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Circular Letter No. 20 (2009)

September 10 , 2009

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 Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008

STATUTORY AND REGULATORY REFERENCES: Public Law 110-343; N.Y. Ins. Law §§ 3103, 3201, 3221, 4303 and 4308

This Circular Letter supersedes Circular Letter No. 20 (2009), dated August 5, 2009. The purpose of this Circular Letter is to provide guidance to insurers, advocates and consumers about the impact of the federal Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 (the “MHPAEA”) on New York’s health insurance market.

I. Mental Health and Substance Use Disorder Benefit Requirements Pursuant to the MHPAEA

On October 3, 2008, Congress enacted the MHPAEA as part of the Emergency Economic Stabilization Act of 2008. The MHPAEA applies to any group health plan, and health insurance coverage offered in conjunction with such plan, that has more than fifty total employees regardless of eligibility (“large group health plan”), and applies to plan years beginning on or after October 3, 2009. Under the MHPAEA, a large group health plan that provides medical and surgical benefits and mental health or substance use disorder benefits must ensure that the financial requirements^[1] and treatment limitations^[2] applicable to the mental health or substance use disorder benefits are no more restrictive than the predominant^[3] financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan. The MHPAEA also prohibits a large group health plan from imposing separate cost sharing requirements or treatment limitations on mental health or substance use disorder benefits. Further, if the large group health plan provides coverage for out-of-network services, then it also must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorders consistent with the MHPAEA.

II. Mental Health and Substance Use Disorder Benefit Requirements in New York State

A. Mental Health Benefits

Currently, New York State’s mental health parity law, known as “Timothy’s Law,” is set forth in N.Y. Ins.

Law §§ 3221(l)(5) and 4303(g) and (h) (McKinney Supp. 2009). Under Timothy's Law, all group and group remittance health insurance policies and contracts issued to group health plans and that provide coverage for inpatient hospital care and/or physician services must provide, respectively, not less than 30 inpatient days per year and/or 20 outpatient visits per year for the treatment of mental health conditions. Timothy's Law also requires group and group remittance health insurance policies or contracts issued to employers with more than 50 eligible employees to provide coverage comparable to other benefits provided by the policy or contract for the treatment of biologically-based mental illnesses and for children with serious emotional disturbances.

For group and group remittance health insurance policies or contracts issued to employers with 50 or fewer eligible employees, Timothy's Law requires that insurers make coverage available for purchase for the treatment of biologically-based mental illnesses and for children with serious emotional disturbances that is comparable to other benefits under the policy or contract.

B. Substance Use Disorder Benefits

Under the New York Insurance Law, group and group remittance health insurance policies or contracts issued to group health plans and that provide coverage for inpatient hospital care must provide coverage for at least 60 outpatient visits per calendar year for the diagnosis and treatment of chemical abuse and chemical dependence,^[4] of which up to 20 visits may be for family members. See N.Y. Ins. Law §§ 3221(l)(7) and 4303(l). Additionally, with regard to such group and group remittance policies or contracts, insurers must make available for purchase an inpatient chemical abuse and chemical dependence benefit that provides at least seven days of active treatment for detoxification and at least 30 days of inpatient rehabilitation. See Ins. Law §§ 3221(l)(6) and 4303(k).

III. Impact of the MHPAEA on New York's Health Insurance Market

The following sections provide an explanation as to how the MHPAEA interacts with the requirements set forth in the New York Insurance Law for mental health and substance use disorder benefits provided by group and group remittance policies and contracts issued to group health plans in New York.

A. Small Groups versus Large Groups

While the MHPAEA only applies to a large group health plan, and health insurance coverage issued in conjunction with such plan, the method for determining whether a group is "small" or "large" under the MHPAEA differs from the Insurance Law — the MHPAEA counts total employees, whereas the Insurance Law counts only eligible employees. Consequently, a "small" group under the Insurance Law may be a "large" group under the MHPAEA. For example, if a group has 58 total employees, but only 30 of those employees are eligible for health insurance coverage, then the Insurance Law considers the group to be a "small" group, while the MHPAEA considers the group to be a "large" group. In that instance, the group or group remittance policy or contract must comply with the MHPAEA.

One way in which insurers may comply with the MHPAEA with regard to groups that are "large" under the MHPAEA but "small" under the Insurance Law is to issue a rider or amendment that provides the additional benefits required by the MHPAEA. The rider or amendment should attach automatically to any large group under the MHPAEA. The insurer should make a diligent effort to ascertain whether a group is a large group under the MHPAEA. Those groups will continue to receive the mental health premium subsidy under Timothy's Law, but will not receive any subsidy for the additional benefits required under the MHPAEA.

Additionally, insurers must make the rider or amendment available to any group that is "small" under both the Insurance Law and the MHPAEA and that wishes to purchase the coverage, because the small group health insurance market in New York State is subject to open enrollment.

B. Treatment Limitations

The MHPAEA provides that a large group health plan, or health insurance coverage issued in conjunction with such plan, that provides both surgical and medical benefits and mental health or substance use disorder benefits may not impose treatment limitations on the mental health or substance use disorder benefits that are more restrictive than the predominant treatment limitations imposed on substantially all of the surgical and medical benefits provided by the plan.

Since under the MHPAEA treatment limitations include days of coverage and number of visits, the MHPAEA prohibits an insurer that issues health insurance coverage in conjunction with a group health plan from imposing annual days of coverage or number of visit limits for the treatment of mental health conditions or substance use disorders, unless those limits are no less favorable than the predominant limits for substantially all of the medical and surgical benefits provided by the policy or contract. For example, if the policy or contract generally does not impose annual inpatient days of coverage limits, then it may not impose inpatient days of coverage limits for the treatment of mental health conditions or substance use disorders. Likewise, if a policy or contract generally does not impose annual provider office visit limits, then it may not impose limits for the outpatient treatment of mental health conditions or substance use disorders.

Therefore, the days of coverage and number of visit limitations permitted under the Insurance Law for mental health and substance use disorder benefits are not permissible under the MHPAEA unless the insurer also imposes those limitations on substantially all of the surgical and medical benefits provided by the policy or contract.

C. Financial Limitations

The MHPAEA provides that a large group health plan, or health insurance coverage issued in conjunction with such plan, that offers both surgical and medical benefits and mental health or substance use disorder benefits may not impose financial requirements on the mental health or substance use disorder benefits that are more restrictive than the predominant financial requirements applied to substantially all of the medical and surgical benefits covered by the plan.

1. Outpatient Mental Health and Substance Use Disorder Benefits Copayments and Coinsurance

In New York, many insurers currently require higher copayments or coinsurance for specialty care office visits than for primary and preventative care office visits. The New York State Insurance Department has approved policies and contracts that apply the primary care office visit copayment or coinsurance to outpatient visits for mental health conditions and substance use disorders. The Department also has approved policies and contracts that apply the specialty office visit copayment or coinsurance to outpatient visits for mental health conditions and substance use disorders.

Insurers may continue to apply either the primary care or specialty care office visit copayment or coinsurance to mental health and substance use disorder benefits with one exception: HMOs may not apply the specialty office visit copayment to outpatient substance use disorder benefits, but rather must continue to apply the primary care office visit copayment in accordance with the “HMO Copayment Maximum Guidelines” developed by the New York State Department of Health and the Insurance Department in consultation with industry trade groups representing HMOs. Insurers that do choose to apply the specialty care office visit copayment or coinsurance to the mental health and substance use disorder benefits should be able to demonstrate that the specialty care office visit copayment or coinsurance is applied to substantially all of the medical or surgical benefits in the policy or contract.

2. Inpatient Mental Health and Substance Use Disorder Benefits Copayments and Coinsurance

Insurers may not impose a copayment or coinsurance for inpatient mental health and substance use disorder benefits that is greater than the copayment or coinsurance required for inpatient hospital care for physical conditions.

3. Mental Health and Substance Use Disorder Benefits Deductibles

Insurers may not subject mental health and substance use disorder benefits to a separate deductible, apart from the deductible, if any, applicable to the other inpatient and outpatient benefits provided by the policy or contract.

D. Inpatient Substance Use Disorder Benefits

The Insurance Law does not mandate that all policies or contracts provide inpatient coverage for substance use disorders. Instead, a group merely must have the opportunity to purchase an inpatient

substance use disorder benefit. Therefore, some plans in New York may not currently provide inpatient substance use disorder benefits.

The MHPAEA, however, does not distinguish between outpatient and inpatient substance use disorder benefits. Hence, it appears that a group or group remittance policy or contract issued to a large group under the MHPAEA that provides hospital, surgical and medical coverage and **outpatient** substance use disorder benefits must now include coverage for **inpatient** substance use disorder benefits at parity in accordance with the MHPAEA's provisions.

The MHPAEA provides that the Secretaries of Labor, Health and Human Services, and the Treasury must issue regulations to carry out the provisions of the MHPAEA no later than October 3, 2009, and the Insurance Department anticipates that the regulations will provide guidance on this issue. The Insurance Department anticipates that it will issue further guidance on this subject upon promulgation of the federal regulations. In the meantime, every insurer is advised that, if it does not amend its filings to provide inpatient substance use disorder benefits by the October 3, 2009 effective date of the MHPAEA, and if the federal regulations ultimately construe the MHPAEA to require such coverage, then policies or contracts will be construed in accordance with the federal regulations, and the insurer will not be entitled to a retroactive rate increase.

Additionally, if a group health plan subject to the MHPAEA has purchased or purchases a policy or contract that contains an inpatient substance use disorder benefit, including the mandated make available inpatient substance use disorder benefit provided for in Insurance Law §§ 3221(l)(6) and 4303(k), then pursuant to the MHPAEA, those policies and contracts must provide inpatient substance use disorder benefits with financial and treatment limitations that are no more restrictive than the predominant limitations imposed on substantially all of the medical or surgical benefits provided by the policy or contract.

E. Partial Hospitalization

Although the MHPAEA is silent about partial hospitalization benefits, Timothy's Law requires all groups to provide benefits for partial hospitalization program services as an offset to covered inpatient days at a ratio of two partial hospitalization visits to one inpatient day of treatment. Group and group remittance policies and contracts issued to a MHPAEA large group must continue to impose this offset to the extent that those policies and contracts continue to have annual days of coverage limits for inpatient hospital coverage for the treatment of mental health conditions. The offset in days is inapplicable to such group and group remittance policies and contracts that do not provide annual days of coverage limits for inpatient hospital coverage. However, these policies and contracts must continue to offer coverage for partial hospitalization visits.

F. Cost Exemption

The MHPAEA provides a limited exemption for a large group health plan based upon the cost of providing the benefits required under the MHPAEA. After complying with the MHPAEA for six months, a large group health plan or insurer offering health insurance in conjunction with such plan may receive an exemption from the U.S. Secretary of Health and Human Services, U.S. Secretary of Labor, or U.S. Secretary of the Treasury for one plan year if it can demonstrate that the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan will increase more than two percent during the first plan year and one percent in each subsequent plan year. However, even if a cost exemption is granted to an insurer offering health insurance in conjunction with a large group health plan, the insurer still must provide all of the mental health and substance use disorder benefits required by the Insurance Law and regulations promulgated thereunder.

Any insurer that receives a cost exemption pursuant to the MHPAEA also should submit to the Insurance Department's Health Bureau a copy of the notice that the insurer submits to the Secretary of the appropriate federal agency as required under the MHPAEA.

G. Effective Date

A large group health plan, and health insurance policies and contracts offered in conjunction with such plan, issued or renewed on or after October 3, 2009 must comply with the MHPAEA.

H. 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. If a submission is necessary, then an insurer should make the submission to the Insurance Department's Health Bureau for review and approval promptly, keeping in mind the October 3, 2009 effective date of the new law. A rate filing also 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 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 to tfusco@ins.state.ny.us.

Very truly yours,

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[1] Under 29 U.S.C. § 1185a(a)(3)(B)(i), "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses.

[2] Pursuant to 29 U.S.C. § 1185a(a)(3)(B)(iii), "treatment limitation" includes limits on the frequency of treatment, number of visits, and days of coverage, as well as other similar limits on the scope or duration of treatment.

[3] 29 U.S.C. § 1185a(a)(3)(B)(ii) defines "predominant" as the most common or frequent of such type of limit or requirement.

[4] Although the Insurance Law refers to "chemical abuse and chemical dependence" and the MHPAEA refers to "substance use disorder," the Department construes these terms to be substantially equivalent and, for the purposes of this circular letter, uses the term "substance use disorder."