WEST VIRGINIA
SECRETARY OF STATE
JOE MANCHIN, III
ADMINISTRATIVE LAW DIVISION

Form #3

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2002 JUL 26 P 3:49

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 Commission TITLE NUMBER: 114

CITE AUTHORITY: West Virginia Code Sections 33-2-10 and 33-16-3a

AMENDMENT TO AN EXISTING RULE: YES___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: ________

TITLE OF RULE BEING AMENDED: ________

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 64

TITLE OF RULE BEING PROPOSED: Mental Health Parity

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.

Brian M Kastich

Authorized Signature

by [signature]
General Counsel

SCANNED

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Mental Health Parity
Title 114, Series 64 - LEGISLATIVE

Type of Rule: __X__ **Legislative** ___**Interpretive** ____**Procedural**

Agency: Insurance Commissioner

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

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1. Effect of Proposed Rule

	ANNUAL		FISCAL YEAR		
	Increase	Decrease	Current	Next	Thereafter
ESTIMATED TOTAL COST	4,000	None	2,000	4000	4,000
PERSONAL SERVICES	4,000	None	2,000	4000	4,000
CURRENT EXPENSE	None	None	None	None	None
REPAIRS AND ALTERNATIONS	None	None	None	None	None
EQUIPMENT	None	None	None	None	None
OTHER	None	None	None	None	None

2. Explanation of above estimates:

This law and accompanying rule requires health care insurers to apply for approval of cost containment measures should results justify and requires the Insurance Commissioner to submit a report annually.

These requirements will increase staff work loads, however estimates indicate the time requirement can be incorporated into our existing work schedules and absorbed into the current budget.

Rule Title: Mental Health Parity
Title 114, Series 64 - LEGISLATIVE

3. Objectives of these rules:

House Bill 4039, codified at W. Va. Code § 33-16-3a, placed the burden on the Insurance Commissioner to make certain regulatory determinations, therefore necessitating promulgation of a rule to provide standards and procedures for the implementation of mental health parity. This rule creates a legal framework within which insurers can develop an environment of parity between mental health and medical-surgical benefits. This rule provides a formula for substituting both an aggregate lifetime limit and annual limit for a health plan that includes no or different limits on different categories of medical and surgical benefits. In addition, this rule defines the parameters of application and calculation for additional cost containment measures, as well as requiring reports from insurers with respect to the impact of mental health parity expenses on budgets from the preceding year. This latter information provides data necessary for the Insurance Commissioner to report to the Legislature, beginning on or before the thirty-first day of December, two thousand five, and annually thereafter.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

None

C. Economic Impact on Citizens/Public at Large.

None

Date: July 26, 2002

Signature of Agency Head or Authorized Representative

VINCENT J. KING, GENERAL COUNSEL

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: July 26, 2002

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:**

   June 18, 2002 - Comment Period.

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

   None

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

   Comment period ended July 18, 2002.

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

   Attached ___X___ **No comments received** _______

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

   July 26, 2002

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

Gara A. Hoke, Associate Counsel
West Virginia Insurance Commission
Legal Division
P.O. Box 50540
Charleston, WV 25305-0540
Phone: (304) 558-0401, ext. 139
Fax: (304) 558-1362
E-mail: hokega@mail.wvnet.edu

g. <u>IF DIFFERENT</u> 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)

Not applicable

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.

Not applicable

b. Date of hearing or comment period:

Not applicable

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

Not applicable

d. Attach findings and determinations and reasons:

Not applicable

Title 114, Series 64

ATTACHMENT TO QUESTION 2 (d):

Three sets of comments were received during the comment period in response to the proposed legislative rule; one from the Health Insurance Association of America ("HIAA"), one from the West Virginia Health Maintenance Organization Association ("HMO Association") and one from Golden Rule Insurance Company.[1]

A. HIAA submits the following comments by letter dated and received on July 18,2002:

1. HIAA proposes that 114 C.S.R. § 64.1.1 (a) (5) be deleted. HIAA states, "This statement of purpose, '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,' does not appear to be supported by statute. Cost containment measures do not have to be the same for medical surgical and mental health benefits. An insurer is simply required not to discriminate between medical surgical and mental health benefits, not that they be the same."

The Commissioner agrees that cost containment measures do not have to be the same once the 2%/1% threshold is met, and the rule so states. However, the Commissioner does not agree with the syntax distinction with regard to the word "discriminate," and therefore declines to make the changes proposed.

2. HIAA proposes inclusion of a new subdivision 1.1.b.3. which would provide that the regulations apply only to health benefit plans.

The Commissioner agrees to amend to state that the rule applies only to health benefit plans. This language will be added to subsection 1.1.b.2. and where there is inconsistency throughout the rule.

3. HIAA proposes a new subdivision, 1.1.c. which would provide that the 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 West Virginia Code.

[1] The Mental Health Coalition of WV filed after the comment period ended. However, no specific changes were requested.

This proposed change is readily evident from the language currently in the statute. However, to alleviate any possible confusion on this point, the Commissioner amends the rule to read,

"1.1.c. This rule does not apply to:

1. Any policy of individual accident and sickness insurance issued in accordance with article fifteen of chapter thirty-three of the West Virginia Code. (W.Va. Code §§33-15-1, et seq.)."

4. HIAA proposes that a subsection (1.6) be included to provide that the rule applies to group health plans which begin on or after the first day of January, 2003, and will cease to be effective on and after the twenty-first day of March, 2007, unless further extended by the Legislature.

The Commissioner agrees that dates of applicability should be added, therefore, a new subsection, 1.1.b.3. shall be added to read,

"1.1.b.3. Group health plans which begin on or after the first day of January, 2003. The provision of this rule shall cease to be effective on and after the thirty-first day of March, 2007, unless further extended by the Legislature."

5. HIAA proposes that the definition of "additional cost containment measures," be amended to state that the additional cost containment measures may result in discrimination between medical surgical benefits and mental health benefits in the administration of the plans, rather than its plan. Also, HIAA proposes that actual costs be included in definition. HIAA believes that this revised definition is more consistent with the intent of House Bill 4039.

The Commissioner disagrees with the premise that the rule be amended to allow language constituting the filing of anything other than every plan for each insurer interested in pursuing the approval of cost containment measures. For this reason, the Commissioner declines the amendment of "additional cost containment measures." However, in light of the volume as described in the comment, the Commissioner has amended and files herewith a new fiscal note. The Commissioner does agree with the proposal of adding actual costs to the definition for clarification purposes.

6. HIAA proposes that the definition of "2.3. base period" be amended to state, "the period used to calculate whether the insurer may claim that its plan exceeds the two percent or one

percent threshold. The base period must be for twelve consecutive calendar months."

The Commissioner both agrees and disagrees with the proposed amendment. Since the insurer is the entity filing the plans, the language will be amended to so reflect. However, the Commissioner declines to support the contention that an insurer will be filing "its plan." W.Va. Code §33-16-3a (a) (2) states "for any plan," meaning individually. In addition, the Commissioner declines to amend the rule to state that the base period is a "twelve consecutive month period" only. It is the goal of the Commissioner to have a calendar year base period to review data throughout the same and for it to be the same for each insurer.

7. HIAA proposes that the definition of "claims" be amended to reflect that "requests for reimbursement for payment of services be made by or on behalf of an insured to an insurer, or its intermediary, administrator or representative."

The Commissioner both agrees and disagrees with the comment and therefore, the rule is amended to state,

"2.4. 'Claims' means, for purposes of this rule, 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."

This amendment provides a more concise definition of "claims" while still allowing the provider to be involved in the process, if necessary.

8. HIAA proposes that the term "group members" be defined as beneficiaries or members receiving health care coverage through a group health benefit plan.

The Commissioner agrees to amend and therefore, 114 C.S.R. § 64.2.7, is amended to read,

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

9. HIAA proposes that administrative expenses be added to the definition of "incurred expenditures." HIAA states that administrative expenses "are arguably already included in the definition."

The Commissioner is inclined to agree that the percentage of those administrative expenses associated with mental health benefits be submitted as part of the incurred expenditures. In addition, the rule will also reflect that only that percentage of the per member per month management expenses, utilization review and capitation paid associated with mental health benefits be submitted as part of the incurred expenditures as well. 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. The Commissioner so amends.

10. HIAA proposed that the definition of insurer be amended to include "Blue Cross/Blue Shield" specifically rather then referring to Blue Cross/Blue Shield by statute only.

By naming a specific health service corporation, the Commissioner is limiting the application of the rule in future instances. Therefore, the Commissioner chooses not to amend the rule to specify Blue Cross/Blue Shield but rather chooses to refer to medical service corporations by statute only.

11. HIAA proposes that the definition of "total anticipated costs" be amended to state "all costs anticipated to be incurred including claims paid, administrative costs, pharmaceutical costs, per member per month management expenses, and utilization review."

The Commissioner is inclined to agree that the percentage of those administrative costs associated with mental health benefits be submitted as part of the total anticipated costs. In addition, the rule will also reflect that only that percentage of the per member per month management expenses, utilization review and capitation paid associated with mental health benefits be submitted as part of the total anticipated costs as well. 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. The Commissioner so amends. The Commissioner declines to amend the rule to include pharmaceutical costs because the intent was to include any pharmaceutical costs associated with mental health benefits in actual claims paid.

12. HIAA proposes that administrative expenses be added to the definition of "total costs."

The Commissioner is inclined to agree that the percentage of those administrative expenses associated with mental health benefits be submitted as part of the total costs. In addition, the rule will also reflect that only that percentage of the per member per month management expenses, utilization review and capitation paid associated with mental health benefits be submitted as part of the total costs as well. 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. The Commissioner so amends.

13. HIAA suggests that a definition for serious mental illness is necessary. Namely, "serious mental illness" means an illness included in the American Psychiatric Association's diagnostic and statistical manual of mental disorders as periodically revised under the diagnostic categories or sub classifications of (i) Schizophrenia and other psychotic disorders; (ii) bipolar disorders; (iii) depression disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine related disorders; (v) anxiety disorders; and (vi) anorexia and bulimia."

The Commissioner disagrees that a definition for serious mental illness is necessary in the rule. W.Va. Code §33-16-3a states that coverage for serious mental illness shall be provided and provides the same. Rules are intended for clarification purposes and since the statute speaks directly to serious mental illness and the rule does not so use, no clarification by way of definition is necessary.

14. HIAA proposes that a definition of "health benefit plan" should be included as set forth in W.Va. Code §33-16-1a(h).

The Commissioner agrees with the proposal and amends the rule to read,

"2.8 '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."

15. HIAA suggests a new section to be entitled, "Providing Benefits for Serious Mental Illness," which would provide that a health benefit plan shall provide benefits to all individual subscribers and members and to all group members for expenses arising from the treatment of serious mental illness but excluding custodial care, residential care or schooling. In addition, this new section would state that an insurer shall not discriminate between medical surgical benefits and mental health benefits but may make determinations of medical necessity and appropriateness, and may use health care quality and management tools. These tools 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, using third party administrators and using patient cost sharing in the form of copayments, deductibles and coinsurance.

The Commissioner chooses not to amend the rule to include a definition of serious mental illness. The purpose of promulgation of rules is to clarify that which is not clear by statute. In this case, House Bill 4039, now W.Va. Code §33-16-3a (a) (1) defines serious mental illness with specificity. Therefore, it would be redundant to amend the rule to include the same definition.

16. HIAA proposes that subsection 3.1 be amended to allow the submission of actual information in addition to actuarial information. Also, the proposed amendment would allow the insurer to base the cost containment measures on total actual costs and total anticipated costs.

The Commissioner chooses not to amend subsection 3.1 as proposed. House Bill 4039, codified at W.Va.Code §33-16-3a (a) (2), requires an "actuarial" demonstration to the insurance commissioner. In fact, actuarial includes actual information. In addition, the allowance of "anticipated costs" as well as "total costs" would forego the ability of the insurance commissioner to make a determination regarding cost containment measures based upon actual experience data if insurers chose not to provide it. For clarification purposes, the rule is amended to provide when total anticipated costs and total costs shall be used.

17. HIAA proposes that subsection 4.1 be amended to allow the insurer to base the cost containment measures on anticipated costs as well actual costs.

Anticipated costs are included in subsection 4.1 therefore, the Commissioner declines to amend.

18. HIAA does not understand the meaning of sections 5 and 6 and seeks clarification of these sections. HIAA also questions the authority of these sections.

While the Commissioner understands the comment, the authority does not exist with the office of the Insurance Commissioner to ignore clear legislative intent. The suggested changes should be offered by way of a proposed statutory amendment. For that reason, the Commissioner declines amendment of sections 5 and 6 of the rule.

19. HIAA questions the authority of the Insurance Commissioner to require that an insurer submit its request at least one hundred and twenty days before the anticipated effective date of renewal of the plan.

The intent of this provision was to allow the Insurance Commission the opportunity to approve or disapprove the filing within 60 days, therefore, allowing the additional 60 days for the insurers to implement the procedures. Since this was for the benefit of the insurers and it is evident from the comment that it is not necessary, the Commissioner agrees to amend the rule to a 60 day filing requirement.

20. HIAA proposes that subsection 7.4 be amended so as to delete the language stating that a directive may be given to add or delete cost containment measures as per the Insurance Commissioner.

The intent of this provision was to convey to insurers that the application for approval of cost containment measures must occur every year. To amend would change the meaning of the subsection, therefore, the Commissioner chooses not to amend.

21. HIAA opposes the provisions of subsection 7.6 which require that a summary of the data and the computation supporting the anticipated costs of mental health parity must be made available to plan participants and beneficiaries, free of charge, upon the participant or beneficiary's written request.

The Commissioner chooses not to amend subsection 7.6 because the information that would be provided to participants and beneficiaries is that which is provided to the Rates and Forms Division, Insurance Commission, and is not considered confidential business information because it is not proprietary in nature.

22. HIAA opposes the inclusion of subsection 7.7 by declaring that there is no authority for the Commissioner to charge an additional fee to perform its statutory duties. HIAA states that

filing fees should be the basis for providing these services by the Commissioner.

The Commissioner agrees to delete the additional fee provision of subsection 7.7.

B. The West Virginia HMO Association submits the following comments by letter dated and received on July 18, 2002:

1. The WVHMO Association points out that as a general rule, the provisions of Chapter 33 do not apply to health maintenance organizations unless specifically referenced in Section 24 of Article 25. While House Bill 4039, the bill amending W.Va. Code §33-16-3a, did not amend Section 24 of Article 25A to include Section 3a of Article 16, it did amend the definition of basic health care services in the HMO Act. Therefore, it appears that the provisions of W.Va. Code §33-16-3a do not pertain to health maintenance organizations or the plans written by health maintenance organizations and should therefore, be clarified in the rule.

The intent of House Bill 4039, the bill amending W.Va. Code §33-16-3a, was to apply the same parity measures to health maintenance organizations. Consequently, the Commissioner chooses not to amend the rule in the proposed fashion.

2. The WVHMO Association proposes that 114 C.S.R. § 64-1.1(a)(5) be deleted. HIAA states, "This statement of purpose, '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,' does not appear to be supported by statute. Cost containment measures do not have to be the same for medical surgical and mental health benefits. An insurer is simply required not to discriminate between medical surgical and mental health benefits, not that they be the same."

See response to HIAA comment 1.

3. The WVHMO Association suggests inclusion of a new subdivision 1.1.b.3. which would provide that the rule applies only to health benefit plans.

See response to HIAA comment 2.

4. The WVHMO Association proposes a new subdivision, 1.1.C. which would provide that the 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 West Virginia Code.

See response to HIAA comment 3.

5. The WVHMO Association proposes that a subsection be included to provide that the rule applies to group health plans which begin on or after the first day of January, 2003 and will cease to be effective on and after the thirty-first day of March, 2007, unless further extended by the Legislature.

See response to HIAA comment 4.

6. The WVHMO Association proposes that "additional cost containment measures" be amended to reflect that the additional cost containment measures may result in differences in the administration of medical surgical benefits and mental health benefits in the administration of plans to more accurately reflect the intent of House Bill 4039. Also, it is proposed that total costs be reflected in the definition as well.

See response to HIAA comment 5.

7. The WVHMO Association proposes an amendment to the term "base period" to state that the insurer may claim that its costs exceeds the two percent or one percent increased cost threshold and that the base period is for a period of twelve calendar months without specifically identifiable dates, such as calendar year.

See response to HIAA comment 6.

8. The WVHMO Association proposes that the definition of "claims" be amended to reflect that requests for reimbursement for payment of services be made by or on behalf of an insured to an insurer, or its intermediary, administrator or representative. Also amendment is proposed to reflect that normally there are no individual requests for reimbursement or proof of loss. Providers file claims with an HMO for services rendered to HMO members.

See response to HIAA comment 7.

9. The WVHMO Association proposes that the term "group members" be defined as beneficiaries or members receiving health care coverage through a group health benefit plan.

See response to HIAA comment 8.

10. The WVHMO Association proposes that for clarification purposes the definition of "incurred expenditures" be amended to reflect the inclusion of capitation paid, pharmaceutical costs and administrative expenses. The WVHMO Association states that arguably administrative expenses are already included in the definition but it is unclear what the sentence, "Incurred expenditures do not include premiums" means.

See response to HIAA comment 9.

11. The WVHMO Association proposes that the definition of insurer be amended to include "Blue Cross/Blue Shield" specifically rather then referring to Blue Cross Blue Shield by statute only.

See response to HIAA comment 10.

12. The WVHMO Association proposes that the definition of "total anticipated costs" be amended to include capitation paid and administrative costs.

The Commissioner is inclined to agree that the percentage of those administrative costs associated with mental health benefits be submitted as part of the total anticipated costs. In addition, the rule will also reflect that only that percentage of the per member per month management expenses, utilization review and capitation paid associated with mental health benefits be submitted as part of the total anticipated costs as well. 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. The Commissioner so amends.

13. The WVHMO Association proposes that administrative expenses be added to the definition of "total costs."

The Commissioner is inclined to agree that the percentage of those administrative expenses associated with mental health benefits be submitted as part of the total costs. In addition, the rule will also reflect that only that percentage of the per member per month management expenses, utilization review and capitation paid associated with mental health benefits be submitted as part of the total anticipated costs as well. 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. The Commissioner so amends.

14. The WVHMO proposes that the rule include a definition of "serious mental illness." Namely, "serious mental illness" means an illness included in the American Psychiatric Association's diagnostic and statistical manual of mental disorders as periodically revised under the diagnostic categories or sub classifications of (i) Schizophrenia and other psychotic disorders; (ii) bipolar disorders; (iii) depression disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine related disorders; (v) anxiety disorders; and (vi) anorexia and bulimia.

See response to HIAA comment 13.

15. The WVHMO Association proposes that the definition of "health benefit plan" set forth in W.Va. Code §33-16-1a(h) be included in the rule.

See response to HIAA comment 14.

16. The WVHMO Association suggests a new section to be entitled, "Providing Benefits for Serious Mental Illness which would provide that a health benefit plan shall provide benefits to all individual subscribers and members and to all group members for expenses arising from the treatment of serious mental illness but excluding custodial care, residential care or schooling. In addition, this new section would state that an insurer shall not discriminate between medical surgical benefits and mental health benefits but may make determinations of medical necessity and appropriateness, and may use health care quality and management tools. These tools 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, using third party administrators and using patient cost sharing in the form of copayments, deductibles and coinsurance.

See response to HIAA comment 15.

17. The WVHMO Association proposes that subsection 3.1 be amended to allow the submission of actual information in addition to actuarial information. Also, the proposed amendment would allow the insurer to base the cost containment measures on total actual costs and total anticipated costs.

See response to HIAA comment 16.

18. The WVHMO Association proposes that subsection 4.1 be amended to include total anticipated costs.

See response to HIAA comment 17.

19. The WVHMO Association does not understand the meaning of sections 5 and 6 and seeks clarification of these sections. The WVHMO Association also questions the authority of these sections.

See response to HIAA comment 18.

20. The WVHMO Association questions the authority of the Insurance Commissioner to require that an insurer submit its request at least one hundred and twenty days before the anticipated effective date of renewal of the plan.

See response to HIAA comment 19.

21. The WVHMO Association proposes that subsection 7.4 be amended so as to delete the language stating that a directive may be given to add or delete cost containment measures as per the Insurance Commissioner.

See response to HIAA comment 20.

22. The WVHMO Association opposes the provisions of 7.6 which require that a summary of the data and the computation supporting the anticipated costs of mental health parity must be made available to plan participants beneficiaries, free of charge, upon the participant or beneficiary's written request.

See response to HIAA comment 21.

23. The WVHMO Association opposes the inclusion of 7.7 by declaring that there is no authority for the Commissioner to charge an additional fee to perform its statutory duties. HIAA states that filing fees should be the basis for providing these services by the Commissioner.

See response to HIAA comment 22.

C. Golden Rule Insurance Company submits the following comments by letter dated and received on July 18, 2002:

1. Golden Rule Insurance Company submits that West Virginia Code Section 33-16-3a (a) only requires health benefit plans to provide coverage for serious mental illness, as defined, and that

insurers may limit their cost exposure or employ methods to control costs for any health benefits plan(including serious mental illness benefits) if the test under 33-16-3a(a)(2) is met.

2. Golden Rule Insurance Company submits that West Virginia Code Section 33-16-3a applies only to group health plans and not all health benefit plans. In addition, it is only applicable to non-employer health benefit plans.

3. Golden Rule Insurance Company states that only employer-based plans must provide these benefits to the same extent as other medical and surgical benefits with respect to aggregate lifetime and annual limits. Non-employer health benefit plans may, by implication, employ coverage limitations on both aggregate lifetime and annual limits.

**Except to say that the rule should be rewritten, Golden Rule Insurance Company offered no proposed changes to the rule, and therefore, no changes were made in response.*

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July 18, 2002
VIA HAND-DELIVERY

RECEIVED
2002
LEGAL DIVISION
W.VA. INS. DEPT.

Ms. Jane Cline, Commissioner
West Virginia Division of Insurance
1124 Smith Street
Charleston, West Virginia 25305

RE: Comments to 114 CSR, Series 64
"Mental Health Parity"

Dear Commissioner Cline:

These comments are submitted on behalf of the Health Insurance Association of America (HIAA) to address proposed Series 64 entitled "Mental Health Parity." (114 C.S.R. § 64-1, *et seq.*) HIAA is the nation's most prominent trade association representing the private health care system. Its 300 members provide health, long term care, dental, disability and supplemental coverage to more than 200 million Americans.

1. HIAA proposes that 114 C.S.R. § 64-1.1(a)(5) be deleted. This statement of purpose, "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," does not appear to be supported by the statute. Cost containment measures do not have to be the same for medical surgical and mental health benefits. This is particularly true if the costs of mental health exceed two or one percent depending on the size of the group provided coverage. W.Va. Code § 33-16-3a(a)(2). It also is true even if the costs of mental health do not exceed this threshold. An insurer is simply required "not to discriminate" between medical surgical and mental health benefits, not that they be the same. W.Va. Code § 33-16-3a(a)(3).

2. HIAA would propose inclusion of a new subdivision 1.1.b.3 which would provide:

"3. Health benefit plans only."

The regulations only apply to health benefit plans. W. Va. Code § 33-16-3a(a)(1) provides in part: "Notwithstanding the requirements of subsection (b) of this section, <u>any health benefit plan</u> . . ."

3. HIAA would propose inclusion of a new subdivision 1.1.C. which provides as follows:

c. 1. This Rule does not apply to:

1. Any policy of individual accident and sickness insurance issued in accordance with article of chapter twenty-three of the Code of West Virginia (W.Va. Code § 33-15-1, *et seq.*).

As authority for this addition, West Virginia Code § 33-16-1(a) provides in pertinent part that "nothing in this article shall apply or affect . . . any policy of individual accident and sickness insurance issued in accordance with article 15 of this chapter. . . ."

In addition, West Virginia Code § 33-16-3a(a)(4) provides that "the provisions of this subsection shall apply with respect to group health plans . . ." Therefore, it is clear that it does not apply to individual coverage.

4. HIAA would propose the inclusion of the following subsection:

1.6 Applicability. The provisions of this rule shall apply to group health plans which begin on and after the first day of January, 2003.

The provision of this rule shall cease to be effective on and after the twenty-first day of March, 2007, unless further extended by the Legislature.

The authority for this subdivision is W.Va. Code § 33-16a-3a(a)(4).

5. HIAA would propose the following changes to the definition of "additional cost containment measures":

2.1 "Additional cost containment measures" means those cost containment measures, including but not limited to limitations on inpatient and outpatient benefits, which are necessary to ensure that the total actual or anticipated costs for treatment for mental health for plans does not exceed two percent of the total costs in such plans, or one percent for plans of twenty-five or less. The additional cost containment measures may result in discrimination between medical surgical benefits and mental health benefits in the administration of ~~its plan~~ the plans.

HIAA believes that this revised definition is more consistent with the intent of House Bill 4039.

6. HIAA would propose that the definition of "base period" be amended as follows:

> 2.3 "Base period" means the period used to calculate whether the insurer may claim that its plans exceed the two percent or one percent increased cost threshold. The base period must be for twelve consecutive calendar months ~~and begin on the first day of the calendar year in the year immediately preceding the year in which the increased cost exemption would be applicable~~.

The statute speaks in terms of "plan years." The key is that based on actuarial data or actual data, the costs will exceed the threshold of two percent or one percent. The experience periods will not necessarily fall on the calendar year, but will vary.

7. HIAA would propose the following revisions to the definition of "claims."

> "Claims" means, for purposes of this rule, ~~individual~~ requests for reimbursement ~~or proof of loss~~ for payment of services made by or on behalf of an insured to an insurer ~~or a provider to an insured~~, or its intermediary, administrator or representative.

8. HIAA would propose that the definition of "group members" be revised as follows:

> 2.7 "Group Members" means beneficiaries or members receiving health care coverage through a group health benefit plan.

9. HIAA would propose that the definition of "incurred expenditures" be amended as follows:

> 2.8 "Incurred expenditures" means costs associated with mental health and medical surgical benefits. Incurred expenditures includes actual claims paid, per member per month case management expenses, administrative expenses, and utilization review during the base period. Incurred expenses do not include premiums.

This amendment is for clarification purposes only. Administrative expenses are arguably already included in the definition.

10. HIAA would propose that the definition of an "insurer" be amended to include "Blue Cross/Blue Shield." Even though the BCBS is captured by the language "who are otherwise subject to W.Va. Code § 33-16-3a," it would be clearer to expressly incorporate these types of insurers into the definition of insurer.

11. HIAA would propose that the definition of "total anticipated costs" be amended as follows:

> 2.14 "Total anticipated costs" means all costs anticipated to be incurred including claims paid, administrative costs, pharmaceutical costs, per member per month management expenses, and utilization review.

12. HIAA would propose that "administrative expenses" be added to the definition of "total costs." (114 C.S.R. § 64-2-15.)

13. HIAA would propose that the regulations include the following definition:

> "Serious mental illness" means an illness included in the American Psychiatric Association's diagnostic and statistical manual of mental disorders as periodically revised under the diagnostic categories or sub classifications of (i) Schizophrenia and other psychotic disorders; (ii) bipolar disorders; (iii) depression disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine related disorders; (v) anxiety disorders; and (vi) anorexia and bulimia.

14. HIAA would propose that the following definition be included:

> "Health benefit plan" shall have the same meaning as set forth in West Virginia Code § 33-16-1a(h).

In the alternative, the full text contained in § 33-16-1a(h) can be included. However, this will also require the inclusion of the definition for "excepted benefits."

15. HIAA would propose the inclusion of a new section to be entitled "Providing Benefits for Serious Mental Illness" which would provide as follows:

> 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 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 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, using third party administrators and using patient cost sharing in the form of copayments, deductibles and coinsurance.

16. HIAA would propose that subsection 3.1 be amended as follows:

3.1 An insurer may apply additional cost containment measures, upon approval of the commissioner, if the insurer submits actual or actuarial information that (i) its total actual costs or total anticipated costs for treatment of mental illness for its plans have exceeded or will exceed two percent ~~of its total actual costs or total anticipated costs~~, or (ii) have exceeded or will exceed one percent for groups with twenty-five members or less, of the total cost or total anticipated cost in any base period.

The industry cannot on a group-by-group basis make this two or one percent analysis. The cost containment measures must be on a block of business, i.e., groups of 25 or less, groups 26 or more. As proposed, this would create an administrative nightmare for both the department and the HMO. Therefore, the determination of one or two percent should be based on an insurer's group business.

17. HIAA would propose the following amendment to subsection 4.1:

4.1 If an insurer anticipates that its total costs or total anticipated costs for the treatment of mental illness for its plans will exceed or have exceeded two percent or one percent for any groups with twenty-five members or less in any base period. . .

The same reasoning applies to this revision as proposed for subsection 3.1 in paragraph 15 above.

18. HIAA does not understand the meaning of sections 5 and 6 and seeks clarification of these sections. HIAA also questions authority of these sections.

19. HIAA questions the authority of the Insurance Commissioner to require that an insurer submit its request at least one hundred and twenty days before the anticipated effective date of renewal of the plan as (set forth in subsection 7.2 (114 CSR 64.7.1). HB 4039 is silent on this issue. Existing law only requires sixty days. W. Va. Code § 33-6-8. The sixty day period for approval or disapproval of the use of cost containment measures is consistent with the statute.

20. HIAA would propose that subsection 7.4 be amended as follows:

> 7.4 The approval or disapproval of additional cost measures shall be based on one years experience.

An insurer will not include the additional cost control measures unless approved by the Commissioner. Therefore, there will be no need to add or delete cost containment measures.

21. HIAA opposes the provisions of 7.6. This information is confidential business information which should not be provided to members.

22. HIAA opposes the inclusion of 7.7 (114 CSR 64.1.7). There is no authority for the Commissioner to charge an insurer an additional fee for the Commissioner to perform its statutory duties. Insurers are already charged substantial fees for filings made to the Department. The monies from these fees already paid to the Commissioner should be the basis for providing these services by the Commissioner.

Submitted by,

T. Randolph Cox, on behalf of the
Health Insurance Association of America

216312

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July 18, 2002

VIA HAND-DELIVERY

RECEIVED
[illegible] 2002
LEGAL DIVISION
W.VA. INS. DEPT.

Ms. Jane Cline, Commissioner
West Virginia Division of Insurance
1124 Smith Street
Charleston, West Virginia 25305

RE: Comments to 114 CSR, Series 64
"Mental Health Parity"

Dear Commissioner Cline:

These comments are submitted on behalf of the West Virginia Health Maintenance Organization Association (WVHMO Association) to address proposed Series 64 entitled "Mental Health Parity." (114 C.S.R. § 64-1, *et seq.*) The WVHMO Association is a state association representing all of the health maintenance organization's currently doing business in West Virginia. The members of the WVHMO Association are the Health Plan, Carelink and Optimum Choice, Inc.

1. The WVHMO Association's preliminary comment goes to the applicability of W. Va. Code § 33-16-3a to health maintenance organizations, and, in particular, whether all or a part of W. Va. Code § 33-16-3a applies to health maintenance organizations. House Bill 4039 passed during the 2002 general session, and it is the prime authority for these regulations. As a general rule, the provisions of Chapter 33 do not apply to health maintenance organizations unless specifically referenced in Section 24 of Article 25. (W. Va. Code § 33-25A-24). House Bill 4039 did not amend section 24; and there was no reference to Section 3A, Article 16 in Section 24 of Article 25A prior to passage of House Bill 4039.

While House Bill 4039 did not amend section 24 of Article 25A to include Section 3a of Article 16, it did amend the definition of basic health care services in the HMO Act to include "treatment for serious mental illness as provided in section 3a, article 16 of this chapter." (W. Va. Code § 33-25A-2(1)) The discussion of serious mental illness is only referenced in Subsection a of Section 3a of Article 16. Subsection b, which deals with annual limits and lifetime limits for health plans, does not reference "serious mental illness." Further,

this provision did not apply to health maintenance organizations when it was originally passed in 1997. Therefore, the provisions of subsection b do not apply to health maintenance organizations or the plans written by health maintenance organizations, and the provisions of Sections 5 and 6 of proposed Series 64 should not be applicable to health maintenance organizations. Further, there would be no limitation on health maintenance organization applying annual or lifetime limitations for mental illness benefits.

In addition, while the amendments of House Bill 4039 require an HMO to provide coverage for serious mental illness, the amendments arguably don't require parity or that an HMO not discriminate between mental illness and medical surgical benefits. As such, other than having to provide coverage for serious mental illness, the provisions of subsection a of section 3A arguably would not apply. Accordingly, a health maintenance organization would be permitted to apply different standards for mental illness benefits. Under this interpretation, the regulations would not apply to health maintenance organizations.

In the alternative, the WVHMO Association would offer the following comments:

2. The WVHMO Association proposes that 114 C.S.R. § 64-1.1(a)(5) be deleted. This statement of purpose, "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," does not appear to be supported by the statute. Cost containment measures do not have to be the same for medical surgical and mental health benefits. This is particularly true if the costs of mental health exceed two or one percent depending on the size of the group provided coverage. W.Va. Code § 33-16-3a(a)(2). It also is true even if the costs of mental health do not exceed this threshold. An insurer is simply required "not to discriminate" between medical surgical and mental health benefits, not that they be the same. W.Va. Code § 33-16-3a(a)(3).

3. The WVHMO Association would propose inclusion of a new subdivision 1.1.b.3 which would provide:

"3. Health benefit plans only."

The regulations only apply to health benefit plans. W. Va. Code § 33-16__-3a(a)(1) provides in part: "Notwithstanding the requirements of subsection (b) of this section, <u>any health benefit plan</u> . . ."

4. The WVHMO Association would propose inclusion of a new subdivision 1.1.C. which provides as follows:

c. 1. This Rule does not apply to:

> 1. Any policy of individual accident and sickness insurance issued in accordance with article of chapter twenty-three of the Code of West Virginia (W.Va. Code § 33-15-1, *et seq.*).

As authority for this addition, West Virginia Code § 33-16-1(a) provides in pertinent part that "nothing in this article shall apply or affect . . . any policy of individual accident and sickness insurance issued in accordance with article 15 of this chapter. . . ."

In addition, West Virginia Code § 33-16-3a(a)(4) provides that "the provisions of this subsection shall apply with respect to group health plans . . ." Therefore, it is clear that it does not apply to individual coverage.

5. The WVHMO Association would propose the inclusion of the following subsection:

> 1.6 Applicability. The provisions of this rule shall apply to group health plans which begin on and after the first day of January, 2003.
>
> The provision of this rule shall cease to be effective on and after the twenty-first day of March, 2007, unless further extended by the Legislature.

The authority for this subdivision is W.Va. Code § 33-16a-3a(a)(4).

6. The WVHMO Association would propose that the definition of "additional cost containment measures" be amended to the following:

> 2.1 "Additional cost containment measures" means those cost containment measures, including but not limited to limitations on inpatient and outpatient benefits, which are necessary to ensure that the total actual or anticipated costs for treatment for mental health for plans does not exceed two percent of the total costs in such plans, or one percent for plans of twenty-five or less. The additional cost containment measures may result in differences in the administration of medical surgical benefits and mental health benefits in the administration of the plans.

The WVHMO Association believes that this revised definition is more consistent with the intent of House Bill 4039.

7. The WVHMO Association would propose that the definition of "base period" be amended as follows:

> 2.3 "Base period" means the period used to calculate whether the insurer may claim that its plans exceed the two percent or one percent increased cost threshold. The base period must be for twelve consecutive calendar months ~~and begin on the first day of the calendar year in the year immediately preceding the year in which the increased cost exemption would be applicable~~.

The statute speaks in terms of "plan years." The key is that based on actuarial data or actual data, the costs will exceed the threshold of two percent or one percent. The experience periods will not necessarily fall on the calendar year, but will vary.

8. The WVHMO Association would propose revisions to the definition of "claims."

> "Claims" means, for purposes of this rule, ~~individual~~ requests for reimbursement ~~or proof of loss~~ for payment of services made by or on behalf of an insured to an insurer ~~or a provider to an insured~~, or its intermediary, administrator or representative.

Normally, there are no individual requests for reimbursement nor proof of loss. Providers file claims with an HMO for services rendered to HMO members.

9. The WVHMO Association would propose that the definition of "group members" be revised as follows:

> 2.7 "Group Members" means beneficiaries or members receiving health care coverage through a health benefit plan.

10. The WVHMO Association would propose that the definition of "incurred expenditures" be amended as follows:

> 2.8 "Incurred expenditures" means costs associated with mental health and medical surgical benefits. Incurred expenditures includes actual claims paid, capitation paid, per member per month case management expenses, pharmaceutical costs, administrative expenses, and utilization review during the base period. Incurred expenses do not include premiums.

This amendment is for clarification purposes only. Administrative expenses are arguably already included in the definition. It is unclear what the sentence "Incurred expenditures do not include premiums" means.

11. The WVHMO Association would propose that the definition of an "insurer" be amended to include "Blue Cross/Blue Shield." Even though the BCBS is captured by the language "who are otherwise subject to W.Va. Code § 33-16-3a," it would be clearer to expressly incorporate these types of insurers into the definition of insurer.

12. The WVHMO Association would propose that the definition of "total anticipated costs" be amended as follows:

> 2.14 "Total anticipated costs" means all costs anticipated to be incurred including claims paid, capitation paid, administrative costs, pharmaceutical costs, per member per month management expenses, and utilization review.

13. The WVHMO Association would propose that "administrative expenses" be added to the definition of "total costs." (114 C.S.R. § 64-2-15.)

14. The WVHMO Association would propose that the regulations include the following definition:

> "Serious mental illness" means an illness included in the American Psychiatric Association's diagnostic and statistical manual of mental disorders as periodically revised under the diagnostic categories or sub classifications of (i) Schizophrenia and other psychotic disorders; (ii) bipolar disorders; (iii) depression disorders; (iv) substance-related disorders with the exception of caffeine-related disorders and nicotine related disorders; (v) anxiety disorders; and (vi) anorexia and bulimia.

15. The WVHMO Association would propose that the following definition be included:

> "Health benefit plan" shall have the same meaning as set forth in West Virginia Code § 33-16-1a(h).

In the alternative, the full text contained in § 33-16-1a(h) can be included. However, this will also require the inclusion of the definition for "excepted benefits."

16. The WVHMO Association would propose the inclusion of a new section to be entitled "Providing Benefits for Serious Mental Illness" which would provide as follows:

> 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 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 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, using third party administrators and using patient cost sharing in the form of copayments, deductibles and coinsurance.

17. The WVHMO Association would propose that subsection 3.1 be amended as follows:

> 3.1 An insurer may apply additional cost containment measures, upon approval of the commissioner, if the insurer submits actual or actuarial information that (i) its total actual costs or total anticipated costs for treatment of mental illness for its plans have exceeded or will exceed two percent ~~of its total actual costs or total anticipated costs~~, or (ii) have exceeded or will exceed one percent for groups with twenty-five members or less, of the total cost or total anticipated cost in any base period.

The industry cannot on a group-by-group basis make this two or one percent analysis. The cost containment measures must be on a block of business, i.e., groups of 25 or less, groups 26 or more as proposed. This would create an administrative nightmare for both the

department and the HMO. Therefore, the determination of one or two percent should be based on an insurer's group business.

18. The WVHMO Association would propose the following amendment to subsection 4.1:

> 4.1 If an insurer anticipates that its total costs or total anticipated costs for the treatment of mental illness for its plans will exceed or have exceeded two percent or one percent for any groups with twenty-five members or less in any base period. . .

The same reasoning applies to this revision as proposed for subsection 3.1 in paragraph 15 above. The WVHMO Association does not believe these sections (5 and 6) apply to HMO's. Nevertheless, the WVHMO Association will offer this limited comment.

19. The WVHMO Association does not understand the meaning of sections 5 and 6 and seeks clarification of these sections. The WVHMO Association also questions authority of these sections.

20. The WVHMO Association questions the authority of the Insurance Commissioner to require that an insurer submit its request at least one hundred and twenty days before the anticipated effective date of renewal of the plan as (set forth in subsection 7.2 (114 CSR 64.7.1). HB 4039 is silent on this issue. The sixty day period for approval or disapproval of the use of cost containment measures is consistent with the statute.

21. The WVHMO Association would propose that subsection 7.4 be amended as follows:

> 7.4 The approval or disapproval of additional cost measures shall be based on one years experience.

An insurer will not include the additional cost control measures unless approved by the Commissioner. Therefore, there will be no need to add or delete cost containment measures.

22. The WVHMO Association opposes the provisions of 7.6. This information is confidential business information which should not be provided to members.

23. The WVHMO Association opposes the inclusion of 7.7 (114 CSR 64.1.7). There is no authority for the Commissioner to charge an insurer an additional fee for the Commissioner to perform its statutory duties. Insurers are already charged substantial fees for

filings made to the Department. The monies from these fees already paid to the Commissioner should be the basis for providing these services by the Commissioner.

Submitted by,

T. Randolph Cox, on behalf of
The West Virginia HMO Association

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Golden Rule®

July 18, 2002

RECEIVED

2002

LEGAL DIVISION
W.VA. INS. DEPT.

Gara Hoke, Associate Counsel
Insurance Commission
1124 Smith St.
P.O. Box 50540
Charleston, WV 25305-0540

RE: Proposed Rule, Mental Health Parity,
Title 114, Series 64

Dear Ms. Hoke:

Golden Rule Insurance Company offers the following comments to the above referenced proposal:

H.B. 4039 amended and reenacted in part W. VA Code §33-16-3a. The opening subsection (a)(1) states that "health benefit plans described in this article . . . shall provide benefits . . . for expenses arising from treatment of serious mental illness." It does not state to what extent those benefits must be provided.

Health benefits plan is defined in statute (33-16-1a(h)) and is a broad term pertaining to health insurance coverage. Serious mental illness was defined carefully and narrowly in the statute itself.

Subsection (a)(2) permits insurers to limit their exposure for these benefits if the total costs for treatment of mental illness exceeds a percentage of total costs for all benefits under the plan (two percent for groups with more than 25 members, one percent for groups with 25 or fewer members). Even though this subsection does not use the term "serious," there would have been no point in confining subsection (a)(1) to serious mental illness if the legislature did not intend for the subsection (a)(2) limits to apply to them.

It is Golden Rule's position that the newly enacted §33-16-3a(a) only requires health benefit plans (both employer-based and non-employer-based) to provide coverage for serious mental illness, as defined, and that insurers may limit their cost exposure for any mental health benefits (including serious mental illness benefits) if the test under 33-16-3a(a)(2) is met (i.e., if the costs for any mental health benefits exceeds two percent or one percent depending on the group size of the costs for all benefits under

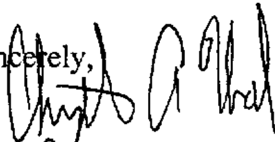
the plan). Carriers may limit both inpatient and outpatient benefits in order to control these costs (§33-16-3a(a)(2)). Carriers can offer additional mental health benefits but are not required to do so.

Furthermore, it is clear from the new statute that §33-16-3a(b) applies only to group health plans and not all health benefit plans. Group health plan is defined in §33-16-1a(g) to mean employee welfare benefit plans. In other words, §33-16-3a(b) has no application whatsoever to non-employer health benefit plans.

In summary, it is Golden Rule's position that health benefit plans need only provide some level of benefits for serious mental illnesses (as defined) and may employ methods to control costs for any mental health benefit (including serious mental illness benefits) (33-16-3a(a)(2). It is also our position that only employer-based plans must provide these benefits to the same extent as other medical and surgical benefits with respect to aggregate lifetime and annual limits. Non-employer health benefit plans may, by implication, employ coverage limitations on both aggregate lifetime and annual benefits.

Therefore, Golden Rule believes that the statute has created an apparent distinction between employer-based and non-employer-based health benefit plans. The statute requires all such plans to provide coverage for serious mental health illnesses but does not specify to what extent. Theoretically, a non-employer-based plan could provide three days of outpatient visits per year for serious mental health illnesses and be fully compliant with the law. We believe the Department should clarify this in its rule. We also believe that the Department can and should rewrite the rule to better conform to the statute as discussed above; e.g., it should clearly state that only serious mental health illnesses must now be covered and that the restrictions on aggregate lifetime and annual limits apply only without employer-based health benefit plan.

Sincerely,



Lee D. Tooman, Jr.
Vice President
Government Relations

Insurance Commissioner
Legislative Rule
Title 114, Series 64

MENTAL HEALTH PARITY

TITLE 114, SERIES 64

BRIEF SUMMARY OF RULE

W. Va. Code § 33-16-3a requires that the Commissioner propose rules for legislative approval, with respect to aggregate lifetime limits and annual limits for those health benefit plans that include no or different limits on different categories of medical and surgical benefits. This rule provides a formula for substituting both an aggregate lifetime limit and annual limit for such health plans. Furthermore, this rule clarifies the calculation data necessary to support additional cost containment measures for insurers that anticipate total costs for treatment for mental illness, for any plan, will exceed or have exceeded two percent of the total costs for such plan in a base period, or one percent for any group with twenty-five members or less. This rule also provides procedures for implementing the aforementioned criteria.

Insurance Commissioner
Legislative Rule
Title 114, Series 64

MENTAL HEALTH PARITY

TITLE 114, SERIES 64

STATEMENT OF CIRCUMSTANCES

The federal Mental Health Parity Act (MHPA) was signed into law on September 26, 1996. The goal was broader health insurance coverage for mental health treatment. Subsequently, the West Virginia Legislature passed House Bill 4039 during the 2002 legislative session, which amended codified mental health provisions at W. Va. Code § 33-16-3a. 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) Define standards by which health care professionals shall implement parity; 4) Minimize the possibilities of confusion and interruption of patient care; and 5) 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. By proposing this rule, the Insurance Commissioner fulfills a statutory duty and a legislative desire to extend broader mental health treatment to subscribers and members of group health plans.

114CSR64
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 64
MENTAL HEALTH PARITY

Section

114-64-1. General.

114-64-2. Definitions.

114-64-3. Allowance of Additional Cost Containment Measures.

114-64-4. Calculation for Application of Additional Cost Containment Measures.

114-64-5. Aggregate Lifetime Limits.

114-64-6. Annual Limits.

114-64-7. Rates and Forms Filings.

114-64-8. Coverage for Alcohol Treatment.

114CSR64
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

FILED
2002 JUL 26 P 3:50
OFFICE WEST VIRGINIA
SECRETARY OF STATE

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

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

5. 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. 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 plans which begin on or after the first day of January, 2003. The provision of this rule shall cease to be effective on and after the thirty-first day of March, 2007, unless further extended by the Legislature.

c. This rule does not apply to:

1. Any policy of individual accident and sickness insurance issued in

accordance with article fifteen of chapter thirty-three of the West Virginia 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. --

1.4. Effective Date. --

§114-64-2. Definitions.

2.1. "Additional 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.

2.2. "Commissioner" means the West Virginia insurance commissioner.

2.3. "Base period" means the period used to calculate whether the insurer may claim the two percent or one percent increased cost exemption. The base period must be twelve consecutive calendar months and begin on the first day of the calendar year in the year immediately preceding the year in which the increased cost exemption would be applicable.

2.4. "Claims" means, for purposes of this rule, 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 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. "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.

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

2.11. "Insurer" means, for purposes of this rule, 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. "Mental illness" means, for purposes of this rule, 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. "Pharmaceutical classes" means a numerical identifier of pharmaceuticals as set forth in the 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. "Therapeutic classes" means a numerical identifier of therapeutic treatments as set forth in the American psychiatric association's diagnostic and statistical manual of mental disorders, as periodically revised.

2.15. "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.

2.16. "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. Allowance of Additional Cost Containment Measures.

3.1. An insurer may apply additional cost containment measures, upon approval of the commissioner, if the insurer submits actuarial information to the 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 year thereafter the insurer submits actuarial information to the commissioner demonstrating its total costs for treatment of mental illness have exceeded two percent, or one percent for any group with twenty-five members or less, for the plan in the base period.

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 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.

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

§114-64-4. Calculation for Application of Additional Cost Containment Measures.

4.1. If an insurer anticipates that its total costs for treatment of mental illness for any plan will exceed or has 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 period, for that plan, divided by,

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

§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 total plan expenditures and are comparable in scope to mental health benefits. The average is calculated by weighting each applicable limit to reflect its share of plan expenditures. Any unlimited categories are figured into the average by using in place of a limit a reasonable estimate of the maximum plan expenditure that could possibly be incurred in connection with all such categories, and weighting this estimate to reflect the proportion of total plan expenditures attributable to all such categories.

§114-64-6. Annual Limits.

6.1. An annual limit may be imposed if the benefit categories to which separate limits apply account for at least one-third of total plan expenditures and are comparable in scope to mental health benefits. The average is calculated by weighting each applicable limit to reflect its share of plan expenditures. Any unlimited categories are figured into the average by using in place of a limit a reasonable estimate of the maximum plan expenditure that could possibly be incurred in connection with all such categories, and weighting this estimate to reflect the proportion of total plan expenditures attributable to all such categories.

§114-64-7. Rates and Forms Filings.

7.1. For those insurers that anticipate total costs exceeding two percent, or exceeding one percent for groups of twenty-five members or less, an application containing actuarial data shall be filed with the Rates and Forms Division, West Virginia Insurance Commission to be qualified to implement any costs containment measures that may be applicable.

7.2. The actuarial 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 additional cost containment measures shall be on an annual basis and may result in a directive to add or delete cost containment measures.

7.5. All insurers shall file an annual report, on a form prescribed by the commissioner, regarding the fiscal impact of mental health parity expenses on their budgets for the preceding year.

7.6. A summary of the data and the computation supporting the anticipated costs of mental health parity and anticipated total costs must be made available to plan participants and beneficiaries, free of charge, upon the participant or beneficiary's written request.

§114-64-8. Coverage for Alcohol Treatment.

Coverage for alcohol treatment shall be included in mental health treatment. Any other language restricting alcohol treatment coverage, including that found in W.Va. Code §33-16-3c, is superceded by W. Va. Code §33-16-3a.

STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

Legal Division

BOB WISE
Governor

JANE L. CLINE
Insurance Commissioner

July 26, 2002

HAND DELIVERED

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, West Virginia 25305

Dear Ms. Cooper:

Please find herewith, one (1) copy of the following for filing:

1) Notice of Agency Approval of a Proposed Rule and Consent of Cabinet Secretary of Tax and Revenue;

2) Legislative Rule-Making Review Committee Questionnaire;

3) Brief Summary of Rule;

4) Statement of Circumstances;

5) Fiscal Note for Proposed Rule; and

6) Agency approved proposed rule entitled "Mental Health Parity" (Title 114, Series 64).

Please contact me if further information is required.

Sincerely,

Jane L. Cline
Insurance Commissioner

JLC/jz
Attachments

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