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**Supplement No. 1
to Circular Letter No. 20 (2009)
September 17, 2010**

TO: All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, and Health Maintenance Organizations (“HMOs”) (collectively, “insurers”)

RE: Impact of the federal Mental Health Parity and Addiction Equity Act of 2008

STATUTORY AND REGULATORY REFERENCES: Public Law 110-343; 45 C.F.R. § 146.136; N.Y. Ins. Law §§ 3103, 3201, 3221, 4303 and 4308 and Article 49

The purpose of this Supplement to Circular Letter No. 20 (2009) is to provide additional guidance to insurers about the impact of the federal Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”) on New York’s insurance market.

Since the issuance of Circular Letter No. 20 (2009), the United States Department of the Treasury, Department of Labor and Department of Health and Human Services have issued interim final rules implementing the MHPAEA. These rules were published in the Federal Register on February 2, 2010, and apply to group health plans and policies or contracts issued to group health plans for plan years beginning on or after July 1, 2010. Codified as 45 C.F.R. §146.136, the interim final rules clarify and/or modify a number of issues that Circular Letter No. 20 (2009) addressed.¹

¹ 45 C.F.R. § 146.136(a) defines “mental health benefits” as “benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).” It also defines “substance use disorder benefits” as “benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any

I. Inpatient Substance Use Disorder Benefits

A. Providing Inpatient Substance Use Disorder Benefits

N.Y. Ins. Law §§ 3221(1)(7) and 4303(1) (McKinney Supp. 2010) require group and group remittance health insurance policies or contracts that provide coverage for inpatient hospital care to include outpatient substance use disorder benefits. However, Insurance Law §§ 3221(1)(6) and 4303(k) only require an insurer to make inpatient substance use disorder benefits available for purchase by the policyholder or contractholder. When the Department issued Circular Letter No. 20 (2009), it was not clear whether the MHPAEA would require policies and contracts that provide coverage for outpatient substance use disorder treatment to also provide coverage for inpatient substance use disorder treatment.

The interim final rules clarify that a group health plan or a policy or contract issued to a group health plan that covers the outpatient treatment of substance use disorders also must include coverage for inpatient treatment of substance use disorders. See 45 C.F.R. § 146.136(c)(2)(ii)(A). The interim final rules separate benefits into “classifications.” See id. The classifications include inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs. See id. The rules provide that if a plan includes mental health or substance use disorder benefits in any classification of benefits, then the plan must provide mental health or substance use disorder benefits in every classification in which the plan provides medical/surgical benefits. See id.

For instance, if a contract or policy provides inpatient in-network medical/surgical benefits, then the contract or policy must provide coverage for inpatient in-network mental health or substance use disorder benefits. Likewise, if the contract or policy does not provide coverage for inpatient out-of-network medical/surgical benefits, such as an exclusive provider organization (“EPO”), then the contract or policy need not provide inpatient out-of-network mental health or substance use disorder benefits. Since a policy or contract issued in New York must include outpatient substance use disorder benefits, 45 C.F.R. § 146.136(c)(2)(ii) requires the policy or contract to include substance use disorder benefits in every other classification for which the contract or policy provides medical/surgical benefits, including in the inpatient classification.

B. Treatment Limitations on Inpatient Substance Use Disorder Rehabilitation Benefits

The interim final rules do not distinguish between detoxification and rehabilitation. Nor do they classify benefits into “acute conditions” and “non-acute conditions.” Thus, it appears that the rules do not permit a group health plan or a policy or contract issued to a group health plan to place an annual day limitation on inpatient rehabilitation for substance use disorders, if it does not place such a limit on inpatient care for medical/surgical conditions.

disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines).”

II. Financial Requirements: Primary Care Copayment vs. Specialty Care Copayment

The interim final rules may impact some insurers' current practice of applying the specialty office visit copayments to mental health and/or substance use disorder benefits. Specifically, the interim final rules describe types of "financial requirements" as including deductibles, copayments, coinsurance and out-of-pocket maximums. See 45 C.F.R. § 146.136(a). The rules provide that a group health plan or a policy or contract issued to a group health plan may not apply any financial requirement to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement of the type applied to substantially all medical/surgical benefits in the same classification. See 45 C.F.R. § 146.136(c)(2)(i).

A type of financial requirement applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification. See 45 C.F.R. § 146.136(c)(3)(i)(A). If the type of financial requirement does not meet the two-thirds threshold, then the policy or contract may not impose that particular type of financial requirement on mental health or substance use disorder benefits. See id. For instance, a policy or contract that imposes copayments on only one-half of the inpatient in-network medical/surgical benefits may not impose copayments on inpatient in-network mental health or substance use disorder benefits.

If the policy or contract imposes a type of financial requirement on at least two-thirds of the medical/surgical benefits in a classification, then the insurer must determine the predominant level of that type of financial requirement for the medical/surgical benefits in that classification. See 45 C.F.R. § 146.136(c)(3)(i)(B)(1). The predominant level of the financial requirement is that which applies to more than one-half of the medical/surgical benefits in that classification. See id. For instance, assuming that copayments apply to substantially all medical/surgical benefits, if a policy or contract imposes a \$50 copayment on one-quarter of the outpatient in-network medical/surgical benefits and a \$25 copayment on three-quarters of the outpatient in-network medical/surgical benefits, then the insurer only may impose a \$25 copayment on outpatient in-network mental health or substance use disorder benefits.

If no single level applies to more than one-half of the medical/surgical benefits in the classification subject to the financial requirement, then the insurer may combine levels until the combination of levels applies to more than one-half of the medical/surgical benefits subject to the financial requirement in the classification. See 45 C.F.R. § 146.136(c)(3)(i)(B)(2). In such case, the least restrictive level within the combination is considered the predominant level of that type of classification. See id.

The determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement is based on the dollar amount of all plan payments for the medical/surgical benefits in the classification expected to be paid under the policy or contract for the plan year. See 45 C.F.R. § 146.136(c)(3).

Thus, the analysis that an insurer must undertake in determining if and to what extent a policy or contract may impose a financial requirement on mental health or substance use disorder benefits under the interim final rules may limit an insurer's ability to apply a specialty office visit copayment to mental health and/or substance use disorder benefits. Those insurers who subject mental health and/or substance use disorder benefits to a specialty office visit copayment must provide written assurance to the Superintendent that the policy or contract is in compliance with the interim final rules.

Subsequent to the publication of the interim final rules, the U.S. Department of Labor's Employee Benefits Security Administration issued a Frequently Asked Questions (FAQ) bulletin. See FAQ About Mental Health Parity and Addiction Equity Act, Employee Benefits Security Administration, United States Department of Labor, <http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>. This bulletin provides that until the issuance of final regulations, the federal agencies in charge of enforcing the MHPAEA will establish a safe harbor under which no enforcement action will be taken against a plan or issuer that divides its outpatient benefits into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under the MHPAEA. See *id.* The two permissible sub-classifications for outpatient benefits include (1) office visits and (2) all other outpatient items and services. See *id.*

III. Utilization Review

Articles 49 of the Insurance and Public Health Laws permit insurers to perform utilization review of mental health and substance use disorder benefits. While Articles 49 of the Insurance and Public Health Laws do not require the utilization review of those benefits to be consistent with the utilization review performed for other benefits under the policy or contract, 45 C.F.R. § 146.136(c)(4) prohibits a group health plan or a policy or contract issued to a group health plan from containing more stringent utilization review requirements for mental health or substance use disorder benefits than it does for medical/surgical benefits.

45 C.F.R. § 146.136(c)(4)(ii) states that utilization review is a "nonquantitative" treatment limitation. Nonquantitative treatment limitations are limitations on the scope or duration of benefits for treatment under the plan that are not expressed numerically. See 45 C.F.R. § 146.136(a). 45 C.F.R. § 146.136(c)(4) provides that a group health plan or a policy or contract issued to a group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification, unless any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to the medical/surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

45 C.F.R. § 146.136(c)(4) sets forth an example wherein a group health plan requires concurrent review for inpatient, in-network mental health/substance use disorder benefits, but only conducts retrospective review for inpatient, in-network medical/surgical benefits. The example concludes that this would violate the rules of the regulation. Thus, 45 C.F.R.

§ 146.136(c)(4) prohibits a group health plan or a policy or contract issued to a group health plan from containing more stringent utilization review requirements for mental health or substance use disorder benefits than it does for medical/surgical benefits.

Note that there is an exception set forth in 45 C.F.R. § 146.136(c)(4)(i) that permits a group health plan or a policy or contract issued to a group health plan to have different utilization review processes on an individual basis if it is based on clinically appropriate standards of care.

IV. Policy Form and Rate Submissions

Insurers should review their policy forms to determine if a policy form submission is necessary to comply with the MHPAEA in light of the interim final rules. If a submission is necessary, then an insurer should make the submission promptly to the Insurance Department's Health Bureau for review and approval. A rate filing should accompany the policy form submission, and the rate filing must include the requisite actuarial memorandum, supporting data and revised rate manual pages. See N.Y. Ins. Law §§ 3201(b)(1) and (c)(3), 4235(g) and (h), and 4308(b) and (c); 11 NYCRR § 52.40(e)(1). If the change in benefits does not result in a change of rates, then a statement of such fact, with actuarial justification, shall constitute the rate filing.

To facilitate prompt and efficient review and approval, the policy form and rate submission should: (1) clearly identify the submission as an "MHPAEA" submission; (2) clearly identify the contracts or policies to which the submission applies; and (3) include an explanation as to how the submission changes the existing mental health and substance use disorder benefits. To expedite filing, insurers should use the System for Electronic Rate and Form Filing ("SERFF"), available at <https://login.serff.com>. When creating a SERFF filing, please enter "MHPAEA" prominently in the field entitled "Filing Description."

Please direct any questions regarding this circular letter to Thomas Fusco, Supervising Insurance Attorney, Health Bureau, New York State Insurance Department, Walter J. Mahoney Office Building, 65 Court Street, Room 7, Buffalo, New York 14202 or by e-mail at tfusco@ins.state.ny.us.

Very truly yours,

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and Bureau Chief, Health Bureau