

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

Form #6

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

**NOTICE OF FINAL FILING AND ADOPTION OF A LEGISLATIVE RULE
AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE.**

AGENCY: Insurance Commissioner TITLE NUMBER: 114

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: _____

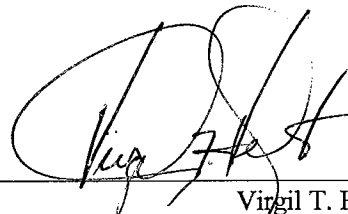
TITLE OF RULE BEING PROPOSED: _____

THE ABOVE RULE HAS BEEN AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE.

AUTHORIZATION IS CITED IN (house or senate bill number) S.B. 407

SECTION 64-7-3, PASSED ON March 13, 2010

THIS RULE IS FILED WITH THE SECRETARY OF STATE. THIS RULE BECOMES EFFECTIVE ON THE
FOLLOWING DATE: April 14, 2010



Virgil T. Helton
Cabinet Secretary
West Virginia Department of Revenue

**TITLE 114
LEGISLATIVE 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 Cost Containment Measures.
- 114-64-5. Aggregate Lifetime Limits.
- 114-64-6. Annual Limits.
- 114-64-7. Rates and Forms Filings.
- 114-64-8. Record Retention Requirements.

**TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER**

**SERIES 64
MENTAL HEALTH PARITY**

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

§114-64-1. General.

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

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

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

1.1.a.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;

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

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

1.1.a.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.

1.1.b. This rule applies to:

1.1.b.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.

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

1.1.b.3. Group health benefit plans which begin after October 3, 2009.

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

insurance issued in accordance 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 14, 2010.

1.4. Effective Date. -- April 14, 2010.

§114-64-2. Definitions.

2.1. "Cost containment measures" means changes to cost-sharing requirements and 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. "Experience period" means the period used to calculate whether the insurer may claim the two percent increased cost exemption. The 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.

2.9. "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).

2.10. "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 experience 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.

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

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 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.

2.13. "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.

2.14. "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.

2.15. "Plan" has the same meaning as defined in W.Va. Code §33-16-1a(h).

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.

2.17. "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.

2.18. "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 experience 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.

2.20. "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 experience 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 may not include custodial care, residential care or schooling.

3.2 An insurer may not apply cost-sharing requirements (e.g. deductibles, co-payments, co-insurance) 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, subject to the nondiscrimination requirements of subsection 3.2 of this section, and, 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.

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

4.1. Except as provided in subsection 4.2 of this section, an insurer may apply cost containment measures, upon approval of the Commissioner, if the insurer submits actuarially

certified information to the Commissioner demonstrating that its total anticipated costs for treatment of mental illness for any plan will exceed two percent of the total anticipated costs for the plan. In order to continue cost containment measures in each year thereafter, the insurer shall submit actuarially certified information to the Commissioner demonstrating its total costs for treatment of mental illness will exceed or have exceeded two percent of total costs for the plan.

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.

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

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

§114-64-5. Aggregate Lifetime Limits.

5.1. 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.

§114-64-6. Annual Limits.

6.1. 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.

§114-64-7. Rates and Forms Filings.

7.1. In order to qualify for mental health parity cost containment measures, an insurer must request approval in the manner prescribed by the Commissioner on the forms available on the Offices of the Insurance Commissioner's website at www.wvinsurance.gov.

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

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

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

§114-64-8. Record Retention Requirements.

8.1. 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.