economic Stabilization Act that was enacted on October 3, 2008)

1. *The bill would require that insurers and employers, if they provide coverage for mental health services, apply cost-sharing requirements (deductibles, co-payments, coinsurance) and treatment limitations (limitations on the frequency of treatment, number of visits, etc) to mental health services that are no more restrictive than those applied to medical and surgical benefits.*
2. *The bill would also require that if an employer or insurer provides coverage of medical and surgical services provided by out of network providers, it must do the same for mental health services.*
3. *The bill would allow employers and insurers to opt out of the bill's provisions for one year if their costs increase by 2% in the first year the requirements are in effect or by 1% in subsequent years.*
4. *The bill allow employers and states to define the scope of "mental health services." The original House bill required plans that cover mental health services to cover treatment of all diagnoses in the Diagnostic and Statistical Manual of Mental Disorders. That provision was removed.*
5. *The small group and nongroup markets are exempted from the terms of the bill, though state laws that cover those markets would continue to apply.State laws that are more protective of consumers are preserved from preemption.*

The 2009 WV legislature enacted a bill (HB 3288) to meet the new federal requirements. However, West Virginia's mental health

parity laws are and have been considerably stronger than these new federal requirements.

--MH benefits continue to be *required* in *all* group health policies, including small groups (33-16-3a(a)) (federal law only applies to groups of 50+).

--Although relief from the parity requirements is permitted under federal and WV law when costs reach a certain level, 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), 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 in 2009 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 mandate; 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 remained the same - mandate for all groups large and small, constant 2% cost-cap, request for cost containment measures (rather than an exemption).

HB 3288 did not specifically address a few issues raised by the federal legislation.

(1) The requirement that parity extend to the use of network providers, i.e. if medical/surgical treatments allowed out of network, the same must be permitted for MH benefits. The Commissioner believes this is covered generally in existing law's non-discrimination provisions. See WVC §33-16-3a(a)(3) ("The insurer shall not discriminate between medical-surgical benefits and mental health benefits in the administration of its plan. ..."). Nevertheless, the proposed rule amendment specifically addresses the out of network question.

(2) The requirement that "determinations as to increases in actual costs under a plan ... for purposes of [the federal law]" must be made by an actuary in a written report and the report and underlying documents must be maintained by the insurer for 6 years. The state code continues to require that cost containment can be applied to small group plan (now defined as under 51) if the "insurer can demonstrate actuarially" that anticipated costs will exceed the 2% cost-cap. However, in HB 3288, for purposes of the large groups, the demonstration of actual costs is not specifically linked to an actuarial report. Moreover, there is no record retention requirement in the code or existing rule. The proposed rule addresses each of these issues.

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

LEGISLATIVE RULE TITLE: MENTAL HEALTH PARITY, TITLE 114, SERIES 64

1. Authorizing statute(s) citation:

W.Va. Code §33-2-10 and 33-16-3a

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

May 29, 2009 - Comment Period

b. What other notice, including advertising, did you give of the hearing?

N/A

c. Date of Public Hearing(s) or Public Comment Period ended:

June 29, 2009 - End of Comment Period

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached _____ **No comments received** X

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

f. Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all *written correspondence* regarding this rule: (Please type)

Timothy R. Murphy, Associate Counsel
West Virginia Insurance Commission
Legal Division
P.O. Box 50540
Charleston, WV 25305-0540
Phone: (304) 558-6279, Ext. 1210
Fax: (304) 558-1362
E-mail: timothy.murphy@wvinsurance.gov

g. IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

Same

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

N/A

b. Date of hearing or comment period:

N/A

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

N/A

d. Attach findings and determinations and reasons:

N/A

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Mental Health Parity (Title 114, Series 64)

Type of Rule: X Legislative ____ Interpretive ____ Procedural ____ Emergency

Agency: 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
Other	N/A	N/A	N/A
2. Estimated Total Revenues	N/A	N/A	N/A

Rule Title: Mental Health Parity (Title 114- 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 rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

Date: 5/29/09

Signature of Agency Head or Authorized Representative

Timothy Murphy, Associate Counsel

Insurance Commissioner
Legislative 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 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).

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 64
MENTAL HEALTH PARITY

Section

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 64
MENTAL HEALTH PARITY

§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

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.

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 antidementia drugs.

~~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.

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

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.

§114-64-6. 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.

§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			

II.

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.