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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

May 24, 2010

Administrative Letter 2010–04

TO: **All Insurers Licensed to Write Accident and Sickness Insurance in Virginia, all Health Services Plans and Health Maintenance Organizations Licensed in Virginia**

RE: **Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Virginia Chapter 693 (Senate Bill 706)**

The purpose of this Administrative Letter is to provide guidance to insurers, health services plans and health maintenance organizations with the filing of forms to comply with the provisions of Chapter 693 (Senate Bill 706), enacted by the Virginia General Assembly during its 2010 legislative session.

Chapter 693 (Senate Bill 706), effective July 1, 2010, amends and reenacts §§ 38.2-3412.1 and 38.2-3412.1:01 of the Code of Virginia, and requires that group health insurance coverage issued to a large employer (an employer who employs on average at least 51 employees in a calendar year) shall provide coverage for mental health and substance abuse services on parity with the coverage for medical and surgical benefits in accordance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Public Law 110-343). The MHPAEA prohibits a group health plan or group health insurance coverage ("group plan") from applying financial requirements (e.g. copayments, coinsurance, deductibles, out-of-pocket maximums) or treatment limitations (e.g. number of visits, number of days of coverage) to the group plan's mental health and substance use disorder benefits that are more restrictive than those applied to its medical and surgical benefits.

In order to expedite and facilitate the review and approval of forms submitted for compliance with the above requirements, the Bureau of Insurance will require the following information in all submissions of group accident and sickness forms providing coverage on an expense incurred basis to large employer groups:

1) A clear identification of the submission as a "MHPAEA" submission;
2) Identification of any and all contracts or policies to which the submission applies, if applicable, along with their associated approval dates in Virginia;
3) Specification of all revisions made to comply with state and federal laws along with a clear explanation of the effect of such revisions; and

4) Inclusion of any and all revised rates affected by the revisions. If there is no change in rates, that should be specified as well.

Carriers are encouraged to complete and return the attached checklist with each form filing submitted for compliance with the requirements of Virginia Code §§ 38.2-3412.1 and 38.2-3412.1:01, as amended by Chapter 693 (Senate Bill 706), and the MHPAEA. While not all-inclusive, the checklist highlights important requirements in the MHPAEA that should be identified and addressed in each submission to the fullest extent possible, as per item # 3, above. Where applicable and appropriate, carriers should identify the provision in each form that conforms to the requirement identified in the checklist. Where compliance cannot be specifically identified in a particular provision, the "comment" field should be completed to verify compliance with a particular requirement.

While the completion and return of the completed checklist is not mandatory, it is strongly encouraged to facilitate the review process and avoid unnecessary delays in the review and approval of the submissions. Continued use of this checklist in conjunction with the applicable product filing checklists is also strongly encouraged. You may view the checklist at:
http://www.scc.virginia.gov/division/boi/webpages/boinaicproductreviewchecklistlh.htm

Carriers are also reminded to review *the Rules Governing the Submission for Approval of Life, Accident and Sickness, Annuity, Credit Life and Credit Accident and Sickness Policy Forms*, Chapter 100, Title 14 of the Virginia Administrative Code for general filing requirements.

Finally, carriers are strongly encouraged to submit their forms as soon as possible in order to be reasonably assured of sufficient review and approval time.

Questions regarding this letter may be directed to:

Robert Grissom
Supervisor, Forms and Rates Section
Life and Health Division
Bureau of Insurance
State Corporation Commission
804-371-9152
bob.grissom@scc.virginia.gov

Cordially,

Alfred W. Gross
Commissioner of Insurance

Attachment

Review Requirements Checklist
Mental Health Parity and Addiction Equity Act

● Effective 4/5/2010 for Plan Years on or After 7/1/2010
● Applies to Employer Groups of More than 50 Employees

Note: Where a specific provision can be referenced, use the column "Page#/Provision" to identify the corresponding page or provision. In all cases, provide clarifying comments in the "Comment" field. Failure to provide a response in each category may delay the review of the filing.

- **A Plan with No Provider Network is considered an Out-of-Network Plan**

REVIEW REQUIREMENTS	REFERENCES	PAGE#/ PROVISION	COMMENTS
Determining Parity	Definition of *Mental Health Conditions* must be consistent with generally recognized independent standards of current medical practice. Exclusions must be consistent with generally recognized independent standards of current medical practice.		
	Definition of *Substance Use Disorders* must be consistent with generally recognized independent standards of current medical practice. Exclusions must be consistent with generally recognized independent standards of current medical practice.		
Financial and Quantitative Requirements	Copays not any higher for services from a mental health specialist than for a primary care provider.		
	Copays not more restrictive than predominant* copay for substantially all**Medical/Surgical Benefits.		
	Coinsurance not more restrictive than predominant coinsurance for substantially all Medical/Surgical Benefits.		
	Deductible not separate from Medical/Surgical Benefits.		
	Out-of-Pocket maximums not separate from Medical/Surgical OOP Maximums.		
	Aggregate lifetime limits and annual limits not more restrictive than those for medical/surgical services (if limits for Medical/Surgical are different, then average limit must be calculated).		
	Number of visits not more restrictive than predominant number of visits for substantially all Medical/Surgical Benefits.		
	Number of days of coverage not more restrictive than predominant number of days for substantially all Medical/Surgical Benefits.		

* **Predominant = More than one-half (1/2) in the classification that is "substantially all"**
** **Substantially All = At least two-thirds (2/3)**

REVIEW REQUIREMENTS	REFERENCES	PAGE#/ PROVISION	COMMENTS
For each of the listed classifications, are benefits on parity with Medical/Surgical Services?	Inpatient, In-network		
	Inpatient, Out-of-network		
	Outpatient, In-network		
	Outpatient, Out-of-network		
	Emergency Services		
	Prescription Drugs		
Nonquantitative Requirements	Medical Necessity/Appropriateness – not applied more stringently than to Medical/Surgical (ex: may not require pre-cert for all Mental Health/Substance Use Disorders (MH/SUD) when pre-cert is only required for in-patient Medical/Surgical).		
	Prescription Drug Formulary Design – For tiered prescription drug plans, level of copay determined without regard to whether the RX is prescribed for Medical/Surgical or MH/SUD Benefits.		
	Step Therapy Protocols – no more restrictive than those for Medical/Surgical Prescription Drugs		
	Methods for determining UCR amounts – no different than methods used for Medical/Surgical Expenses.		

REVIEW REQUIREMENTS	REFERENCES	PAGE#/ PROVISION	COMMENTS
Nonquantitative Requirements	Exhaustion of Employee Assistance Program Benefits is not required for MH/SUD Benefits.		
Coverage Units: Financial Requirements and Treatment Requirements must be evaluated separately	Individual Medical/Surgical vs. Individual MH/SUD		
	Family Medical/Surgical vs. Family Mental Health Coverage		
Stand-alone mental health/substance abuse disorder benefit plans	Mental health/substance abuse disorder benefit must be compared for parity to all group health plan options (Indemnity/Major Medical, PPO, HMO) offered.		

Contact the Life and Health Forms and Rates section at (804) 371-9110 if you have questions or need additional information about the above requirements.