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COST OF PARITY

SUMMARY OF ACTUARIAL COST ANALYSES OF FEDERAL AND STATE MENTAL HEALTH PARITY

I. FEDERAL MENTAL HEALTH PARITY LEGISLATION

Actuarial studies estimate the cost of mental health parity at between 3 and 4% increase in individual premiums.

According to an actuarial analysis conducted by the firm of Coopers & Lybrand, the full mental health parity as proposed for in the original Domenici-Wellstone amendment, would have ***increased premiums in the private sector by only about 3.2%.***

Additional government and private industry studies have reached similar actuarial conclusions. In a letter to Senator Nancy Kassebaum (R-KS) dated April 23, 1996, the Congressional Budget Office (CBO) estimated the ***cost impact of the Domenici-Wellstone amendment at 4%.*** Results of a Milliman & Robertson study found that ***parity for mental illness would increase plan premiums by only 3.9%.***

II. COST DATA AVAILABLE FOR STATES WITH MENTAL HEALTH PARITY LAWS IN EFFECT

Actual state experiences have resulted in an increase in individual premiums of between 1 and 2.2%, consistent with federal actuarial studies.

MARYLAND In 1993, Maryland enacted parity for mental illness and drug abuse. Maryland has shown a continuing ***decline in the length of inpatient stays in both psychiatric hospitals and psychiatric units of general hospitals.***

MINNESOTA Minnesota's full mental health parity legislation became effective August 1, 1995. According to John Gross, director of Health Care Policy-Insurance Federation, "No one has cited rising mental health costs as reasons for premium increases." The Minnesota Department of Commerce, the state agency that regulates indemnity insurance, ***estimated costs of 1% of total premium dollars for mental health parity.*** Medica, an independent consulting organization, estimated Minnesota costs for mental health parity is ***$.26 per member per month (pmpm).***

NEW HAMPSHIRE New Hampshire Blue Cross Blue Shield has indicated that while they do not have final data, the data they have collected gives them no reason to believe that their original estimate of a 1.5% increase in premium costs is inaccurate.

NORTH CAROLINA In 1992, the North Carolina State Employee Health Plan established mental health and substance abuse benefits with full comprehensive parity of coverage. Since that time, mental health payments as a portion of total health payments have ***decreased from 6.4% to 3.7% of total health care costs for the fiscal year ending June 30, 1995.***

RHODE ISLAND Rhode Island requires all health insurers to provide coverage for the medical treatment of serious mental illness under the same terms and conditions as coverage for other illnesses and diseases. In Rhode Island, preliminary data indicate that the ***increased premium costs amounts to only 30 cents pmpm.***

TEXAS In Texas, a parity requirement for the state employees' plan resulted in new initiatives to create a managed behavioral health care benefit, which resulted in a 47.9% decrease in the cost of behavioral health care for the 170,000 enrollees in the managed fee for service, point of service and preferred provider option.

III. COOPERS & LYBRAND ACTUARIAL ANALYSIS OF ADDITIONAL STATES WITH PROPOSED OR PENDING PARITY LEGISLATION.

Projected mental health parity costs of between 1.9 and 3.9% in additional states are consistent with federal actuarial studies and actual state experiences.

ARIZONA Actuarial analysis of comprehensive parity and substance abuse legislation proposed in Arizona would ***increase costs by 3.2% or $3.90 pmpm.***

ARKANSAS The projected impact of full parity legislation originally proposed in Arkansas would have ***increased costs by 2.3% or $2.61 pmpm.***

DELAWARE Actuarial analysis of comprehensive parity legislation proposed in Delaware would have ***increased costs by 3.9% or $5.16 pmpm.***

GEORGIA Actuarial analysis of full parity legislation originally proposed in Georgia projected an ***increase in costs of only 2.4% or $3.10 pmpm.***

MASSACHUSETTS Original comprehensive parity legislation proposed in Massachusetts utilized the SAMHSA definition for functional impairment. This legislation would ***increase costs by only 1.9% or $2.72 pmpm.***

NORTH CAROLINA The proposed North Carolina mental illness and chemical dependency parity bill would ***increase costs by only 3% or $3.34 pmpm.***

PENNSYLVANIA Comprehensive mental health legislation currently proposed in Pennsylvania would ***increase costs by only 3.1% or $4.26 pmpm.***

SOUTH DAKOTA Actuarial analysis of full parity legislation originally proposed in South Dakota projected an ***increase in costs of 4.1% or $4.03 pmpm.***

UTAH Utah's full parity legislation was projected to ***increase costs by 2.4% or $2.69 pmpm.***

VERMONT Actuarial analysis projected that a comprehensive parity and substance abuse bill would ***increase costs by 3.4% or $3.45 pmpm.***

ARIZONA

An Actuarial Analysis of Comprehensive Mental Health Benefits and Other Options for Improved Coverages in the State of Arizona

February 1998

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te requirement is the only real option that will allow implementation of comprehensive parity to all ds at a minimum cost. A state-wide requirement creates a level playing field for all insurers and for an appropriate spreading of risks across a large population. Optional requirements are ctive as selection of optional coverages is usually minimal and anti-selection drives up the cost of the option.

The proposed bill for Arizona requires mental health and substance abuse parity for insured policies regulated under the Arizona Insurance Commissioner's authority. The bill covers all insured individual and group policies. State law cannot affect most large employers because their plans are self-insured and governed under federal ERISA laws rather than State law. Many ERISA plans have already moved in the direction of expanded mental health benefits, usually in conjunction with a managed care carve-out.

While the C&L cost analysis is appropriate for all categories of required coverage, the variation from expected costs is greatest for small groups and individual plans of coverage. However, Arizona requires modified community rating in the small group market through the use of rating bands. Therefore, a state-wide requirement for parity creates a level playing field for all insurers and should provide adequate risksharing over a large population to minimize any cost increase applicable to the experience of any one group.

Coopers & Lybrand developed a matrix of plan options to estimate the range and impact of legislation on the employer market. Four delivery systems of varying intensity of managed mental health care are used in the modeling. Mental Health costs and associated cost increases are stated as a percentage of a typical underlying plan of medical/surgical benefits. In this way, a percentage impact on employer health care plans is determined.

The four delivery systems assumed are:

Delivery System 1. Indemnity plans with utilization review found on typical medical plans. There is no special mental health or substance abuse focus and the review (preadmission certification and continued stay review) generally only applies to inpatient care.

Delivery System 2. Indemnity plans with specialized mental health and substance abuse utilization review. The utilization review applies to inpatient care, but may also apply to intensive or lengthy outpatient treatments.

Delivery System 3. Preferred Provider (PPO) and Point of Service (POS) plans that have specialized mental health and substance abuse networks. These are not carve-out programs, but act with similar attention to negotiated rates, utilization controls, and limited provider access. There is no gatekeeper mechanism. Plan design and costsharing are primarily used to channel members to network providers.

Delivery System 4. HMO/Gatekeeper plans and carve-out mental health programs. Access to mental health and substance abuse providers is through a primary care gatekeeper or other similar intensive utilization controls. Provider reimbursements are highly negotiated. HMO POS plans are also included.

Plan design modeling assumptions are established with commonly found benefit limits within each delivery system.

A summary of the current and four parity options priced within the four delivery systems is:

1. **Current** - typical mental health and substance abuse benefit design as in current market.

2. **Partial Parity** - as used in this paper partial parity means mental health and substance abuse equality with medical care for inpatient days and outpatient visit limits only.

3. **SMI Parity** - mental health benefits equal to medical benefits when diagnosis identifies a serious mental disorder. SMI Parity includes costsharing provisions that are separate but equal to medical plan costsharing.

4. **Full Parity** - mental health and substance abuse benefits equal medical care benefits with separate but equal costsharing provisions. For example, a plan can have a medical deductible of $250 and a separate but equal $250 deductible for mental health and substance abuse expenses.

5. **Comprehensive Parity** - same as full parity except that the insured plan has composite costsharing provisions. That is, a single deductible and maximum out-of-pocket limit applicable to all eligible expenses.

The following table summarizes the actuarial modeling results for mental health and substance abuse combined. The composite impact on the health insurance market ranges from 0.9% for Partial Parity to 3.2% for Comprehensive Parity. The cost increase for Fee-for-Service plans range from 1.3% to 4.3%. The lowest cost impact occurs under HMO & Gatekeeper programs where the cost impact of the parity options range from 0.7% to 2.2%.

The percentage impact in Arizona is consistent with national estimates for mental health and substance abuse illness costs. We assumed a $25,000 annual maximum for a typical current mental health benefit. This provides a conservative (high) cost increase, since the cost impact analysis is determined from the current market costs. The Mental Health Parity Act of 1996 will remove that limit for plans above 50 employee lives. Therefore, this analysis includes the cost of implementing the federal act for employers above 50 lives. National data indicates a typical current plan maximum of $40,000 lifetime limit. Since the impact of this legislation is on fully insured groups, we chose the lower limit to reflect the more limited mental health plan designs of this market segment.

Table 1
Mental Health & Substance Abuse Combined

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity: Partial	SMI	Full	Comprehensive
Fee-for-Service	1	20%	1.3%	2.8%	3.5%	4.3%
Managed Indemnity	2	25%	1.1	2.3	2.8	3.6
PPO & POS	3	25%	0.7	2.1	2.6	3.0
HMO & Gatekeeper	4	30%	0.7	1.2	1.5	2.2
Composite Market Analysis			0.9%	2.0%	2.5%	3.2%
Composite PMPM			$1.12	$2.46	$3.08	$3.90
Net Market Impact			0.4%	0.8%	1.0%	1.3%
Net PMPM Impact			$0.45	$0.98	$1.23	$1.56

Similar values were run for mental health parity only. All assumptions were held constant as to plan design for medical benefits, managed care impacts, and percentage distribution of the various delivery systems. Values for mental health only are shown below.

The Arizona proposal strongly endorses and requires parity for mental health and substance abuse. The attached analysis calculates parity for the proposed bill (Table 1) and mental health only (Table 2). The purpose of this analysis is to frame the cost discussions with facts related to the cost of various options that might come under debate.

Table 2
Mental Health Only

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity: Partial	SMI	Full	Comprehensive
Fee-for-Service	1	20%	0.9%	2.0%	2.5%	3.1%
Managed Indemnity	2	25%	0.7	1.7	2.1	2.7
PPO & POS	3	25%	0.6	1.7	2.2	2.5
HMO & Gatekeeper	4	30%	0.5	0.8	1.0	1.1
Composite Market Analysis			0.6%	1.5%	1.9%	2.3%
Composite PMPM			$0.84	$1.95	$2.44	$2.95
Net Market Impact			0.24%	0.6%	0.8%	0.9%
Net PMPM Impact			$0.34	$0.78	$0.98	$1.18

The C&L modeling assumes a reasonable, but conservatively low managed care penetration for Arizona. The assumptions were established conservatively to account for the impact of fewer small groups currently using managed care. C&L did not find data available to determine the split of managed care for behavioral health plans in Arizona solely for insured plans.

Employers respond to any potential increase in benefit costs in variety of ways including, competitively marketing the plan to obtain lower premiums, intensely negotiating lower provider costs, cutting plan administrative costs, increasing plan cost-sharing by members, increasing premium contributions by members, reducing other benefits, and in the extreme, dropping plan coverages and reducing wages (or wage increases).

The Congressional Budget Office (CBO) typically estimates that these employer responses to required coverages will result in cost offsets of about 60% of the gross cost estimates. Using the standard CBO economic modeling approach, employer contributions for health costs would rise about 40% of the estimate or only 1.3 percent.

Based upon an analysis using generally accepted actuarial practices, the total impact of the proposed Arizona mental health and substance abuse parity bill is equal to 3.2% of current employer claims or about $3.90 per member per month. However, the employer will respond in various ways to partially offset any potential cost increases. Therefore, the expected employer contributions for health costs will rise about 1.3% or $1.56 per member per month. Assuming an average of 3 members per family this translates into an equivalent wage increase of $.027 per hour.

An Actuarial Analysis of Comprehensive Mental Health and Substance Abuse Benefits and Other Options for Improved Coverages in the State of Arizona

I. Introduction

The Arizona Psychological Association, the Mental Health Association of Arizona, the Arizona Alliance for the Mentally Ill, and the American Psychological Association engaged Coopers & Lybrand (C&L) to provide actuarial analysis and consulting advice on the mental health benefit proposal being developed for the 1998 Arizona legislative session. This report presents a detailed discussion and cost analysis of the primary proposal -- **Comprehensive Parity**, defined as coverage of insured mental health and substance abuse on the same basis as medical care coverage (parity). This report presents cost estimates for "mental health only" and "mental health and substance abuse combined." This report also includes analyses of other parity options to improve mental health benefits. The purpose of including other options is to more accurately frame the broader discussion of mental health and substance abuse benefits and to provide a complete documentation of costs as legislative questioning and debate develops in Arizona.

This report was commissioned by the Arizona Psychological Association, the Mental Health Association of Arizona, the Arizona Alliance for the Mentally Ill, and the American Psychological Association. No mental health organization (including those mentioned) or any other outside entity inappropriately influenced the choice of assumptions. The assumptions made in this report are made from independent analysis and research, proprietary C&L data bases, and, where needed, professional experience and judgment. The actuarial modeling is sufficiently complex to appropriately simulate the multitude of mental health and substance abuse disorder benefits offered by employers and represents a fair and accurate analysis of mental health and substance abuse costs. The modeling reflects Arizona specific data where available and appropriate.

This report includes a discussion regarding the existing legislative language and the need for clarifications to assure proper implementation of the above understandings. This report reflects the language of H.B. 2580, current legislative understandings, and proposed amendments to H.B. 2580 that have been described to C&L. At the time of developing this report such amendments have not been finalized.

The pricing and cost methods follow generally accepted actuarial practices. The modeling results are then compared to similar analyses performed by the Congressional Budget Office and the Congressional Research Services involving similar mental health and substance abuse parity proposals made at the national level. Coopers & Lybrand L.L.P. takes no responsibility for inappropriate use of this report or the actual impact of any legislation passed by the State of Arizona.

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II. Comprehensive Parity & Legislative Issues

The proposed 1998 Arizona legislation (the Bill) is referred to as H.B. 2580 and would amend the State of Arizona Code relating to health insurance. Under the proposed Bill all policies "that provide health benefits and services for physical illnesses shall provide benefits for the diagnosis and treatment of mental disorders and drug and alcohol abuse disorders under the same terms and conditions that apply to covered benefits under the contract for the diagnosis and treatment of physical illnesses." The bill applies to individual policies, group indemnity policies, and HMOs.

There is one year transition period from effective date of the bill, July 1, 1999 to June 30, 2000, where inpatient and partial hospitalization benefits are set at a minimum of 60 days. Full parity is applicable from July 1, 2000 forward.

Legislative language is subject to regulatory clarification and judicial interpretations. There is often uncertainty during the period of implementation and during the development of case law. In some instances, original intent is changed through that process. The Arizona Bill (as with any bill) could encounter problems due to uncertain language, undefined terms, and potential unintended consequences.

Based upon our experience with other state and federal mental health and substance abuse legislation, it may be helpful for the Arizona legislation to clarify areas that are not affected by the bill and how the bill should not be construed. Several areas of clarification are needed by the framers of the legislation before the cost impact as described in this legislation can be considered appropriate:

1. H.B. 2580 states, "*Benefits ...may be delivered under a managed care system.*" Clarifying language may be helpful to state that the bill should not be construed to prevent preadmission screening, continued stay reviews, case management, and other managed care techniques to assure that only medically necessary services are reimbursed under the contract.

2. Similarly, clarification may be helpful assuring continuation of current market plans that provide for mental health carve-out plans, specialty mental health and substance abuse provider networks, and the use of specialty criteria for medical necessity. For example, we assume under managed care arrangements (PPOs and HMOs), mental health and substance abuse providers can be capitated even if medical providers are not. C&L assumed that separate managed care mental health carve-out programs with differing reimbursements and risksharing arrangements are possible under the Arizona proposal. However, clarification may be needed to assure proper interpretation and implementation.

3. Clarifying legislation or regulation may assist in determining how a plan should handle multiple medical/surgical limits. Exceptions from wellness benefits (generally paid at 100%) are sometimes specifically excluded from parity comparisons.

4. Substance abuse parity should be reviewed to assure it does not prevent benefit differences that reflect practical considerations, such as day restrictions on detox programs. C&L assumes that medical necessity and medical management will be extended to control costs for substance abuse parity.

Changes are suggested only to improve clarity and prevent misinterpretations. These clarifications can be handled through legislation, regulation, or legislative history that defines intent.

III. Impact of State Required Coverage

The proposed bill for Arizona requires mental health and substance abuse parity for insured policies regulated by the Arizona Insurance Commissioner's authority. The bill requires parity for individual and group policies. Individual policies represent about 2.9% of the non-elderly population in Arizona. The national average is 4.5% for individual policies. The affected group policies are fully insured plans that are generally covering fewer than 200 employees.

State law cannot affect most large employers because their plans are self-insured and governed under federal ERISA laws rather than State law. Many employer benefit plans, that cover 100 or more employees, have already chosen to be exempt from State insurance laws. As more employers choose self-insurance and governance under ERISA, the effect is that the pool of employer plans impacted by State requirements (i.e. the proposed mental health and substance abuse disorder parity bill) grows smaller. National analysis indicates a range of 40-60% of non-elderly covered lives are under ERISA plans.

A state-wide requirement creates a level playing field for all insurers and allows for an appropriate spreading of risks across a large population. A State requirement is the only real option that will accomplish the objective of improved mental health and substance abuse coverage with the minimum cost increase. Optional requirements are ineffective as selection of optional coverages is minimal and anti-selection drives up the cost.

While the C&L cost analysis is appropriate for all categories of required coverage, the variation from expected costs is greatest for individual policies and small groups. However, Arizona requires banded rating (modified community rating) in the small group market. Therefore, state-wide requirement for parity creates a level playing field for all insurers and will provide adequate risksharing over a large population to minimize any cost increase applicable to the experience of any one group or individual policyholder.

Part of any legislative discussion of parity is the concern for individual coverage and the smallest of businesses in the state. Based upon EBRI, November 1996, Issue Brief, Arizona has 24% uninsured, below the average of 17.7% uninsured nationally. Arizona has 60.2% of its population covered by employment based health care (lower than national average of 65.3%).

Based on national averages, approximately forty percent (40%) of Arizona employers with 1 to 4 employees have health coverage. Sixty-one percent (61%) of Arizona employers with 5-9 workers have health coverage. Seventy-six percent (76%) have health coverage among businesses with 10-24 employees. While the cost increase may not be great for mental health and substance abuse parity, many small employers find it difficult to provide a comprehensive package of benefits when they are in a start-up phase. It may be appropriate to consider an individual or small group (under 5 workers) exemption or some modification from the bill requirements.

The federal approach of requiring parity only when an employer provides mental health and substance abuse coverage does not seem appropriate for state legislation (with the possible exception of partial parity). The federal act creates a "minimum standard" or floor of protection with which all insurance plans must comply.

Under the federal approach, the employer (especially a small employer) can then decide to drop coverage or not cover mental health and substance abuse at all. This would defeat the value of pooling across all group plans. Optional coverage would encourage anti-selection that could develop into unaffordable costs. Federal legislation excluded employers with 50 or fewer lives. However, the federal requirement is applicable to all remaining groups, including ERISA groups, so all groups above 50 employees are affected.

State mental health and substance abuse parity requirements may encourage some employers to become self-insured, move to ERISA plans, and become exempt from state oversight. But as in Minnesota, (see Appendix A) the legislative impact is expected to be minimal. Changing to a self-insured plan includes accepting additional risks that many employers are unwilling or unable to accept. The number of members with group health coverage is increasing. Based upon the Employee Benefit Research Institute estimates, after a long period of decline, the percentage of employees with employment-based health insurance has increased each year since 1993.

IV. Parity Options

To assist the process of legislation in Arizona, Coopers & Lybrand has produced five calculations. Analysis includes a plan representative of current Arizona mental health and substance abuse plans and four mental health and substance abuse parity options as defined below.

1. <u>Partial Parity</u> - C&L calculations for partial parity reflect equality for inpatient day and visit limits. An employer can still apply any deductible, coinsurance, or other plan design limitations. The cost analysis assumes the required Mental Health Parity Act of 1996 is effective (actual effective date is 1/1/98) and applicable for all size groups. That is, the mental health and substance abuse benefits are after compliance with existing federal parity of lifetime and annual limits.

2. Parity by SMI Diagnosis - The C&L model assumes costs of serious mental illnesses (SMI) diagnoses are covered at full parity with medical care. The model assumes insurance carriers, HMOs, and managed behavioral health companies can appropriately manage, verify, and monitor mental health and substance abuse diagnoses. Pricing reflects potential for "diagnosis creep" and the natural uncertainty of changing clinical conditions.

Arizona is not proposing SMI parity coverage. SMI is not common, but it is frequently a part of any mental health and substance abuse parity debate. Costs are shown only in anticipation of that discussion. Problems associated with "diagnosis creep" and the lack of savings relative to full and comprehensive parity led the national proposal by Senators Domenici and Wellstone away from SMI. The C&L model most closely follows the National Advisory Mental Health Council (NAMHC) definition of severe mental health (see Appendix B). This is because the best data available on SMI analysis is developed under that definition.

3. Full Parity - Full parity provides equality of mental health and substance abuse (all diagnoses) and medical care coverages within an insured plan with separate but equal costsharing for deductible, maximum out of pocket, and annual or lifetime maximums. For example, a plan can have a medical deductible of $250 and a separate but equal $250 deductible for medical and chemical dependency expenses.

4. Comprehensive Parity - Comprehensive parity is used in this report to represent mental health and substance abuse covered under insured policies on the same basis as medical care. This is the primary proposal in Arizona for mental health and substance abuse parity. All eligible health care expenditures are used to accumulate towards a common plan deductible, maximum out of pocket limit, and annual or lifetime limits. Comprehensive parity includes equal inpatient and outpatient coverages that remove any arbitrary day or visit limits on mental health and substance abuse disorders when no such limits are used for medical care. (see Appendix A for actual experience in Minnesota and North Carolina)

V. Delivery Systems Modeling Assumptions

The four delivery systems assumed are:

Delivery System 1. Indemnity plans with utilization review found on typical medical plans. There is no special mental health and substance abuse focus and the review (preadmission certification and continued stay review) generally only applies to inpatient care.

Delivery System 2. Indemnity plans with specialized behavioral health utilization review. The utilization review applies to inpatient care, but may also apply to intensive or lengthy outpatient treatments.

Delivery System 3. Preferred Provider (PPO) and Point of Service (POS) plans that have specialized mental health and substance abuse networks. These are not carve-out programs, but act with similar attention to negotiated rates, utilization controls, and limited provider access. There is no gatekeeper mechanism. Plan design and costsharing are primarily used to channel members to network providers.

Delivery System 4. HMO/Gatekeeper plans and carve-out managed behavioral health care programs. Access to mental health and substance abuse providers is through a primary care gatekeeper or other similar intensive utilization controls. Provider reimbursements highly negotiated. HMO POS plans are also included.

Plan design modeling assumptions are established with commonly found benefit limits within each delivery system. A typical current design and four mental health and substance abuse parity designs are outlined (see next section) for each delivery system. Each option assumes compliance with the recently passed federal legislation, the Mental Health Parity Act of 1996 (MHPA) which provides for equality of annual and lifetime limits. Groups of 50 or fewer lives are not impacted by this federal legislation.

Cost estimates in this report are increased by the full impact of MHPA even though the law is already applicable to the larger cases. Estimated costs for insured plans under each of the delivery systems is minimal. C&L estimated the additional costs under each delivery system in a report "An Actuarial Analysis of S.2031, the 'Mental Health Parity Act of 1996' " as .25%, .13%, .05%, and .015%, respectively (an average of 0.12%). We assumed an average current plan annual maximum of $25,000 for mental health and substance abuse costs.

VI. Plan Design Modeling Assumptions

Mental Health And Substance Abuse coverages under employer health plans have evolved with numerous design variables for inpatient care, outpatient care, and other alternative services. Excluded from recent federal legislation, small employer group mental health and substance abuse benefits can be very restrictive. However, nearly all employer plans provide some level of mental health and substance abuse coverage. Approximately 1-2% of employers do not provide for inpatient mental health and substance abuse coverage, and 2-3% of employers do not provide outpatient mental health benefits.

Plans vary significantly in providing coverage for alternative services, such as partial hospitalization, day care, intensive outpatient care, etc. Sometimes these benefits are only provided under a custom-designed program of care for a specific patient. The variables of day limits, visit limits, annual maximums, lifetime maximum, managed care programs, alternate coverages, etc., add to the complexity of modeling the impact of the Arizona bill.

There is little information on the percentage of plans covered under different benefit combinations. However, it is possible to estimate the cost impact of mental health and substance abuse parity legislation through reasonable assumptions and proper modeling. Coopers & Lybrand has developed a matrix of plan options to estimate the potential range and impact of legislation on the employer market. Four delivery systems of varying intensity of managed mental health and substance abuse disorder care are used in the modeling. Mental Health And Substance Abuse costs and associated cost increases are stated as a percentage of a typical underlying plan of medical/surgical benefits. In this way, a percentage impact on employer health care plans is determined.

All cost information is based on health care cost projections to January 1, 1998. For modeling purposes it is assumed that all medical plans provide $1,000,000 lifetime medical and mental health and substance abuse limits. Current plan design assumptions use a $25,000 annual limit for mental health and substance abuse. This is the current design assumption for all plans even though the MHPA requires the same limits as for medical/surgical for cases above 50 lives.

To provide a conservative (high) estimate of the impact of state mental health and substance abuse parity laws, C&L assumed an average $25,000 limit for all insured plans as the present benefit design. Under this assumption, the full impact of the federal law is included for group plans. According to the 1991 Bureau of Labor Statistics Employee Benefits Survey, approximately 15% of private plans already include inpatient mental health "as any other illness." Those plans in Arizona would generally be unaffected by the proposed bill.

Representative plan designs by "Delivery System" and type of parity:

Plan Design: Delivery System 1

		Current	Partial	SMI Parity	Full	Comprehensive
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Coinsurance	80%	80%	80%	80/100%	80/100%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/80%	80/100%	80/100%
Max Out of Pocket		None	None	None/$1250	$1,250	Comp $1250
Lifetime Maximums:		$25K	$1 M	$1M	$1 M	$1 M
Provider Network:		None	None	None	None	None
Utilization Review:		Basic	Basic	Basic	Basic	Basic

Plan Design: Delivery System 2

		Current	Partial	SMI Parity	Full	Comprehensive
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Coinsurance	80%	80%	80%	80/100%	80/100%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/80%	80/100%	80/100%
Max Out of Pocket		None	None	None/$1250	$1,250	Comp $1250
Lifetime Maximums:		$25K	$1 M	$1M	$1 M	$1 M
Provider Network:		None	None	None	None	None
Utilization Review:		Special	Special	Special	Special	Special

Plan Design: Delivery System 3 (Network)

In Network Benefits		Current	Partial	SMI Parity	Full	Comprehensive
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Coinsurance	80%	80%	80/90/100%	90/100%	90/100%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	80/90/100%	90/100%	90/100%
Max Out of Pocket		None	None	None/$1250	$1,250	Comp $1250
Lifetime Maximums:		$25K	$1 M	$1M	$1 M	$1 M
Provider Network:(80%)		Yes	Yes	Yes	Yes	Yes
Utilization Review:		Special	Special	Special	Special	Special

Plan Design: Delivery System 3 (Out of Network)

Out of Network Benefits		Current	Partial	SMI Parity	Full	Comprehensive
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/70%	70%	70%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/70%	70%	70%
Max Out of Pocket		None	None	None	None	None
Lifetime Maximums:		$25K	$1 M	$1M	$1 M	$1 M
Provider Network (20%)		No	No	No	No	No
Utilization Review:		Special	Special	Special	Special	Special

Plan Design: Delivery System 4 (Network)

In Network Benefits		Current	Partial	SMI Parity	Full	Comprehensive
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Copayment	$100/day	$100/day	$100/100%	100%	100%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Copayment	$10/visit	$10/visit	$10/visit	$10/visit	$10/visit
Max Out of Pocket		None	None	None/$1250	$1,250	Comp $1250
Lifetime Maximums:		$25K	$1 M	$1M	$1 M	$1 M
Provider Network:(90%)		Yes	Yes	Yes	Yes	Yes
Utilization Review:		Special	Special	Special	Special	Special

Plan Design: Delivery System 4 (Out of Network)

Out of Network Benefits		Current	Partial	SMI Parity	Full	Comprehensive
Inpatient	Days/Yr	30	Unlim	30/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/70%	70%	70%
Outpatient:	Visits/Yr	20	Unlim	20/Unlim	Unlim	Unlim
	Coinsurance	50%	50%	50/70%	70%	70%
Max Out of Pocket		None	None	None	None	None
Lifetime Maximums:		$25K	$1 M	$1M	$1 M	$1 M
Provider Network (10%)		No	No	No	No	No
Utilization Review:		Special	Special	Special	Special	Special

VII. Managed Care Modeling Assumptions

Data provided by the Hoechst Marion Roussel Managed Care Digest and the InterStudy Competitive Edge: HMO Industry Report 7/1/96 shows commercial HMO enrollment in Arizona below national averages at 40% of the state population for a total of 1,771,600 lives. National average HMO penetration in 1996 was 29.2% of the U.S. population. Arizona HMO managed care enrollment increased 25.9% in 1996, placing Arizona well above the national HMO growth rate of 14.4%.

As in other states, HMO penetration varies by location. Larger more populated cities and regions tend to have higher HMO penetration and other forms of managed care. In 1996, using Metropolitan Statistical Areas the percentage of Americans with commercial health insurance enrolled in plans by type are:

	Fee-for-Service	POS/PPO	HMO
Phoenix-Mesa	7.9%	37.2%	54.9%
Tucson	7.0	16.4	76.6
Las Vegas(NV/AZ)	12.2	46.7	41.1

The InterStudy Competitive Edge:Regional Market Analysis as of 1/1/97 shows the following HMO enrollments in key Arizona MSAs:

	Population	HMO Enrollment	Penetration
Flagstaff	119,000	15,291	12.8%
Phoenix-Mesa	2,606,000	864,799	33.2%
Tucson	768,800	323,739	42.1%
Yuma	131,100	9,752	7.4%

HMOs operating in Arizona include: HealthPartners Health Plans, HMO Arizona, Intergroup of Arizona, Premier Healthcare of Arizona, PacifiCare, CIGNA, and United HealthCare.

Arizona enrollment in PPO/POSs is estimated at 30% of the population. It is believed that managed behavioral health care has greater penetration than medical coverage. While statistics on managed behavioral carve out programs are not readily available, United/Aetna (HAI), U.S Healthcare/CIGNA (MCC), Value Health, Merit Behavioral Health, and others have been marketing carve-out programs in Arizona to large and medium sized plans in advance of employers' movement to managed medical plans.

To account for the lower managed care penetration of smaller insured groups, C&L estimates the managed behavioral care contracts are 30% HMO and/or carve out plans and 25% PPO/POS. Managed indemnity is estimated at 25% with the balance of 20% with Fee-for-service and minimal utilization review. We have not factored in the continued growth in managed care (expanding HMO, PPO, managed indemnity, and carve out behavioral health programs). These assumptions were verified as reasonable and conservative with the HMO and PPO industry reporting and associations.

VIII. Cost Estimates from Modeling

Delivery System 1

Typical Medical Plan Claim Cost: $138.60
Percentage of Plans with Delivery System 1: 20%

	MH&SA Claim Costs Per Member Per Month				
Type of MH&SA Coverage	Current	Partial	SMI	Full	Comp.
Inpatient:	$4.44	$5.90	$ 7.17	$ 7.85	$ 8.34
Outpatient:	$ .89	$1.20	$ 2.07	$ 2.36	$ 2.99
Total MH PMPM Claims Costs	$5.33	$7.10	$ 9.23	$10.21	$11.33
Additional PMPM:Claims Cost		$1.77	$3.90	$4.88	$6.00
MH&SA as a Percent of the Medical Plan:	3.8%	5.1%	6.7%	7.4%	8.2%
MH&SA Incr. as % of Medical Plan:	0.0%	1.3%	2.8%	3.5%	4.3%

Cost Increase for Proposed Arizona MH&SA Parity as a Percentage of Base Medical Plan.....4.3%

Delivery System 2

Typical Medical Plan Claim Cost: $138.60
Percentage of Plans with Delivery System 2: 25%

Type of MH&SA Coverage	MH&SA Claim Costs Per Member Per Month				
	Current	Partial	SMI	Full	Comp.
Inpatient:	$3.32	$4.20	$5.29	$5.78	$ 6.22
Outpatient:	$0.90	$1.53	$2.07	$2.36	$ 3.03
Total MH&SA PMPM Claims Costs	$4.22	$5.73	$7.36	$8.14	$ 9.25
Additional PMPM:Claims Cost		$1.51	$3.14	$3.92	$5.03
MH&SA as a Percent of the Medical Plan:	3.0%	4.1%	5.3%	5.8%	6.6%
MH&SA Incr. as % of Medical Plan:	0.0%	1.1%	2.3%	2.8%	3.6%

Cost Increase for Proposed Arizona MH&SA Parity as a Percentage of Base Medical Plan.....3.6%

Delivery System 3

Typical Medical Plan Claim Cost: $119.70
Percentage of Plans with Delivery System 3: 25%

Type of MH&SA Coverage	MH&SA Claim Costs Per Member Per Month				
	Current	Partial	SMI	Full	Comp.
80% In-Network					
Inpatient:	$2.24	$2.77	$3.35	$3.63	$3.56
Outpatient:	$0.87	$1.20	$2.33	$2.70	$3.04
Total MH&SA PMPM Claims Costs	$3.11	$3.97	$5.69	$6.33	$6.60
20% Out-of-Network					
Inpatient:	$1.81	$2.21	$3.25	$3.61	$4.68
Outpatient:	$0.90	$1.23	$1.72	$1.92	$2.24
Total MH&SA PMPM Claims Costs	$2.71	$3.44	$4.97	$5.53	$6.92
Composite PMPM Claims Costs	$3.03	$3.86	$5.54	$6.17	$6.66
Additional PMPM:Claims Cost		$0.83	$2.51	$3.14	$3.63
MH&SA as a Percent of the Medical Plan:	2.5%	3.2%	4.6%	5.1%	5.5%
MH&SA Incr. as % of Medical Plan:	0.0%	0.7%	2.1%	2.6%	3.0%

Cost Increase for Proposed Arizona MH&SA Parity as a Percentage of Base Medical Plan.....3.0%

Delivery System 4

Typical Medical Plan Claim Cost: $100.80
Percentage of Plans with Delivery System 4: 30%

Type of MH&SA Coverage	MH&SA Claim Costs Per Member Per Month Current	Partial	SMI	Full	Comp.
90% In-Network					
Inpatient:	$1.19	$1.40	$1.88	$2.05	$2.34
Outpatient:	$1.30	$1.79	$1.69	$1.79	$2.12
Total MH&SA PMPM Claims Costs	$2.49	$3.19	$3.57	$3.84	$4.46
10% Out-of-Network					
Inpatient:	$1.81	$2.21	$3.25	$3.61	$4.68
Outpatient:	$0.90	$1.23	$1.72	$1.92	$2.24
Total MH&SA PMPM Claims Costs	$2.71	$3.44	$4.97	$5.53	$6.92
Composite PMPM Claims Costs	$2.51	$3.22	$3.71	$4.01	$4.71
Additional PMPM:Claims Cost		$0.70	$1.20	$1.50	$2.19
MH&SA as a Percent of the Medical Plan:	2.5%	3.2%	3.7%	4.0%	4.7%
MH&SA Incr. as % of Medical Plan:	0.0%	0.7%	1.2%	1.5%	2.2%

Cost Increase for Proposed Arizona MH&SA Parity as a Percentage of the Medical Plan.....2.2%

The following table summarizes the actuarial modeling results. The composite impact on the health insurance market ranges from 0.9% for Partial Parity to 3.2% for Comprehensive Parity. The cost increase for Fee-for-Service plans range from 1.3% to 4.3%. The lowest cost impact occurs under HMO & Gatekeeper programs where the cost impact of the parity options range from 0.7% to 2.2%.

Table 1
Mental Health & Substance Abuse Combined

Type of Delivery System	#	Distribution	Percentage Increase in Base Medical Plan for Change to Type of Parity: Partial	SMI	Full	Comprehensive
Fee-for-Service	1	20%	1.3%	2.8%	3.5%	4.3%
Managed Indemnity	2	25%	1.1	2.3	2.8	3.6
PPO & POS	3	25%	0.7	2.1	2.6	3.0
HMO & Gatekeeper	4	30%	0.7	1.2	1.5	2.2
Composite Market Analysis			0.9%	2.0%	2.5%	**3.2%**
Composite PMPM			$1.12	$2.46	$3.08	**$3.90**
Net Market Impact			0.4%	0.8%	1.0%	**1.3%**
Net PMPM Impact			$0.45	$0.98	$1.23	**$1.56**

Similar values were run for mental health parity only. All assumptions were held constant as to plan design for medical benefits, managed care impacts, and percentage distribution of the various delivery systems. Values for mental health only are shown below.

The Arizona proposal strongly endorses and requires parity for mental health and substance abuse. The attached analysis calculates parity for the proposed bill (Table 1) and mental health only (Table 2). The purpose of this analysis is to frame the cost discussions with facts related to cost of various options that might come under debate.

Table 2
Mental Health Only

			Percentage Increase in Base Medical Plan for Change to Type of Parity			
Type of Delivery System	#	Distribution	Partial	SMI	Full	Comprehensive
Fee-for-Service	1	20%	0.9%	2.0%	2.5%	3.1%
Managed Indemnity	2	25%	0.7	1.7	2.1	2.7
PPO & POS	3	25%	0.6	1.7	2.2	2.5
HMO & Gatekeeper	4	30%	0.5	0.8	1.0	1.1
Composite Market Analysis			0.6%	1.5%	1.9%	**2.3%**
Composite PMPM			$0.84	$1.95	$2.44	**$2.95**
Net Market Impact			0.24%	0.6%	0.8%	**0.9%**
Net PMPM Impact			$0.34	$0.78	$0.98	**$1.18**

The C&L modeling assumes a reasonable, but conservatively low managed care penetration for Arizona. The assumptions were established conservatively to account for the impact of fewer small groups currently using managed care. C&L did not find data available to determine the split of managed care for behavioral health plans in Arizona solely for insured plans.

IX. Comparison to Congressional Budget Office Calculations

In a letter to Senator Nancy Kassebaum (R-KS) dated April 23, 1996, the Congressional Budget Office (CBO) estimated the cost impact of the mental health and substance abuse parity proposal by Senators Domenici (R-NM) and Wellstone (D-MN) at 4.0%. The Domenici-Wellstone proposal is similar to the Comprehensive Parity option presented in this paper which includes parity of coverage for mental health and substance abuse. The CBO cost estimate including mental health and substance abuse and substance abuse is 5.3% for Fee for Service plans and 4.0% for the market composite that includes managed care plans. As written in the CBO letter, "Because employers would be better able to control costs for mental health and substance abuse disorder services, CBO assumed that the average premium increase initially would be 4 percent."

The C&L model result is 4.3% for the Delivery System 1 Comprehensive Parity calculation (Table 1, fee-for-service). This is directly comparable to the CBO value of 5.3%. The composite market analysis C&L model result of 3.2% (see Table 1) relates directly to the 4.0% cost estimate of the CBO. C&L has performed similar analysis in numerous states. In most states, the CBO values are slightly higher than the C&L values. In Arizona the C&L results are about 80% of the National values determined by CBO. The difference is values seem to be caused mainly by the fact the there is more managed care in Arizona than in the nation as a whole. In addition, the relative costs of mental health and substance abuse costs to medical/surgical costs in Arizona are low relative to national relationships.

This analysis indicates a fair comparison of the governmental economic analysis and C&L actuarial analysis of the cost of mental health and substance abuse parity legislation. In general, the Congressional Budget Office national cost estimates are similar to the C&L models for Arizona (especially when accounting for the difference in managed care penetration). The estimated costs show a consistency and comparability between the C&L model results and the Congressional Budget Office estimates for mental health and substance abuse parity costs.

X. Impact on Employer Premium Contributions

Employers respond to any potential increase in benefit costs in variety of ways including, competitively marketing the plan to obtain lower premiums, intensely negotiating lower provider costs, cutting plan administrative costs, increasing plan costsharing by members, increasing premium contributions by members, reducing other benefits, and in the extreme, dropping plan coverages and reducing wages (or wage increases). The CBO typically estimates that these employer responses to required coverages will result in cost offsets of about 60% of the gross cost estimates. Using the standard CBO economic modeling approach, employer contributions for health insurance would rise about 40% of the estimate or 1.3 percent.

XI. Conclusions

Based upon the Coopers & Lybrand mental health and substance abuse modeling, the proposed Arizona mental health and substance abuse parity legislation has an aggregate cost impact of 3.2 percent increase over the current market costs of health care ($3.90 per member per month). Employers are likely to respond in varying ways to offset any cost by increasing deductibles, copays, and reducing other benefits. The net employer cost is determined by using the CBO ratio of 40% of the total cost. This reflects the net impact on employer costs after benefit design and other offsets. This approach yields a net employer cost impact of about 1.3% or $1.56 per member per month. This analysis is consistent with the Congressional Budget Office estimates of mental health and substance abuse parity studied in 1996 during the national debate over the Domenici-Wellstone Amendment.

The impact of the proposed Arizona legislation varies based upon the type of delivery system and utilization controls built into an insured plan. For example, the impact is lowest for managed care programs with strong utilization controls. These plans already have internal cost controls and significant case management oversight. Preferred Provider Organizations (PPOs) and Point of Service plans (POS) are impacted on average 3.0%, HMO and other gatekeeper models show cost increases of 2.2 percent.

Based upon an analysis using generally accepted actuarial practices, the total impact of the proposed Arizona mental health and substance abuse parity bill is equal to 3.2% of current employer claims or about $3.90 per member per month. However, the employer will respond in various ways to partially offset any potential cost increases. Therefore, the expected employer contributions for health costs will rise about 1.3% or $1.56 per member per month. Assuming an average of 3 members per family this translates into an equivalent wage increase of $.027 per hour.

Appendix A

Additional Information on Parity Options

I. Partial Parity

A. Parity for Day and Visit Limits

Partial parity is a term that describes incremental reform proposals to improve mental health and chemical dependency benefits. Proposals that move mental health and chemical dependency coverage closer to full parity with medical care coverage are referred to as partial parity. For example, the recently passed federal legislation, the Mental Health Parity Act of 1996, made equal the use of lifetime and annual limits. The partial parity proposal priced in this paper requires that inpatient day and visit limits for medical and mental health and substance abuse coverage be equal. There are usually no such coverage limits on members who access medical inpatient and outpatient services.

Sample legislative language for partial parity would include the following:

1. If a plan does not include a day limit or a visit limit on substantially all medical and surgical benefits, the plan or coverage may not impose any day limit or any visit limit on mental health and substance abuse benefits.

2. If a plan or coverage includes a day limit or a visit limit on substantially all medical and surgical benefits, the plan or coverage shall either:

   a. apply the applicable day limit or visit limit both to the medical and surgical benefits to which it otherwise would apply and to mental health and substance abuse benefits and not distinguish in the application of such limits between such medical and surgical benefits and mental health and substance abuse benefits; or

   b. not include any day limit or any visit limit on mental health and substance abuse benefits that is less than the applicable day limit or visit limit for medical and surgical benefits.

B. Parity for Out-of-Pocket Costs

Another approach to partial parity follows the development of coverage for high cost medical illness. Insurance contracts are financial vehicles that are designed to lessen the impact of medical costs. Therefore, the issue of severity is addressed for medical care on the basis of finances rather than diagnosis by limiting the maximum out-of-pocket costs required of a covered individual. Under most traditionally designed (non-HMO) plans, the insurance plan pays 100% of eligible expenses after a front-end deductible ($250) and $1,000 of patient costsharing in a given calendar year. Many HMO plan designs have no maximum out-of-pocket limits because the copayments are minimal (i.e. $10 per office visit).

II. Interim Report to Congress by the National Advisory Mental Health Council

A report entitled "Parity in Coverage of Mental Health Services in an Era of Managed Care" is a product of the Department of Heath and Human Services, the National Institutes of Health and the National Institute of Mental Health. This report is an interim report to Congress by the National Advisory Mental Health council. The study's major findings are:

> "1. Based upon empirical studies and economic simulations across diverse populations, managed care approaches, and parity structures suggest that the introduction of parity in combination with managed care results in lowered costs and lowered premiums (or, at most, very modest cost increases) within the first year of parity implementation.
>
> 2. These findings do not support earlier concern about potentially high financial costs caused by parity. Prior estimates were based on fee-for-service (FFS) models that are no longer valid for a market dominated by managed care and likely to become even more so."

A. Texas

On September 1, 1992, the State of Texas implemented legislation requiring parity in mental health insurance coverage for State and local government employees. Parity was also required for the treatment of chemical dependency. Experience for 170,000 members in managed FFS/PPO/POS (non-HMO) coverage for the years 1992 through 1995 shows a 47.9% decrease in the cost of care for mental health and chemical dependency.

B. Maryland

On July 1, 1995, the State of Maryland implemented parity legislation that applied to all insurers. The legislation applied to those mental health and addictive disorders determined to be medically necessary and treatable. After parity was instituted, a small increase was observed in the number of inpatient admissions per 1000; that increase was more than offset by a more significant decrease in the average length of inpatient stays. Outpatient visits decreased as much as 9%, although isolated instances of increased outpatient utilization were seen.

For one insurer, the proportion of the total medical premium attributable to the mental health benefit actually decreased by 0.2 percent after the implementation of full parity. A second managed care company with extensive experience in Maryland subsequently confirmed that their average expense per member per month increased by less than 1.0 percent during the first 7 months after full implementation of parity.

Since 1992 when parity was established and a single deductible was implemented, mental health payments as a portion of total health payments decreased from 6.4% to 3.4% of total health care costs for the fiscal year ending June 30, 1996. Mental health payments (excluding chemical dependency) have decreased under the State Health Plan from $6.49 PMPM in 1992 to $4.06 PMPM in 1996. Clearly, North Carolina is a different state and population. However, the impact on costs to the state plan should be a strong indicator that fears of large cost impacts are unfounded. It is typical that actual experience achieved through plan design changes is lower than conservative actuarial analysis.

A 3 missing

Appendix B

Alternative Language for Serious Mental Illness (SMI) Parity

Arizona is not proposing SMI parity coverage. This appendix is presented to provide additional details on the definitions used for SMI parity. SMI is not common, but it is frequently a part of any mental health parity debate. Costs for SMI are shown only in anticipation of that discussion. Problems associated with "diagnosis creep" and the lack of savings relative to full and comprehensive parity led the national proposal by Senators Domenici and Wellstone away from SMI.

The C&L model most closely follows the National Advisory Mental Health Council (NAMHC) definition of *severe* mental illness. For purpose of this analysis, serious mental illness and severe mental illness are used as comparable. This is because the best data available on SMI analysis is developed under the NAMHC definition. The definition of serious mental illness is important because substantially greater benefits are paid as a result of a professionally rendered diagnosis.

A. National Advisory Mental Health Council

Coopers & Lybrand conducted analyses of parity language for serious mental illness during national debates on health care. Senator Domenici attempted to define serious mental illness following the language developed by the National Advisory Mental Health Council. Some of the statistical basis of the actuarial work presented in this document is developed from the National Advisory Mental Health Council definition of SMI. C&L uses this definition for statistical analysis because it allows consistent use of existing data.

> Severe mental illness is defined through diagnosis, disability, and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, manic depressive disorder, autism, as well as severe forms of other disorders such as major depression, panic disorder, and obsessive compulsive disorder.

B. Expanded SMI Language for Children

The following definition for severe mental illness establishes parity language that includes diagnoses for illness that inflict children.

> The term "severe mental illness" means an illness that is defined through diagnosis, disability and duration, and includes disorders with psychotic symptoms such as schizophrenia, schizoaffective disorder, bipolar disorder, dementia, autism, and other pervasive developmental disorders, as well as severe forms of other disorders such as major depression, panic disorder, obsessive compulsive disorder, multiple personality disorder, anorexia nervosa, bulimia, learning disorder associated with brain damage, phobia associated with significant functional impairment, and disruptive behavior disorders of childhood, as determined by the Secretary of Health and Human Services.

C. United States Substance Abuse and Mental Health Services Administration

The Center for Mental Health Services also established definitions for children and adults with "serious emotional disturbance" and "serious mental illness", respectively. States use these definitions to include incidence and prevalence estimates of the two populations as part of a State application for a Community Mental Health Services Block Grant awards. The definitions are:

A. Children with a serious emotional disturbance are persons:
   1. from birth up to age 18,
   2. who currently or at any time during the past year,
   3. have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R,
   4. that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community.

B. Adults with serious mental illness are persons:
   1. age 18 and over,
   2. who currently or at any time during the past year,
   3. have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R,
   4. that has resulted in functional impairment which substantial interferes with or limits one or more major life activities.

These definitions were adopted by the Substance Abuse and Mental Health Services Administration (SAMHSA) and published in the Federal Register on May 20, 1993. This language was proposed by the mental health community as an amendment to the Domenici-Wellstone Amendment in 1996. Severe and/or serious mental health definitions never became a part of the Domenici-Wellstone Amendment or the Mental Health Parity Act of 1996.

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ARKANSAS

Info from
Ron Bachman

Arkansas
Mental Health Parity
Work Group

Sample Agenda

A. The Problem
  1. Presenters
    a. MH Patients
    b. Parents/Family members of Patients
    c. State MH Agencies
  2. Issues
    a. Financial Impact on Individual/Family
    b. Impact on care/treatment/cure
    c. Impact on State/County/Local public sector MH programs

B. Treatment Efficacy
  1. Presenters
    a. Practicing psychiatrists
    b. Practicing psychologists
    c. Researchers - NIMH/Local Teaching Hospitals/BJC
  2. Issues
    a. Changes in inpatient/outpatient care
    b. The continuum of care options
    c. Efficacy/Outcomes

C. The Costs
  1. Presenters
    a. C&L Actuary
    b. M&R Actuary
    c. BCBS of Arkansas Actuary
  2. Issues
    a. Current costs
    b. Projected costs
    c. Arkansas specific data and National studies
    d. Experience of other states/employers with MH parity
    e. Price options that may be considered from partial parity to comprehensive parity

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D. Risk Assumption
1. Presenters
a. Insurance Company - HIAA
b. HMO Company - AARP
c. BCBS of Arkansas
d. MBHO - Value Behavior Health/Merit/Other
2. Issues
a. Issues of risk assumption
b. Managed care controls
c. Case management

E. Business Concerns
1. Presenters
a. Small business - NFIB
b. Other business - Chamber of Commerce
c. Employer with low/no MH coverage
d. Employer with high/parity MH coverage
e. ERISA plan HR manager - Tysons/Walmart
f. Economist
2. Issues
a. Mandated coverage
b. Cost concerns
c. Impact on coverage of Health care
d. Uninsured
e. Unemployment
f. Small business impact

F. Solutions/Options - Work Group closed session (price final outcome)

G. Legislation - as/if appropriate

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NORTH CAROLINA

NC Comprehensive Major Medical Plan for Teachers and State Employees

Data on the Mental Health Benefit

Since 1992, the State Health Plan has provided mental health benefits at the same levels as physical health benefits in a managed environment through a contract with Value Behavioral Health. Using the current structure, a very affordable and cost-contained mental health benefit has been achieved. All data about the State Health Plan has to be framed within the broader benefit structure, i.e. that a very affordable and cost-contained mental health benefit has been achieved:

1. with full coverage **parity** with non-mental health conditions (since 1992),
2. with **no separate additional deductible** for mental health services,
3. with **full freedom-of-choice** of mental health providers,
4. with **only moderate management** of generous benefits when compared to other typical mental health plans, and
5. with a **broad demographic** and **large number** of covered lives (400,075).

KEY DATA POINTS INCLUDE:

1. **Contrary to broad insurance industry attributions** about "skyrocketing" mental health costs relative to the overall health benefit payments (e.g. double-digit 10-15% of payouts), **the State Health Plan has consistently had mental health expenses considerably lower.** Figures since 1989 have ranged from 7.1% downward for mental health as a portion of total payouts.
2. Since parity was established (1992) and a single insurance deductible implemented in 1992, **mental health payments** as a portion of total health payments **decreased from 6.4% to 3.4%** which is a 47% cumulative reduction for the fiscal year ending June, 1996.
3. **Utilization patterns remain constant** and at a very modest level for outpatient over the years:
   - 6-7% seek out-patient services in any year
   - Half of the people using services go for only 4-5 sessions and three-quarters of the people seeking services complete treatment within 11-13 sessions
   - Over the span of several years, the percentage of people utilizing more extended outpatient services (utilization > 26) has remained constant and extremely low (0.40-0.75%)
4. Since 1992, **hospital days** paid by the Plan have been **reduced by 64%.**
5. Within a parity benefit, mental health payments, expressed as a monthly cost per covered life, have been extremely reasonable and very well cost contained. The **cost per life per month** for the year ending June, 1997, **was $4.54** (including the cost of administrative overhead). This figure is lower than in June, 1990, even without adjustment for inflation.
6. These actual utilization/cost **figures compare favorably** with actuarial projected figures generated by Coopers and Lybrand for the NC Health Planning Commission for a variety of benefits structure scenarios including versions similar to the State Health Plan. Coopers and Lybrand mental health cost data was itself viewed quite favorably by the Benefits Committee, which included members from the business sector.

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office 5/98

AUG. 14. 1998 4:07PM PRICEWATERHOUSECOOPERS GHRS NO. 3165 P. 4

AUG. 14. 1996 4:08PM PRIVATEATTORNEYSGENERS NO. 3183 P. 3

NC COMPREHENSIVE MAJOR MEDICAL PLAN FOR TEACHERS AND STATE EMPLOYEES

Mental Health Costs

Fiscal Year Ending

	June-97	June-96	June-95	June-94	June-93 (Full MH Mgmt)	June-92 (No Outpatient Cap or MH Mgmt)	June-91	June-90
TOTAL: Actives & Dependents	292,572	305,924	322,627	322,960	322,088	330,613	351,189	341,098
TOTAL: Covered Lives	393,965	404,210	415,225	412,529	409,302	416,302	433,069	420,184
Total Mental Health Payments	$19,008,825	$19,936,676	$20,424,916	$23,138,778	$25,812,004	$32,361,152	$30,839,831	$27,914,870
— Total Payments PMPY*	$48.25	$49.32	$49.19	$56.09	$62.57	$77.92	$71.19	$66.43
— Total Payments PMPM*	$4.02	$4.11	$4.10	$4.67	$5.21	$6.49	$5.93	$5.54
— % of Total of all Medical Claims Paid	3.3%	3.4%	3.7%	4.5%	5.2%	6.4%	6.1%	6.6%
Total Administrative Payments	$2,452,923	$2,493,405	$2,476,755	$2,404,000	$2,273,662			
— Total Payments PMPY	$6.23	$6.23	$5.96	$5.72	$5.56			
— Total Payments PMPM	$0.52	$0.52	$0.50	$0.48	$0.46			
Breakdown of Cost Per Member Per Month								
— Mental Health PMPM	$4.02	$4.11	$4.10	$4.67	$5.21			
— Administrative PMPM	$0.52	$0.52	$0.50	$0.48	$0.46			
Total Cost Per Member Per Month	$4.54	$4.61	$4.60	$5.15	$5.67	$6.49	$5.93	$5.54

***Note: PMPY and PMPM - is actually per covered life per year or per month**

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office

5/98

NC COMPREHENSIVE MAJOR MEDICAL PLAN FOR TEACHERS AND STATE EMPLOYEES

Mental Health Experience (Excluding Substance Abuse)
Inpatient/Outpatient Data

Fiscal Year Ending

	FY 6/97	FY 6/96	FY 6/95	FY 6/94	FY 6/93	FY 6/92	FY 6/91	FY 6/90
Inpatient (Actives & Dependents Only)								
# of Admissions	781	876	971	1,092	1,142	1,276	1,403	1,387
Adm/10,000	26.7	29.8	30.3	34.1	35.5	38.2	39.5	39.8
Days/10,000	269.8	308.5	318.9	391.8	484.9	807.1	859.8	917.9
ALOS	10.1	10.8	10.5	11.5	13.7	21.1	21.7	23.1
ALOS (outliers greater than 50 days excluded)	(10.1)	(9.3)	(9.2)	(10.8)	(12.2)			
Outpatient (Actives & Dependents Only)								
Patients	20,113	20,519	20,562	19,874	19,659	20,520	21,092	18,913
Patients as %	6.8%	6.7%	6.4%	6.1%	6.1%	6.1%	6.0%	5.8%
Visits	160,666	179,225	172,664	185,866	193,601	217,944	212,612	192,488
Visits/1000 members	549	551	539	557	602	653	609	567
Visits/Patient								
- Median	4.0	4.0	4.0	4.0	4.0	5.0	5.0	5.0
- 75th Percentile	11.0	11.0	12.0	13.0	13.0	13.0	14.0	14.0
- Mean	8.0	8.3	8.5	9.2	9.8	10.6	10.1	10.2
Utilization > 26 Visits								
- # of patients	1,203	1,216	1,508	1,842	1,842	2,462	2,499	2,173
- % of patients	6.0%	5.9%	7.3%	8.3%	9.4%	12.1%	11.8%	11.5%
- % of covered lives	0.41%	0.40%	0.47%	0.51%	0.57%	0.75%	0.71%	0.64%

Prepared by NC Psychological Association from data supplied by the NC State Health Plan Office 5/98

MAINE

APPROVED

JL 3 '95

BY GOVERNOR

CHAPTER

407

PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-FIVE

H.P. 432 - L.D. 595

An Act Regarding Insurance Coverage for Mental Illness

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24 MRSA §2325-A, sub-§5-C, as amended by PL 1995, c. 19, §1, is repealed and the following enacted in its place:

5-C. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A is subject to this subsection.

A. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital or medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

This subsection does not apply to policies, contracts and certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 2. 24 MRSA §2325-A, sub-§5-D is enacted to read:

5-D. Mandated offer of coverage for certain mental illnesses. Except as otherwise provided, coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group nonprofit hospital and medical services organization health care plan contracts is subject to this subsection.

A. All individual and group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. Every nonprofit hospital and medical services organization and nonprofit health care plan must make available coverage in all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 that provides benefits meeting the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital or medical service organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual or group contract.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 3. 24 MRSA §2325-A, sub-§8, as enacted by PL 1983, c. 515, §4, is amended to read:

8. **Reports to the Superintendent of Insurance.** Every nonprofit hospital or medical service organization subject to this section shall report its experience for each calendar year ~~beginning with 1984~~ to the superintendent not later than April 30th of the following year. The report ~~shall~~ must be in a form prescribed by the superintendent and ~~shall~~ include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all nonprofit hospital or medical service organizations in an annual report.

Sec. 4. 24 MRSA §2325-A, sub-§9, as amended by PL 1993, c. 586, §2, is repealed.

Sec. 5. 24-A MRSA §2749-C is enacted to read:

§2749-C. Mandated offer of coverage for certain mental illnesses

1. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A by all individual policies is subject to this section.

A. All individual policies must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All individual policies and contracts executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must make available coverage providing benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts

are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual policy.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

2. **Contracts; providers.** Subject to approval by the superintendent pursuant to section 2305, an insurer incorporated under this chapter shall offer contracts to providers authorizing the provision of mental health services within the scope of the provider's licensure.

3. **Limits; coinsurance; deductibles.** A policy or contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

4. **Reports to the superintendent.** Every insurer subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for individual health care policies, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

5. **Application.** Except as otherwise provided, the requirements of this section apply to all policies and contracts

executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996. For purposes of this section, all policies are deemed renewed no later than the next yearly anniversary of the contract date. Nothing in this section applies to accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

Sec. 6. 24-A MRSA §2843, sub-§5-C, as amended by PL 1995, c. 19, §1, is repealed and the following enacted in its place:

5-C. Coverage for treatment for certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A is subject to this subsection.

A. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a nonprofit hospital or medical service organization, a provider of medical treatment

for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

This subsection does not apply to policies, contracts and certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism or other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 7. 24-A MRSA §2843, sub-§5-D is enacted to read:

5-D. Mandated offer of coverage for certain mental illnesses. Except as otherwise provided in subsection 5-C, coverage for medical treatment for mental illnesses listed in paragraph A by all group contracts is subject to this subsection.

A. All group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must make available coverage providing benefits that meet the requirements of this

paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing insurer, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

Sec. 8. 24-A MRSA §2843, sub-§7, as enacted by PL 1983, c. 515, §6, is amended to read:

7. Reports to the Superintendent of Insurance. Every insurer subject to this section shall report its experience for each calendar year ~~beginning with 1984~~ to the superintendent not later than April 30th of the following year. The report ~~shall~~ must be in a form prescribed by the superintendent and ~~shall~~ include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for group health care contracts, both separated between those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all insurers in an annual report.

Sec. 9. 24-A MRSA §2843, sub-§8, as amended by PL 1993, c. 586, §4, is repealed and the following enacted in its place:

8. Application. This section does not apply to accidental injury, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

Sec. 10. 24-A MRSA §4234-A is enacted to read:

§4234-A. Mental health services coverage

1. Findings. The Legislature finds that:

A. Mental illness affects nearly 170,000 people of this State each year, resulting in anguish, grief, desperation, fear, isolation and a sense of hopelessness of significant levels among victims and families;

B. Consequences of mental illness include the expenditure of millions of dollars of public funds for treatment and losses of millions of dollars by businesses in the State in accidents, absenteeism, nonproductivity and turnover. Excessive stress and anxiety and other forms of mental illness clearly contribute to general health problems and costs;

C. Typical health coverage in this State discriminates against mental illness, the victims and affected families with nonexistent or limited benefits compared to provisions for other illnesses; and

D. Experience in this State and several other states demonstrates that the risk of mental illness can be insured at reasonable cost and with adequate controls on quality and utilization of treatment.

2. Policy and purpose. The Legislature declares that it is the policy of this State to:

A. Promote equitable and nondiscriminatory health coverage benefits for all forms of illness including mental and emotional disorders that are of significant consequence to the health of people of the State and that can be treated in a cost-effective manner;

B. Ensure that victims of mental and other illnesses have access to and choice of appropriate treatment at the earliest point of illness in the least restrictive settings;

C. Ensure that costs of treatment of mental illness are supported through an equitable combination of public and private responsibilities; and

D. Ensure that the Legislature reasonably exercises its legal responsibility for insurance policy in this State by prescribing types of illnesses and treatment for which benefits must be provided.

3. Definitions. For purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Day treatment services" includes psychoeducational, physiological, psychological and psychosocial concepts, techniques and processes necessary to maintain or develop functional skills of clients, provided to individuals and groups for periods of more than 2 hours but less than 24 hours a day.

B. "Inpatient services" includes a range of physiological, psychological and other intervention concepts, techniques and processes used in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Human Services or in an accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting.

C. "Outpatient services" includes screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventive concepts, techniques and processes provided to individuals and groups.

D. "Person suffering from a mental or nervous condition" means a person whose psychobiological processes are impaired severely enough to manifest problems in the area of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the area of intellect, emotion or physical well-being.

E. "Provider" means an individual included in Title 24, section 2303, subsection 2, a licensed physician, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Mental Health and Mental Retardation. All agency or institutional providers named in this paragraph shall ensure that services are supervised by a psychiatrist or licensed psychologist.

4. Requirement. Every health maintenance organization that issues individual or group health care contracts providing coverage for hospital care to residents of this State shall provide benefits as required in this section to any subscriber or

other person covered under those contracts for conditions arising from mental illness.

5. Services. Each individual or group contract must provide, at a minimum, the following benefits for a person suffering from a mental or nervous condition:

A. Inpatient services;

B. Day treatment services; and

C. Outpatient services.

6. Coverage for treatment of certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A is subject to this subsection.

A. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must provide benefits that meet the requirements of this paragraph. For purposes of this paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.

This subsection does not apply to policies, contracts or certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

7. **Mandated offer of coverage for certain mental illnesses.** Except as provided in subsection 6, coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group contracts is subject to this subsection.

A. All individual and group contracts shall make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician:

(1) Schizophrenia;

(2) Bipolar disorder;

(3) Pervasive developmental disorder, or autism;

(4) Paranoia;

(5) Panic disorder;

(6) Obsessive-compulsive disorder; or

(7) Major depressive disorder.

B. All individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after July 1, 1996 must make available coverage providing benefits that meet the requirements of this paragraph. For purposes of this

paragraph, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary and appropriate. When making the determination of whether treatment is medically necessary and appropriate, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual or group contract.

This subsection may not be construed to allow coverage and benefits for the treatment of alcoholism and other drug dependencies through the diagnosis of a mental illness listed in paragraph A.

8. **Contracts; providers.** Subject to approval by the superintendent pursuant to section 4204, a health maintenance organization incorporated under this chapter shall allow providers to contract, subject to the health maintenance organization's credentialling policy, for the provision of mental health services within the scope of the provider's licensure.

9. **Limits; coinsurance; deductibles.** A policy or contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

10. **Reports to the superintendent.** Every health maintenance organization subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for individual and group health care contracts, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all health maintenance organizations in an annual report.

11. **Application.** Except as otherwise provided, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on and after July 1, 1996. For purposes of this section, all contracts are deemed renewed no later than the next yearly anniversary of the contract date.

MISSOURI

State of Missouri
Proposed
Mental Illness and Substance Abuse
Insurance Act

Section 1. Short Title.- Sections 1 to 6 shall be known as the "Mental Health and Substance Abuse Insurance Act."

Section 2. Definitions.- For the purposes of sections 1 to 6 the following terms shall mean:

(1) "Director", the director of the department of insurance of this state;

(2) "Health insurance policy" or "policy", all group health insurance policies providing coverage on an expense-incurred basis, all group service or indemnity contracts issued by a not for profit health services corporation, all self-insured group health benefit plans of any type or description to the extent that regulation of such plans is not preempted by federal law, and all such health insurance policies or contracts that are individually underwritten or provide such coverage for specific individuals and members of their families as non-group policies, which provide hospital treatments. The term shall also include any group or individual contract issued by a health maintenance organization. The provisions of section 1 to 6 shall not apply to policies which provide coverage for a specified disease only, other than for mental illness or chemical dependency;

(3) "Insurer", an entity licensed by the department of insurance to offer a health insurance policy;

(4) "Mental illness", mental disorder and substance abuse in children and adults as follows:

(a) a child with a mental illness (including substance abuse) is a person from birth up to age 18, who has a diagnosable mental, behavioral or emotional disorder that is classified as an Axis I disorder and results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Axis I disorders shall be determined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(b) an adult with a mental illness (including substance abuse) is a person age 18 or over, who has a diagnosable mental, behavioral or emotional disorder that is classified as an Axis I disorder and results in functional impairment which substantially interferes with or limits one or more of the adult's major life activities. Axis I disorders shall be determined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(5) "Rate, term, or condition" means any lifetime limits, annual payment limits, episodic limits, inpatient or outpatient service limits, and out-of-pocket limits. This definition does not include deductibles, copayments, or coinsurance prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of mental illness and physical health conditions.

Section 3. Mental Illness Not a Mandated Benefit. Minimum Standard Provision. Insured Choice Available Within a Policy. -

(1) Nothing in this bill shall be construed as requiring the coverage of mental health and substance abuse.

(2) If any mental illness benefits are provide by the health insurance policy, the coverage provided shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to evaluation and treatment for mental illness than for access to evaluation and treatment for a physical condition, generally.

(3) A health insurance policy shall be construed to be in compliance with this section if at least one choice for treatment of mental illness provided to the insured with the policy has rates, terms, and conditions that place no greater financial burden on the insured than for access to treatment of physical conditions, generally.

(4) The director may disapprove any policy that the director determines to be inconsistent with the purposes of this section.

Section 4. Allowance for Managing the Provision of Benefits. Provision for Medically Necessary and Clinically Appropriate Treatments. -

(1) Nothing in this bill shall be construed as:

(a) Requiring the same rates, terms, or conditions between treatments for mental illness and preventive care; or

(b) Prohibiting a health insurance policy from negotiating separate reimbursement rates and service delivery systems, such as but not limited to a mental health carve-out program; or

(c) Prohibiting a health insurance policy from managing the provision of benefits through common methods including but not limited to pre-admission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental illness only to those that are deemed medically necessary and clinically appropriate.

(2) An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and clinically appropriate care and treatment for each patient.

Section 5. Exceptions to the Provision for Parity for Certain Services. Waiver for Excessive Cost Impact on Employers.-

(1) The provisions of section 3 shall not be violated if the insurer decides to apply different limits or exclude entirely from coverage the following:

(a) Marital, family, educational, or training services unless medically necessary and clinically appropriate;

(b) Services rendered or billed by a school, halfway house, residential treatment facility or a member of any such entity's staff;

(c) Care that is substantially custodial in nature;

(d) Services and supplies that are not medically necessary nor clinically appropriate;or

(e) Treatments that are considered experimental.

(2) The director shall grant a policyholder a waiver from the provisions of Section 3 if the policyholder demonstrates to the director by actual experience over a 24 month period that compliance with sections 1 to 6 has increased the cost of the health insurance policy by an amount that results in a financial hardship to the policyholder.

Section 6. Effective Date. Department to Conduct Experience Study. Sunset Provision.-

(1) The provisions of Sections 1-6 apply to applications for coverage made on or after January 1, 2000, and to health insurance policies issued or renewed on or after such date to residents of this state. Multi-year group policies need not comply until the expiration of their current multi-year term unless the policyholder elects to comply before that time.

(2) The director shall perform a study to assess the impact of the Mental Health and Substance Abuse Insurance Act on insurers, business interests, providers, and consumers of mental illness treatment services. The director shall report the findings of this study to the general assembly by January 1, 2004.

(3) Unless renewed by actions of the state legislature and the governor, this act shall be inactive as of 1/1/2005.

Section 7. Compliance of Policies Covering State Employees.

(1) Notwithstanding the provisions of sections 1 to 6, all health insurance policies which cover state employees including the Missouri Consolidated Health Care Plan shall include coverage for mental illness.

Multi-stage Screening Requirements for Coverage of MH/SA Catastrophic Insurance Parity Legislation

I. Definition of Mental illness
  1. Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)
  2. Limited to Axis I
  3. Axis I includes requirement for functional disablement
  4. Missouri definition includes additional functional disability requirements.
II. Medically Necessary and Clinically Appropriate
III. Managed Care Provisions
  1. Preadmission screening
  2. Continued Stay Reviews
  3. Discharge Planning
  4. Case Management
  5. Other mechanisms to assure medically necessary and clinically appropriate
IV. Parity Provided Only Through Managed care Network
  1. Compliance with at least one employee choice for treatment
V. Specific Exclusions Allowed
  1. Marital, family, educational or training services
  2. School, halfway house, residential treatment facility
  3. Custodial care
  4. Experimental

Benefit Limitations Allowed

1. Mental Illness need not be covered at all.
2. Higher than physical conditions deductibles, coinsurance, and copayment amounts
3. Need not cover out-of-network mental illness services on the same basis as out-of-network physical illnesses.
4. Selected mental health services are specifically allowed to be excluded

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

State of Missouri
Proposed
Mental Illness and Substance Abuse
Insurance Act

Section 1. Short Title.- Sections 1 to 6 shall be known as the "Mental Health and Substance Abuse Insurance Act."

Section 2. Definitions.- For the purposes of sections 1 to 6 the following terms shall mean:

(1) **"Director"**, the director of the department of insurance of this state;

(2) **"Health insurance policy" or "policy"**, all group health insurance policies providing coverage on an expense-incurred basis, all group service or indemnity contracts issued by a not for profit health services corporation, all self-insured group health benefit plans of any type or description to the extent that regulation of such plans is not preempted by federal law, and all such health insurance policies or contracts that are individually underwritten or provide such coverage for specific individuals and members of their families as non-group policies, which provide hospital treatments. The term shall also include any group or individual contract issued by a health maintenance organization. The provisions of section 1 to 6 shall not apply to policies which provide coverage for a specified disease only, other than for mental illness or chemical dependency;

(3) **"Insurer"**, an entity licensed by the department of insurance to offer a health insurance policy;

(4) **"Mental illness"**, mental disorder and substance abuse in children and adults as follows:

(a) a child with a mental illness (including substance abuse) is a person from birth up to age 18, who has a diagnosable mental, behavioral or emotional disorder that is classified as an Axis I disorder and results in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Axis I disorders shall be determined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(b) an adult with a mental illness (including substance abuse) is a person age 18 or over, who has a diagnosable mental, behavioral or emotional disorder that is classified as an Axis I disorder and results in functional impairment which substantially interferes with or limits one or more of the adult's major life activities. Axis I disorders shall be determined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

JAN 7 1999 5:40PM PRICEWATERHOUSECOOPERS GHRS NO. 5821 P. 2

(5) **"Rate, term, or condition"** means any lifetime limits, annual payment limits, episodic limits, inpatient or outpatient service limits, and out-of-pocket limits. This definition does not include deductibles, copayments, or coinsurance prior to reaching any maximum out-of-pocket limit. Any out-of-pocket limit under a policy shall be comprehensive for coverage of mental illness and physical health conditions.

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(1) Nothing in this bill shall be construed as requiring the coverage of mental health and substance abuse.

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(3) A health insurance policy shall be construed to be in compliance with this section if at least one choice for treatment of mental illness provided to the insured with the policy has rates, terms, and conditions that place no greater financial burden on the insured than for access to treatment of physical conditions, generally.

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(c) Prohibiting a health insurance policy from managing the provision of benefits through common methods including but not limited to pre-admission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental illness only to those that are deemed medically necessary and clinically appropriate.

(2) An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and clinically appropriate care and treatment for each patient.

JAN 7 1999 5:41PM PRICEWATERHOUSECOOPERS GHRS NO. 5821 P. 3

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(c) Care that is substantially custodial in nature;

(d) Services and supplies that are not medically necessary nor clinically appropriate;or

(e) Treatments that are considered experimental.

(2) The director shall grant a policyholder a waiver from the provisions of Section 3 if the policyholder demonstrates to the director by actual experience over a 24 month period that compliance with sections 1 to 6 has increased the cost of the health insurance policy by an amount that results in a financial hardship to the policyholder.

Section 6. Effective Date. Department to Conduct Experience Study. Sunset Provision.-

(1) The provisions of Sections 1-6 apply to applications for coverage made on or after January 1, 2000, and to health insurance policies issued or renewed on or after such date to residents of this state. Multi-year group policies need not comply until the expiration of their current multi-year term unless the policyholder elects to comply before that time.

(2) The director shall perform a study to assess the impact of the Mental Health and Substance Abuse Insurance Act on insurers, business interests, providers, and consumers of mental illness treatment services. The director shall report the findings of this study to the general assembly by January 1, 2004.

(3) Unless renewed by actions of the state legislature and the governor, this act shall be inactive as of 1/1/2005.

Section 7. Compliance of Policies Covering State Employees.

(1) Notwithstanding the provisions of sections 1 to 6, all health insurance policies which cover state employees including the Missouri Consolidated Health Care Plan shall include coverage for mental illness.

JAN. 7 1999 5:42PM PRICEWATERHOUSECOOPERS GHRS NO. 5821 P. 4

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JAN. 7. 1999 5:42PM PRICEWATERHOUSECOOPERS GHRS NO. 5821 P. 5

NEW HAMPSHIRE

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SENATE BILL AMENDED BY THE SENATE

SB 767-FN

STATE OF NEW HAMPSHIRE

In the year of Our Lord
One Thousand Nine Hundred and Ninety-Four

AN ACT

relative to mental illness coverage under insurance policies.

Be it Enacted by the Senate and House of
Representatives in General Court convened:

1 New Chapter; Coverage for Certain Biologically-Based Mental Illnesses. Amend RSA by inserting after chapter 417-D the following new chapter:

CHAPTER 417-E

COVERAGE FOR CERTAIN BIOLOGICALLY-BASED MENTAL ILLNESSES

417-E:1 Coverage for Certain Biologically-Based Mental Illnesses.

I. For the purposes of this chapter "mental illness" means a clinically significant or psychological syndrome or pattern that occurs in a person and that is associated with present distress, a painful symptom or disability, impairment in one or more important areas of functioning, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

II. Notwithstanding any other provision of law, each insurer that issues or renews any policy of group or blanket accident or health insurance and each hospital service corporation under RSA 419, medical service corporation under RSA 420 and health maintenance organization under RSA 420-B providing benefits for disease or sickness in the state of New Hampshire shall provide benefits for treatment and diagnosis of certain biologically-based mental illnesses under the same terms and conditions and

which is no less extensive than coverage provided for any other type of health care for physical illness.

III. The following mental illnesses, as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, shall be covered under this section:

(a) Schizophrenia.

(b) Schizoaffective disorder.

(c) Major depressive disorder.

(d) Bipolar disorder.

(e) Paranoia and other psychotic disorders.

(f) Obsessive-compulsive disorder.

(g) Panic disorder.

(h) Pervasive developmental disorder or autism.

IV. The benefits required under this section shall begin when benefits provided under RSA 415:18-a, 419:5-a, 420:5-a, and 420-B:8-b, as applicable are exhausted.

2 Applicability. This act shall be applicable to any health insurance contract, policy, certificate, or plan issued or renewed on or after January 1, 1995.

3 Effective Date. This act shall take effect January 1, 1995.

The following are the diagnostic codes for the diagnoses in NH **SB767**

Diagnosis	ICD-9-CM[1]	DSM-III-R[2]
• Schizophrenia	all 295 codes	all 295 codes
• Schizoaffective disorder	295.7	295.7
• Major depressive disorder	296.2; 296.3; 296.82	296.2; 296.3; 311.00
• Bipolar disorder	296.0; 296.1; 296.4; 296.5; 296.6; 296.7; 296.8; 296.81; 296.9	296.4; 296.5; 296.6; 296.7; 301.13
• Paranoid and other Psychotic Disorders	296.9; 296.99; all 297 codes all 298 codes	297.1; 297.30; 298.80; 298.90
• Obsessive-Compulsive Disorder	300.3	300.30
• Panic Disorder	300.01	300.01; 300.21
• Pervasive Developmental Disorder, Autism	All 299 codes	299.00; 299.80

[1] World Health Organization: International Classification of Diseases, 9th revision
[2] Diagnostic and Statistical Manual of Mental Disorders, third edition revised

NH - OCTOBER 1993

IF YOU ONLY WORK ON ONE AMI ISSUE IN 1993-94 . . . . .

PARITY IN HEALTH INSURANCE IN NH - THE TIME IS NOW!!

At the September Board meeting the Board voted to go for equal insurance coverage for biologically based mental illness in the NH Legislature. This "parity" with other physical illnesses is long overdue. The Clinton Plan does not promise parity until the year 2001 - WHAT THEY CALL FUTURE EQUALITY IS WHAT WE CALL CURRENT DISCRIMINATION. It is very important that you get involved in this legislative effort. And RIGHT NOW is the time to begin organizing in your Affiliate.

There are THREE THINGS YOU MUST DO IN ORDER TO BE READY TO ADVOCATE:

1. SELECT A LOCAL PARITY LEADER OR TWO CO-LEADERS FOR YOUR AFFILIATE. Some leaders have already agreed to coordinate the AMI campaign for equal coverage - their names are attached. The LOCAL PARITY LEADER will be the primary contact person bewteen the AMI Legislative Committee and each affiliate. The LOCAL PARITY LEADER will receive phone calls from the Legislative Committee alerting them to hearings. The LOCAL PARITY LEADER will be the first caller in each affiliate's TELEPHONE TREE, and will have an extra supply of information materials on the PARITY LEGISLATION for local members and representatives. CALL PEGGY STRAW (9243069) O4R THE AMI OFFICE (MIKE OR DEB) AND TELL US WHO YOUR PARITY LEADER(S) IS/ARE.

2. GET YOUR TELEPHONE TREE UP AND RUNNING! The tree should include all of your members who care about insurance equality, even if they don't attend your regular support group meetings. A telephone tree is fast, easy, and cheap way to reach your members, BUT IT TAKES WORK TO SET IT UP. The concept is simple: One person calls two people who each call two people, etc. If one of the two people cannot be reached, (then the first person calls all four people on their branch of the tree) However you do it, GET A TELEPHONE TREE UP AND WORKING STARTING TODAY!!!

3. TELL US YOUR INSURANCE STORY!!! HAVE YOU OR YOUR FAMILY MEMBER HAD PROBLEMS WITH INSURANCE?? DID YOU THINK YOUR INSURANCE COVERAGE WAS SUFFICIENT, ONLY TO FIND OUT THAT THE 'MENTAL HEALTH" BENEFIT RAN OUT ON THE FIRST EPISODE? DO YOU KNOW SOMEBODY ELSE WHO HAS HAD THIS HAPPEN?? THERE IS NOTHING SO POWERFUL AS PERSONAL STORIES, AND THE TIME IS NOW TO SPEAK OUT. *IF YOU OR SOMEONE YOU KNOW HAS EXPERIENCED INSURANCE DISCRIMINATION, CALL MIKE, DEBBI, OR AN AMI VOLUNTEER AT THE AMI OFFICE AND LET US KNOW RIGHT AWAY. IF YOU DON'T SPEAK OUT, NOBODY WILL!!*

UNION LEADER
CONCORD MONITOR
FOSTERS DAILY DEM.
KEENE SENTINEL

HOMERUN!

NASHUA TELEGRAPH
COOS COUNTY DEMOCRAT

Not everyone happy with Hillary Clinton's visit

UNION LEADER & AP WIRE 12.3.93.

CONCORD (AP) – Two groups protested Hillary Rodham Clinton's visit, one because she didn't visit a mental health center, the other because her health plan allows abortions.

The New Hampshire Right to Life Committee said in a statement that the Clinton plan "will ration health care and classify abortion as a 'health-care benefit.'"

If Congress approves the plan, the group said, "every American will be forced to pay for abortion through mandatory insurance

"The Clinton plan belongs in bookstores right next to the works of Stephen King. It's a real horror story."

The Alliance for the Mentally Ill of New Hampshire said it was disappointed that Mrs. Clinton did not visit the Mental Health Center of Greater Manchester, which the alliance said was on her itinerary at one point.

The visit Thursday would have been "a firsthand chance for Mrs. Clinton to see how successful and fiscally prudent we in New Hampshire are in treating people with mental illness," the group said in

AMI OF NH
10 FERRY ST. UNIT 314
CONCORD, NH 03301
TEL: 603 225 5359

November 28, 1993

Dear Local Leader,

AMI of NH' s legislative committee is moving forward on NH's own insurance parity bill. A copy of this bill is attached. During December, we ask you, as an affiliate president or leader, to do a couple of things to help.

1. Write letters to you local newspaper editor about insurance discrimination for serious mental illness. A sample letter is attached, but please, ***use your own words!*** Give this assignment to several of your group's members, so that one letter appears each week between now and the first of the year, when the legislative session begins. Remember that every member who writes must use their own words.

2. Come to the press conference and bring your members.

PRESS CONFERENCE

FAIR INSURANCE COVERAGE FOR MENTAL ILLNESS

WHEN: MONDAY DECEMBER 13TH, 9:45 AM

WHERE: LOBBY OF LEGISLATIVE OFFICE BUILDING, CONCORD, DIRECTLY BEHIND STATE HOUSE.

THE PRESS CONFERENCE WILL BE FOLLOWED BY A STRATEGY MEETING AT THE AMI OF NH OFFICE, NORTH MAIN STREET, IMMEDIATELY FOLLOWING THE PRESS CONFERENCE.

Someone from the legislative committee will be calling you week to confirm your plan for letters to the editor and attending the press conference. **If we are to win fair insurance coverage in NH for serious mental illness we must have your participation.**

SINCERELY,

PEGGY STRAW, LEGISLATIVE COMMITTEE
MIKE MALLOY, DIRECTOR

11/93

AMI OF NH
10 FERRY ST. UNIT 314
CONCORD, NH 03301
TEL: 603 225 5359

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SINCERELY,

MIKE MALLOY, DIRECTOR

The following is a draft of the legislation filed in the New Hampshire Senate. The language will be modified to conform to drafting requirements, but the essential elements of the bill will be unchanged.

AN ACT
RELATIVE TO MENTAL ILLNESS COVERAGE

Sponsors: Senate: J. Shaheen(D), C. Lamirande(D), E. Podles(R), L.Fraser(R), J. Delahunty(R), R. Hough(D)
House: E. Crory(D), D. Sytek(R), B. Packard(R), A. Torr(R), T. Nardi(D), Manning

Notwithstanding any other provision to the contrary, each hospital or major medical contract or certificate delivered or issued for delivery in the State of New Hampshire by a health insurance company, non-profit health service organization, health maintenance organization, and contracts issued to employers or an individual on a group or individual basis that provides benefits for diseases or sicknesses shall provide benefits for treatment and diagnosis of certain biologically based mental illness under the same terms and conditions and which is no less extensive than coverage provided for any other type of health care.

Mental illness covered under this section shall be as follows:
Schizophrenia,Schizoaffective Disorder, Major Depressive Disorder, Bipolar Disorder, Paranoid and other Psychotic Disorders, Obsessive-Compulsive Disorder, Panic Disorder, Pervasive Developmental Disorder, or Autism

The benefits required under this section shall begin when benefits provided under the current mental health mandate are exhausted.

This act shall be applicable to any health insurance contract, policy, certificate, or plan that is issued on or after January 1, 1995. This act shall take effect 30 days after passage.

AMI of N.H.
10 Ferry St. Unit 314
Concord, N.H. 03301

NH

MORE TALKING POINTS FOR SB767

Senate Bill 767 will require that NH insurance companies provide coverage for biologically based mental illness to the same exent that they cover other physical illness.

• **This is a mental *illness* bill. It is *not* a mental *health* bill.** Mental illnesses are low incidence biological brain disorders experienced by 2.8% of the adult population in any given year.[1] On the other hand, "mental health" problems are experienced by many people. This is not to suggest that mental health problems aren't significant and often very painful - but this bill proposes expanded coverage *only* for that 2.8% of the population who experience biologically based disorders of the brain.

• **It is time that we treated the brain as a part of the body.** Serious mental illnesses are disorders of the brain - not unlike Alzheimer's or Parkinson's disease. They are not the result of unhealthy lifestyles, or choice, or personal weakness, or poor parenting. They are diseases of the brain.

• **It is time for the discrimination in insurance coverage to stop.** Insurance that covers biologically based mental illness at lesser amounts than other physical illness is nothing less than discrimination.

• **Covering biological brain disorders will not "break the bank" in insurance premiums.** People with serious mental illness represent about 2.4% of the insured population in any given year. AMI of NH's independently commissioned cost study indicates that coverage for these illnesses would increase premiums by $2.50/month per individual and $6.75/month per family. Cost studies in California (Coopers and Lybrand, 1991) indicated a 78¢ monthly premium increase, and a Minnesota study put costs at $1.00 per month. A 1991 Maryland study indicated that coverage of all diagnoses would cost less than $1.00 per month per individaul and $2.50 per month per family.

• **Serious mental illness is diagnosable and treatable, like other physical illness.** While mental illness is not curable - it is treatable, like severe diabetes. Treatments for mental illness are effective. Early treatment of schizophrenia is 60% effective in reducing symptoms and 80% effective for bipolar disorder -- as compared with 41% success rate in treating cardiovascular disease through angioplasty.[2] The accuracy of diagnosing serious mental illness is also similar to other physical illness.

There is nothing as powerful and persuasive as your personal story. If you are a family member of a person with mental illness -- tell your story in a way that is always sensitive to your family member's need for personal dignity and privacy. Your family comes first.

---

[1] National Institute of Mental Health Epidemiological Catchment Area Study cited in "Health Care Reform for Americans With Serious Mental Illnesses: Report of the National Mental Health Advisory Council", U.S.Dept. of Health and Human Services, Public Health Service, National Institutes of Health, 1992.

[2] Scientific reports on treatment efficacy are numerous and are reprinted in a special section of the Report of the National Mental Health Adivsory Council cited above. This report is available from the AMI library.

Alliance for the Mentally Ill of New Hampshire
10 Ferry St. Unit 314, Concord, NH 03301
tel. 603-225-5359

12/94

NEWS RELEASE
ANNOUNCEMENT OF NEWS CONFERENCE

Contacts:
- Ms. Doris "Rick" Sherman, Bedford, President, AMI of NH, tel. 603-472-3830 (office), 472- 5902 (home)
- Michael Malloy, Director, AMI of NH, tel. 603-225-5359 (office), 774-6633 (home)
- Rona Purdy, Durham NH, AMI of NH Board, Board member, National Alliance for the Mentally Ill tel. 603-868-1122 (home)
- Sibyl Shalo, Media Relations, National Alliance for the Mentally Ill, Arlington, VA tel.(703) 524-7600

AMI of NH Supports Fair NH Insurance Coverage for Mental Illness

The Alliance for the Mentally Ill of New Hampshire will be holding a news conference Monday December 13, 1993 at 10:00 AM, lobby of the Legislative Office Building, Concord to announce their support of a Senate Bill that provides for parity insurance coverage for mental illness with physical illness. Families from every part of New Hampshire are expected to attend the press conferenece.

The bill has broad bi-partisan support, led by Senator Jeanne Shaheen (D-Madbury) and Representative Elizabeth Crory (D-Hanover). Co-sponsors include Senators Leo Fraser, Carol Lamirande, Eleanor Podles, and Joseph Delahunty. Other House sponsors include Representatives Donna Sytek, Bonnie Packard, Ann Torr, and Theodora Nardi.

The subject of equal coverage for mental illness is a major issue of Health Care Reform. "We must end discrimination in health coverage for serious mental illness," said Ms. Rick Sherman, Bedford, President of the Alliance for the Mentally Ill of New Hampshire. "Mental illnesses are diseases, no different than diabetes or heart disease. Like diabetes, mental illness can be treated successfully. But the discrimination must end," Ms. Sherman stated.

At the recent Forum on Health Care Reform, Dr. Margaret Seiden, a neurologist, AMI -NH Board member, and mother of a son with schizophrenia, said that limiting coverage for mental illness is "a throwback to the days when mental illness was thought to be the fault of the family."

AMI-NH Executive Director Michael Malloy indicated that "equal coverage for mental illness is AMI-NH's Number One priority this year. The people of New Hampshire must understand that no matter what changes Health Care Reform brings to New Hampshire, we must protect people with mental illness. The community-based system we have developed here in New Hampshire is at risk if we do not properly cover those who are the most sick."

This bill provides equal coverage for mental illness as physical illnesses. The illnesses covered are:
1. Schizophrenia
2. Schizoaffective Disorder
3. Major Depressive Disorder
4. Bipolar Disorder
5. Paranoid and other Psychotic Disorders
6. Obsessive-Compulsive Disorder
7. Panic Disorder
8. Pervasive Developmental Disorder, or Autism

At the News Conference news organizations will be able to get background on mental illness and coverage for brain diseases. and accounts of how people who live in this coverage area have been affected by inadequate insurance. First-person follow-up accounts for specific regions of New Hampshire will also be available from the AMI-NH office. Contact (603) 225-5359 Michael Malloy.

XXX

CONCORD NH MONITOR Dec 14, 1993 PAGE 1 - LOCAL SECTION

Better health benefits sought for mentally ill

Proposed bill would ensure equal coverage

By SCOTT HILYARD
Monitor staff

People with heart disease have better health insurance coverage available to them than do people with schizophrenia. A group familiar with the state's mental health system thinks that is wrong.

Yesterday, the group announced its support for legislation that would require insurance companies to provide equal benefits for mental and physical illnesses.

"It is time that we all recognize that the brain is a part of the body and it too can become sick, like the heart, lungs or kidneys," said Rick Sherman, the president of the Alliance for the Mentally Ill of New Hampshire.

The bill, sponsored by Sen. Jeanne Shaheen, a Democrat from Madbury, would make it illegal for insurance companies to reduce benefits for people diagnosed with mental illnesses such as autism, schizophrenia, bipolar disorder, psychotic disorders and others. The cost of the legislation has not been determined, although Shaheen said it would save money in the long run. People who get treatment for mental illness cost health care systems less than do people who do not get the proper treatment, she said.

"It is good health care and it is good economics," Shaheen said.

The remarks were made at a press

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AP

Alliance members want equal benefits for mental and physical illnesses.

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■ HEALTH

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Currently, people diagnosed with symptoms of mental illness have limited coverage from private insurers and Medicaid. Mental illnesses are categorized differently by insurers than other diseases of the brain, such as Alzheimer's, Huntington's and Parkinson's diseases.

Sherman spoke of a person who lives near Keene who has manic depressive illness. That person wrote to the alliance:

"My insurance coverage is minimal as compared to 'normal' members of my family. I have bipolar disorder, inherited from my grandparents. The limit on my coverage is $10,000 lifetime. A hospital stay would wipe me out in no time. It is not sufficient."

> "The limit on my coverage is $10,000 lifetime. A hospital stay would wipe me out in no time. It is not sufficient."
>
> — *Letter from a person with manic depressive illness*

The health insurance industry sets lower lifetime limits on mental illnesses and hi[illegible] deductibles. Sherman calls th[illegible]scrimination and said it has far-reaching consequences.

"Far from saving money, this approach shifts costs to programs like state support and Medicaid, shifts treatment to crisis intervention and other modalities that are least effective, and shifts service delivery to emergency rooms and other settings that are most expensive," he said. "It also places extreme financial hardships on families who thought that their insurance was a safeguard against catastrophe."

The bill, sponsored in the House by Rep. Elizabeth Croy, a Democrat from Hanover, has bipartisan support in both chambers.

The bill would provide coverage for the following illnesses: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoid and other psychotic disorders, obsessive compulsive disorder, panic disorder and autism.

Concord NH Monitor Tuesday 12/14/93 page 1 local Section

Manchester NH UNION LEADER
12/14/93 PAGE ONE

Bill Seeks To Equalize Benefits for Mentally Ill

Insurance Firms Would Be Forced

By PAUL TOLME
Associated Press Writer

CONCORD (AP) — State legislation proposed yesterday would force insurance companies to provide mental health benefits that are equal to coverage for other illnesses.

Mental illnesses have long been snubbed by insurers, and now aren't being adequately addressed by President Clinton, said members of the Alliance for the Mentally Ill of New Hampshire. The bill would fill gaps in Clinton's proposals and would attack the bias against mental illnesses, they said.

Sen. Jeanne Shaheen, one of the sponsors, said Clinton's plan allows for such a state policy.

"States can choose to add to the (Clinton) package," said Shaheen, D-Madbury. She predicted the bill will meet opposition because of the initial cost.

"Insurance companies are going to have some reservations because of that," she said. However, "the long-term costs are going to be less."

The bill, to be introduced in January, would apply to any insurance plans issued after Jan. 1, 1995. Schizophrenia, depression, paranoia, panic disorder, autism, obsessive-compulsive disorder and other illnesses would be covered.

The mentally ill often are shunned, and the families sometimes are considered to be the cause, said Doris "Rick" Sherman, president of the alliance.

Mental illnesses "are equal opportunity brain diseases" and can affect anyone, she said. "Like diabetes, it can be treated but not cured."

Although some companies now cover illnesses such as depression, mental illnesses are the problems "most discriminated against in public and private medical insurance," she said. The mentally ill rank just behind AIDS patients when it comes to being shunned by the community, she said.

Coverage runs out under most insurance policies for the mentally ill, even though the illnesses can be lifelong.

"The impact on New Hampshire families can be devastating," said Peggy Straw, past director of the alliance. "Mental illness can absolutely impoverish a family."

Margaret Selden, who criticized the Clinton plan at a health care forum attended by Hillary Rodham Clinton, said providing less coverage for the mentally ill is "part of the old historical notion that mental illnesses ... are something to be shunned."

The Clinton plan only provides coverage for a certain amount of out-patient visits for the mentally ill, she said.

Hillary Clinton essentially said "you should feel lucky" that any coverage is being provided, said Selden, a neurologist at the state psychiatric hospital. "All we're saying is, 'Let's be fair.'"

Recent studies have shown that providing equal coverage for serious mental illnesses would add an extra monthly cost of 50 cents to $1 per person insured, according to the alliance.

However, studies done in the mid-1980s by the Bureau of Labor Statistics showed hospital coverage for mental illnesses was limited to 30 to 60 days, compared with 120 days or more for physical illnesses.

Clark Dumont, spokesman for Blue Cross/Blue Shield of New Hampshire, said the bill would have a greater effect on health maintenance organizations, which control costs partly by limiting the number of doctors' visits covered.

Also, only 40 percent of New Hampshire's insured population would be affected, he said. That's because the other 60 percent receive coverage from self-insured employers, who create their own coverage.

Self-insured companies are exempt from state laws and are regulated by the federal government, which means they wouldn't have to abide by the proposal, he said.

"It may not have the effect they want," he said. "The only ones affected would be the ones not large enough to self-insure, which would be small businesses."

Jim Cole/AP

MEMBERS of the Alliance for the Mentally Ill display charts at a news conference yesterday in Concord.

> *'Mental illness can absolutely impoverish a family."*
>
> Peggy Straw
> Past Director
> Alliance for the Mentally Ill

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Better health benefits sought for mentally ill

Proposed bill would ensure equal coverage

By SCOTT HILYARD
Monitor staff

People with heart disease have better health insurance coverage available to them than do people with schizophrenia. A group, familiar with the state's mental health system thinks that is wrong.

Yesterday, the group announced its support for legislation that would require insurance companies to provide equal benefits for mental and physical illnesses.

"It is time that we all recognize that the brain is a part of the body and it too can become sick, like the heart, lungs or kidneys," said Rick Sherman, the president of the Alliance for the Mentally Ill of New Hampshire.

The bill, sponsored by Sen. Jeanne Shaheen, a Democrat from Madbury, would make it illegal for insurance companies to reduce benefits for people diagnosed with mental illnesses such as autism, schizophrenia, bipolar disorder, psychotic disorders and others. The cost of the legislation has not been determined, although Shaheen said it would save money in the long run. People who get treatment for mental illness cost health care systems less than do people who do not get the proper treatment, she said.

"It is good health care and it is good economics," Shaheen said.

The remarks were made at a press

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■ HEALTH

Continued from Page B-1

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Currently, people diagnosed with symptoms of mental illness have limited coverage from private insurers and Medicaid. Mental illnesses are categorized differently by insurers than other diseases of the brain, such as Alzheimer's, Huntington's and Parkinson's diseases.

Sherman spoke of a person who lives near Keene who has manic depressive illness. That person wrote to the alliance:

"My insurance coverage is minimal as compared to 'normal' members of my family. I have bipolar disorder, inherited from my grandparents. The limit on my coverage is $10,000 lifetime. A hospital stay would wipe me out in no time. It is not sufficient."

> **"The limit on my coverage is $10,000 lifetime. A hospital stay would wipe me out in no time. It is not sufficient."**
>
> *— Letter from a person with manic depressive illness*

The health insurance industry sets lower lifetime limits on mental illnesses and higher deductibles, Sherman calls that discrimination and said it has far-reaching consequences.

"Far from saving money, this approach shifts costs to programs like state support and Medicaid, shifts treatment to crisis intervention and other modalities that are least effective, and shifts service delivery to emergency rooms and other settings that are most expensive," he said. "It also places extreme financial hardships on families who thought that their insurance was a safeguard against catastrophe."

The bill, sponsored in the House by Rep. Elizabeth Crory, a Democrat from Hanover, has bipartisan support in both chambers.

The bill would provide coverage for the following illnesses: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoid and other psychotic disorders, obsessive-compulsive disorder, panic disorder and autism.

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Group supports mental illness insurance bill

Wants insurance companies to cover disease

By [illegible]
Democrat Staff Writer

CONCORD — Advocates for the mentally ill want to see the disease treated as an illness like other afflictions.

Holding a press conference today in the Legislative Office Building, members of the Alliance for the Mentally Ill turned out to support legislation that would require insurance companies to cover mental illness (or emotional illness) the same as physical illness.

State Sen. Jeanie Shaheen, D-Madbury, the prime sponsor of the bill, said she became involved in the issue after being contacted by a Dover woman whose daughter suffered from multi-personality disorder.

The woman said her daughter could not find help and asked Ms. Shaheen if she could help.

She said she discovered there really isn't a great deal of coverage to help such people and her bill would change that.

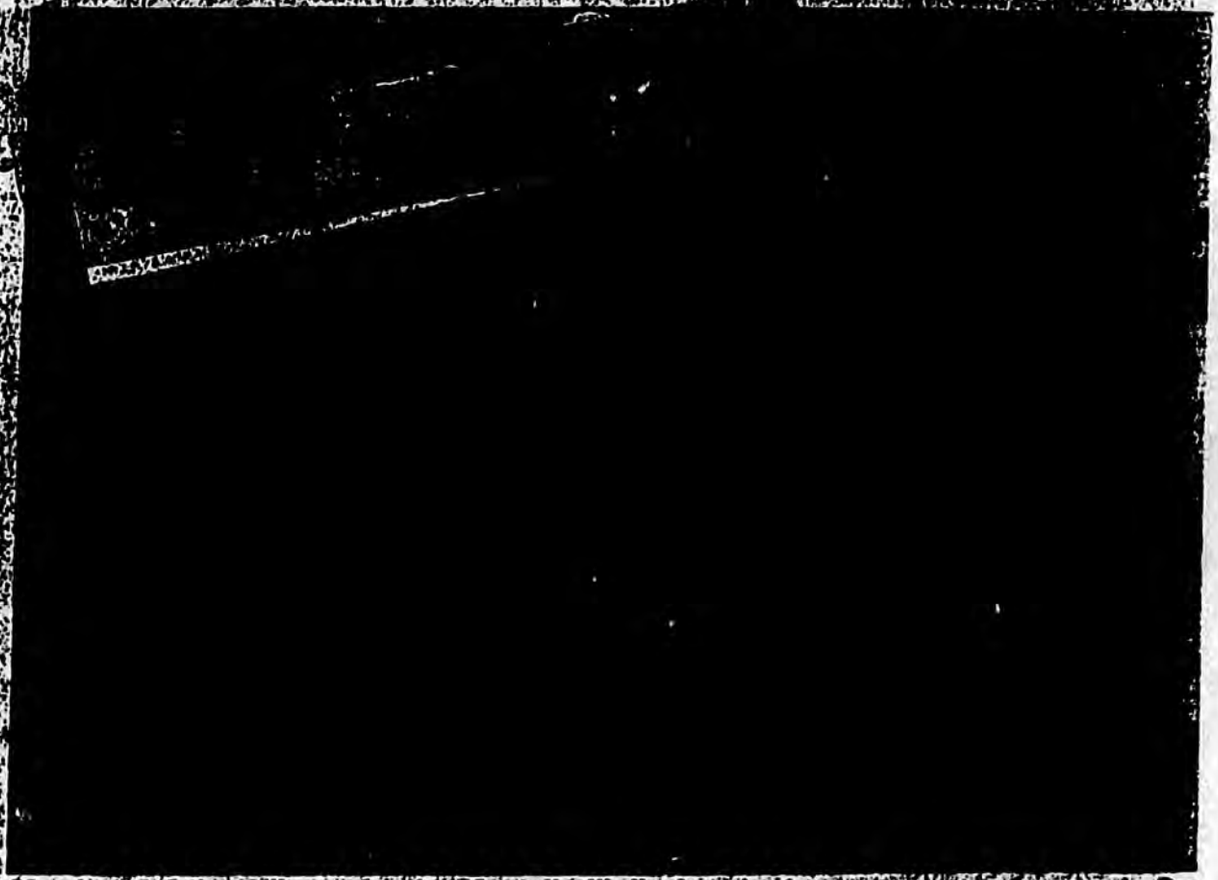
"This is not just good health care, it's good economics," Ms. Shaheen said.

The bill would require health insurance cover schizophrenia, schizoaffective disorder, major depressive disorder, manic depressive disorder, obsessive compulsive disorder, psychotic disorders, panic disorder and autism.

The alliance is comprised of parents, spouses, or siblings of people with mental illness or those who have a serious mental illness themselves.

The alliance's president, Doris "Rick" Sherman, called the lack of insurance coverage for mental illness one of the most serious injustices in society today.

"Like diabetes, mental illness represents a chemical imbalance. Like diabetes, it can be treated and managed, but not cured. It does not result from bad parenting. It has nothing to do with weakness or the will or poor response to stress," she said.



Members of the Alliance for the Mentally Ill display charts at a news conference in Co[n]cord Monday. The group announced legislation that will be introduced in January tha[t] would require insurance companies to cover mental illness to the same degree as othe[r] illnesses. (AP)

She said mental illness is the one disease most discriminated against in both public and private health insurance.

"Leaving biologically based mental illness untreated costs much more than it saves," said Ms. Sherman, and she cited a recent Massachusetts Institute of Technology study that indicated untreated major depression cost business and industry $43 billion.

She also explained that most hospitalization coverage for mental illness is less than for physical illnesses, and that fewer outpatient visits are allowed for mental illness.

Most people affected don't realize that their health policies don't cover mental illness, she said. "They only learned of it when they needed it the most," Ms. Sherman said.

Former alliance President Peggy Straw of Peterborough read from letters the association has received from families in which one member has a serious mental illness, including a letter from a retired man in Stratham.

In the letter, the man told of out-of-pocket costs associated with his child's illness.

"Mental illness can impoverish a family," Ms. Straw said.

She noted that many people with mental illness are discharged from hospitals when their insurance coverage runs out, with hospitals saying the person has improved.

Another alliance member D[r]. Margaret Selden, a Concord ne[u]rologist with a schizophrenic so[n] said people with mental illness a[re] viewed through an old stigm[a]. "You're still seeing jokes, movi[es] and cartoons making fun of peo[ple] with mental illness," she said.

At a recent health care forum in Hanover attended by Hillary Clinton, Ms. Selden said she asked t[he] first lady about the national pl[an] and the mental health coverage.

Ms. Selden said Ms. Clinton ba[si]cally said they should consid[er] themselves lucky because they a[re] worse off now before the proposa[l].

Ms. Selden said that was not an answer.

"Let's be fair. Let's treat ment[al] illness like an illness, which it is.

OPINION

Portsmouth Herald (N.H.) Monday, December 20, 1993

Letters to the Editor

Mental illness needs insurance

To the Editor —

Healthcare and healthcare insurance is currently being given priority attention these days, and properly so. New legislation at both the national and state level is being considered with a view toward reforming the present system.

It is extremely important that during this process due regard be given to the subject of mental illness. Healthcare insurance and some versions of proposed new legislation tend to discriminate unfairly against coverage for the major mental illnesses. Insurance policies typically exclude coverage, or severely limit coverage, for mental illnesses such as schizophrenia and bipolar depression. The majority of experts now agree that these diseases are the result of chemical imbalances of the brain. They are biological, physical diseases much the same as diabetes, Parkinson's Disease and various other physical diseases that insurance policies generally cover.

Why should an illness caused by a diseased brain be less deserving of coverage and treatment than diseases of other bodily organs? This discrimination is a throwback to the days when mental illness was not understood as it is today.

I am a member of the Alliance for the Mentally Ill. Most of our members are parents, siblings, spouses or other relatives, or in many cases friends of someone with mental illness. We know firsthand of the misery and hardship endured not only by the afflicted person but by families and friends. This can be especially difficult financially for families when they find, often to their surprise, that their medical insurance either does not cover mental illness or puts a dollar limit on treatment not applicable to other illnesses.

It is important that any reform, any new legislation, correct this inequity and cover these major mental illnesses on a parity with

Mental health bill deserves your support

To the editor:

To the editor:

I am a member of the Alliance for the Mentally Ill. I had a son who suffered from schizophrenia. I have seen what lack of treatment can do as well as the recovery possible with effective treatment.

Senate Bill 767-FN would require that all health insurance in New Hampshire provide the same coverage for biologically based mental illnesses as is provided for other brain diseases such as Parkinson's, Alzheimer's and Huntington's. This bill, sponsored by Jean Shaheen and Ann Torr, will mandate fair coverage for serious, long-term mental illness. It is not concerned with transient mental and emotional problems or substance abuse. They are already covered.

For fair insurance coverage for serious mental illness support Senate Bill 767-FN.

Nancy Leonard
Dover

Severe mental illness

Senate Bill 767, relative to insurance coverage for mental illness, is scheduled for hearing before the Senate Insurance Committee Feb. 17 at 9 a.m. in the Legislative Office Building, Room 101.

The purpose of insurance is to prepay in to a risk fund against catastrophes that might bankrupt us. Fire, life, accident and health insurance protect against the calamity we hope will never occur. Health insurance covers cancer, heart disease, multiple sclerosis, muscular dystrophy, arterial disease, all devastatingly expensive. Insurance companies, however, draw a line when it comes to mental illnesses, although most have an organic origin and at present are being successfully medicated to cure or alleviate behavioral symptoms.

Research in the past decade has verified that physical problems affecting behavior cause mood disorders, schizophrenia, schizoid affective and other major mental illness. These physical problems are treatable in the same way as other organic diseases, with proper diagnosis and medication. This discrimination against one of the most tragic of organic dysfunctions is grossly unfair.

In the past the lack of definite knowledge concerning mental ills plus Freudian misinformation wasted money on fruitless cures. Today psychiatric hospital expenses should be regulated according to the amount of care the patient requires — acute care, convalescent care or just medication supervision.

Timely and appropriate psychiatric care can prevent human tragedy, return patients to school or the work place and improve quality of life. It is economically sound and ethically essential.

RUTH Du BOSE
Concord

Concord

Mentally ill need good insurance

To the Editor:

Thank God that, today, the diagnosis and treatment of severe mental illness is as precise and effective as for other disorders.

This most devastating and heartbreaking illness has come out of the Dark Ages, but sufferers still face some stigma and discrimination from some individuals who do not understand mental health problems. They are biologically based physical disorders.

Research has established effective medication and therapy. Timely treatment reduces symptoms 80 percent and more, thereby reducing the need for hospitalization.

The Alliance for the Mentally Ill of New Hampshire has proposed Senate Bill 767 relative to insurance coverage for people with biologically based mental illness. Insurance coverage for these should be equal to all other illnesses.

Costs to taxpayers are reduced if insurance coverage is adequate and victims get proper medical treatment.

Instead, victims often become homeless, ill-treated and wrongly jailed instead of taken to an appropriate treatment facility. Often these tragedies are caused by simple lack of knowledge and resources.

If mental illness was given the same support, enthusiasm, exposure, acceptance and understanding as other illnesses, many of the present problems victims and their families face would not exist.

Please support S.B. 767 and pray for the relief of the stigma and suffering the mentally ill experience.

Chester and Nancy Orban
Sandown, N.H.

Sunday Eagle-Tribune 2/6/94

PARITY INSURANCE BILL

CALLING ALL AMI MEMBERS! It is time to get to work again!!!

It is extremely important that your group be in contact with their state legislators that they have "adopted" - just to touch base at first and then to lobby hard for our Senate Parity Insurance Bill that still has no number. Our policy of "adoption" is, for those who are new in the organization, to just get acquainted with your assigned legislator by befriending them if you do not already know them, asking them out/over for breakfast or lunch or even a brisk walk, whatever strikes your fancy, and then telling them your story and how tragic it is that mental illness is discriminated against in so many ways when it is a no fault disease or chemical imbalance like diabetes and deserves to be treated like any other disease.

Remember there are 424 legislators in the house and Senate so we need all of you to be "adopters". Although our bill will originate in the Senate, it will have to be voted on in the House so it is **extremely Important** that we touch base with all our legislators. We will want them to know how expensive it is to get private care and how the lack of insurance has affected our lives. It seem more and more likely that the Clinton Health Plan will allow only minimum benefits for mental health coverage, so consequently we have to maximize coverage in our states.

Telephone contact: When contacting a legislator, it is important that your message be brief, relevant and specific. Be sure to leave your name, your AMI group name, your address and phone #. i.e. "Hello, this is ------calling. I am a member of the -------- Alliance for the Mentally Ill. I live on ------street in ------- and my phone # is --------. I am callling about the Parity Insurance Bill (mention it by number which we will get to you when it is assigned). I have a family member who has a mental illness and have had inadequate (or no) insurance coverage for a disease that has plagued our family for years and has(made us reliant on the public system) (kept us from getting medical care) , and made our lives a nightmare. **Please give your support** to a bill which will require coverage equal to that for other illnesses. It is unfair that people with serious mental illness be discriminated against in health care benefits compared to other illnesses.

Writing letters: A brief, one page handwritten (legible) letter is best by a constituent (who lives in the legislator's district and votes for them). We are told they sometimes vote on bills by how many letters they get in support. Address your letters to:
The Honorable John Doe-(for House members), State House, Concord, N.H. 03301. :
SenatorJohn Doe-(for state Senators), State House, Concord.

If you have a specific insurance horror story, tell it briefly, leaving out names that might confuse your story. Write in your groups and share your stories. It helps.

Alliance for the Mentally Ill of New Hampshire
10 Ferry St. Unit 314
Concord, NH 03301

NEWS RELEASE

Contacts: Doris "Rick" Sherman - Bedford, President, AMI of NH, tel: 473-3830 (office); 472-5902 (home).
Michael Malloy - Director, AMI of NH, tel: 225-5359 (office); 774-6633 (home)

FAMILIES AND PEOPLE WITH MENTAL ILLNESS ASK FOR INSURANCE DISCRIMINATION TO END

SENATE INSURANCE COMMITTEE TO HEAR S 67 ON THURSDAY, 9:45am

On Thursday, February 17th, 9:45am, people with serious mental illness, their families, and friends will testify before the Senate Insurance Committee in support of SB767. SB767 would require that health insurance policies provide coverage for serious mental illness to the same extent that they cover all other physical illnesses.

The subject of equal coverage for serious mental illness is a major issue in Health Care Reform. "We must end discrimination in insurance against serious mental illness," said Ms. Rick Sherman, President of the Alliance for the Mentally Ill of New Hampshire (AMI of NH). ""This is a mental illness bill -- Mental illnesses are low incidence brain disorders, much like Parkinsons or Alzheimers diseases. They can be treated effectively. But most people aren't aware that their insurance policies place much lower annual and lifetime caps on coverage for these brain diseases than for other illnesses. The brain can get sick, like any other part of the body."

The cost of health care is also a major issue in health care reform. Michael Malloy, Director of the Alliance for the Mentally Ill, states: "Providing better coverage for serious brain disorders will not break the bank - and will add relatively little to most monthly premiums. Why should someone who has worked hard all their lives and paid their insurance premiums end up receiving public assistance to pay for services? Most people aren't aware of this discrimination in their health insurance until it they need treatment, and by then it is too late."

XXX

Note: At the hearing news organizations will be able to obtain background on mental illness and coverage for brain diseases and hear accounts of how people who live in this coverage area have been affected by inadequate insurance. Some first-person follow-up accounts for specific regions of NH will also be available.

TALKING POINTS FOR SB767

Senate Bill 767 will require that NH insurance companies provide coverage for biologically based mental illness to the same exent that they cover other physical illness.

• **This is a mental *illness* bill. It is *not* a mental *health* bill.** Mental illnesses are low incidence biological brain disorders experienced by 2.8% of the adult population in any given year. On the other hand, "mental health" problems are experienced by many people. This is not to suggest that mental health problems aren't significant and often painful - but this bill proposes expanded coverage only for that 2.8% of the population who experience biologically based disorders of the brain.

• **It is time that we treated the brain as a part of the body.** Serious mental illnesses are disorders of the brain - not unlike Alzheimer's or Parkinson's disease. They are not the result of unhealthy lifestyles, or choice, or personal weakness, or poor parenting.

• **It is time for the discrimination in insurance coverage to stop.** Insurance that covers biologically based mental illness at lesser amounts than other physical illness unfairly discriminates.

LEGISLATIVE ALERT

January 16, 1994

Senate Bill 767
An act relative to insurance coverage for mental illness

Hearing Scheduled for:
Thursday, February, 17th 1994
9:00 AM
Senate Insurance Committee
Legislative Office Building Room 101

nate Bill 767 will be heard by the Senate Insurance Committee on February 17th. Between now and e time of the hearing, there are several very important things that you can do to help.

Letters to the editor - write letters to the editor supporting SB767 and educating readers about rious mental illness. To those of you who have already written letters - thanks.

Organize your family or consumer group to write a letter to the editor and have everyone sign it.

C[redacted]and write your state senator and ask them to support SB767. Tell them why this is impor-nt, tell your personal story.

your senator is already a sponsor of the bill, write to thank them for their support and tell them hy it is important. You may wish to bring paper, pens, and stamped envelopes to your group eeting in late January and early February to have all attendees write to their senator. If your sena-r is not on the Senate Insurance Committee, ask them to share your letter with the Insurance Com-ittee before the Feb. 17th hearing.

In early February call around to your members and to others you've already talked to, to remind em of the hearing and how important their attendance and letters are.

* A list of your State Representatives and State Senators is attached. Please concentrate on writ-g to your State Senator at this time - this includes all Senators and especially those who are on e Senate Insurance and Senate [illegible]nce Committees, where this bill must pass before it goes over the House.

Alliance for the Mentally Ill of New Hampshire
10 Ferry St. Unit 314, Concord, NH 03301
603-225-5359

HH

grass roots-family support advocacy

The Alliance for the Mentally Ill of New Hampshire

10 Ferry Street, Unit 314 • Concord, NH 03301

Office (603) 225-5359
Family Line (NH) 1-800-242-NAMI

PORTSMOUTH HERALD

Mental health at issue

PAGE 1

Speakers urge Senate to pass insurance bill

By Leslie Miller
Herald Staff

CONCORD — People struggling with mental illnesses pleaded, often tearfully, yesterday for passage of a Senate bill that would require health insurance to cover biologically-based mental illnesses just like any other disease.

"The brain should be equal to the heart. Both are key to a healthy life," said Nancy Maguire of Bedford. Her mother and husband both suffer from bipolar disorder, also known as manic depression. Maguire said she doesn't look forward to the day when the $10,000 lifetime cap on claims for her husband's lithium prescriptions and hospitalization runs out.

WITNESSES testified that many insurance plans fail to cover mental illnesses adequately. Dr. Goffree Barnett, president of the New Hampshire Psychiatric Society, said depression in children often lasts 32 weeks, but one Healthsource plan only provided 20 weeks of coverage. Blue Cross/Blue Shield of New Hampshire caps claims at $5,000 a year, which means 90 percent of children don't get adequate coverage, he said.

"If the illness recurs, you often run out of benefits," said Barnett.

He testified the cost to society of youthful mental illness is dramatic, resulting in suicide, homicide and deterioration of the family. "The impact of an ill child on a family is dramatic," he said.

Peter Wells of Healthsource, a health maintenance organization that backs the bill, estimated the cost to consumers would be minimal. A 500-employee company with $1.3 million in premiums would see only a $24,000 cost increase, he said.

Paula Rogers, lobbyist for the Health Insurance Association of America, warned that the coverage would come at a price — higher premiums. Her group opposes the bill.

Rogers' argument drew no sympathy from Deborah Holland of Manchester, who has had difficulty paying for her son's treatment after he tried to kill himself.

"No one should have to be burdened with payments of $1,800 a month," she said. "I didn't sell my house. I sold everything else, including blood," she said.

"For God's sake, do not let this happen. It's cruel and unnecessary. They'll tell you the premiums will go up. Tough. Tough."

"I am a manic depressive who has reached my $10,000 maximum," said Elizabeth Carignon, a pre-school teacher. "I had been told for years my illness is no different from a diabetic's," she said, crying. "What kind of message is it to have one-tenth the coverage of a biologically-based illness."

Catherine Rock testified she suffers from borderline personality disorder and pleaded to amend the bill to cover her illness. "We need it so desperately," she said.

The bill covers schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

(The Associated Press contributed material to this report.)

CONCORD NH MONITOR 2/18 ??

Senate hears plea for coverage

Mental health insurance said lacking

By M.L. ELRICK
Monitor staff

Inadequate insurance coverage for mental illness compounds the devastation of victims and families after their money runs out, an emotional crowd told a Senate committee yesterday.

The brain, they said, is no different than the heart or lungs. When it gets sick it should get equal insurance coverage, said Rick Sherman of the Alliance for the Mentally Ill.

"When the brain goes bad is it not the equivalent of all other organs?" Sherman said.

Sherman and dozens of others filled a senate Insurance committee hearing to support a bill requiring insurers to provide the same coverage for biologically-based mental illnesses, such as schizophrenia and autism, as they do for physical maladies.

Many insurers currently cap the amount they'll pay for mental illnesses or limit the number of visits they'll reimburse. Victims, families and state officials testified that coverage is often inadequate to properly treat or care for the mentally ill. Many waited hours to testify on the issue, and although committee chairman Sen. Joseph Delahunty, a Salem Republican, made it clear they didn't have to persuade the committee to endorse the bill, about a dozen people weren't about to pass on the oppotunity to tell their story.

Debra Holland, of Goffstown, was the first. While several people recounted their experiences on the verge of tears, she spoke in anger, pulling out what she said were the $224 monthly receipts for her son's Prozac.

Holland said her insurance coverage ran out quickly after her son was diagnosed with a mental illness. She said she's still without coverage, but tries to make sure he gets proper treatment.

"I didn't sell my house but I sold everything else and no one should have to do that," Holland said.

Doctors from the New Hampshire Psychiatric Society, New Hampshire Hospital, and Department of Health and Human Services said equal coverage would help diagnose and treat mental illness in children as well as adults, saving the state money in the short and long runs.

Although insurance companies opposing the bill cited increased costs, Dr. Thomas Fox said of the 32,563 people treated for problems of varying severity in the state's mental health system, 1,429 had adequate coverage and 75 had passed the maximum coverage of their health insurance.

Blue Cross & Blue Shield of New Hampshire and Healthsource support the bill, which is opposed by Matthew Thornton Health Plan

MANCHESTER NH UNION LEADER 2/18/94

Witnesses to Senate: Give Equal Coverage For Mental Illnesses

By NORMA LOVE
Associated Press Writer

CONCORD (AP) — Health insurance should cover mental illnesses just as any other biologically based disease, witnesses told a Senate committee yesterday.

"This is a simple issue of fairness," said Sen. Jeanne Shaheen, D-Madbury, prime sponsor of legislation to require the coverage.

Most existing insurance plans fail to cover basic treatment of the diseases, supporters said.

Deborah Holland of Manchester said she's been struggling to pay for her son's treatment after he tried to kill himself.

"I didn't sell my house. I sold everything else, including blood," she said.

Shaheen's bill would require insurers to cover schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

The illnesses are covered under mental health provisions of most plans, but many have a $10,000 lifetime cap on claims.

Paula Rogers, lobbyist for the Health Insurance Association of America, warned that the coverage would come at a price — higher premiums. Her group opposes the bill.

But Peter Wells of Healthsource, a health maintenance organization which backs the bill, estimated the cost to consumers would be minimal.

Dr. Thomas Fox of the state Division of Mental Health said only 75 people out of the 1,429 who sought help last year from community mental health programs for diseases covered by the bill exceeded their insurance caps.

"We're not talking large numbers or lots of money," he said.

Dr. Griffree Barnett, president of the New Hampshire Psychiatric Society, said the price of not requiring insurance coverage translates into higher jail costs, treatment of youngsters through tax-paid programs at school and in the community, and in suicides.

Sen. JEANNE SHAHEEN
"Simple issue of fairness"

For example, children can undergo episodes of depression lasting three years, he said. Healthsource pays for 20 visits to the doctor a year while Blue Cross covers $5,000 in outpatient services a year with a $10,000 lifetime cap.

Dartmouth-Hitchcock Medical Center

Dartmouth Medical School Department of Psychiatry

Robert M. Vidaver, M.D., F.A.P.A.
Professor of Psychiatry
Vice Chairman

February 17, 1994

Memo to Senate Insurance Committee
RE: Senate Bill 767

I am in strong support of SB 767.

Schizophrenia, bipolar disorder, major depression, OCD, the major brain disorders, are in fact very real diseases of the brain. Schizophrenia, for example, originates, most probably, in early childhood or before as structural distortions in the arrangement or pattern of neurons in certain key areas of the cortex -- the left pre-frontal, hippocampal and parahippocampal regions, and the limbic system -- leading years later as the brain matures during adolescence and early adulthood to profound disturbances in brain chemistry and the interpretation of information within the brain.

Anatomic and functional assays of these regions through the use of radioactive tracers, brain scans, and blood flow studies (MRI, PET, and SPEC) and neuropsychological testing clearly demonstrate reduced amounts of brain tissue in these areas, disorganized neuronal patterns, and lowered and abnormal levels of metabolic function, translating into both (a) the positive symptoms, hallucinations and delusions, for example, at times of acute psychosis and (b) a characteristic pattern of impaired verbal memory and learning, attention and visual motor-processing which persists even after the psychosis has disappeared.

The net effect of these disturbed neuronal patterns and chemical dysfunction is akin to trying to listen to AM radio in the midst of a thunder storm; the words are there, but the static interferes with perception no matter how desperately one tries to hear; one misperceives and misinterprets.

Newer medications, taking advantage of the past decade's avalanche in brain research are increasingly able to target their effects upon specific neuron groups and potentiate, or block, disturbances in the targeted neurotransmitter to bring the whole system back into balance. Newer medications, such as clozapine, the soon-to-be-released respiridone, and Sertindole (already available in Europe) promise to bring about the same kind of relief in schizophrenia that insulin provides in the control of diabetes (which, of course, it cannot cure) or steroids provide in alleviating the symptoms of life-long rheumatoid arthritis.

Nor is this far from home. The vast majority, upwards of 98%, of New Hampshire's most severely and persistently afflicted individuals live in the community, independently in apartments, with their families, and in group homes living ordinary lives, coming and going as everybody else, through the aegis of a plethora of community programs, in turn bulwarked by periods of brief hospitalization. New Hampshire Hospital admits some 1,000 persons a year, community hospitals probably twice that number; yet our average length of stay is just nine days. Newer medicines, community-based rehabilitation, and crisis-centered brief hospitalization are able to control the biological consequences of their brain disease, but only if these medications and community programs are maintained in place over a life time. Thus, the need for SB 767.

That does not mean, however, great expense to insurers or the State. My own studies and that of many other investigators and economists have clearly demonstrated the economy of community-based treatment offered on a preventative and maintenance basis to reduce the need for expensive hospitalization and, above all, eliminate long-term institutionalization with its million-dollar-per-patient price tag to the State.

New Hampshire Hospital, 105 Pleasant Street, Concord, NH 03301
(603) 271-5202 FAX (603) 271-5395

At New Hampshire Hospital the introduction of a new medicine, clozapine, for a small group of 47 of our most severely afflicted individuals resulted in the discharge of 32 of them. Over and above the advantage to them as human beings, the Hospital achieved a net savings of some 6,084 inpatient days, worth $2,860,000 over the first year alone. In effect, New Hampshire Hospital did not need more beds and was able to keep its overall census constant because a new medication allowed us to care for patients in the community at a fraction of the cost.

Lastly, I would like to distinguish between brain disease, as covered by SB 767, and personality disorders. Everyone has a personality -- friendly or unfriendly, kind, generous, introvertive, outgoing, compassionate or sadistic, gloomy or optimistic. We all have personalities. How we become who we are is a complex of many inputs: inate temperament, culture, parents, siblings, school mates, dreams, aspirations, and the experience of cold reality. Many of us wish we were "better", nicer, less self-centered. Certainly our personalities can create difficulties for us; an angry, impulsive temperament or self-defeating pattern can cause great discomfort. Psychotherapy can help if we are strongly motivated to change (not at all if we are not). But these are not the ailments nor treatments to be covered by SB767. They have a wholly different origin, are amenable to time-limited treatment and co-pay charges exactly because the individual can change, if he or she wants to, while individuals with schizophrenia can never "will" their brains to change. They are victims of a strange, but controllable, disease.

Robert M. Vidaver, MD, FAPA

Citizen Editorial

Mental Illness

The brain is the most complex — and therefore misunderstood — organ in the human body. For centuries, the most enlightened societies have struggled with how to diagnose and treat its maladies.

On the eve of the 21st century, we know more about the brain than ever before, and amazing technological advancements and pioneering research reveal more of its secrets almost daily. This knowledge is often difficult to assimilate because it confronts deeply ingrained societal stereotypes and firmly rooted public policy priorities.

Time to recognize it for what it is

This conflict is popping up in New Hampshire and across the country as mental health advocates armed with increasingly strong empirical evidence challenge health care providers, politicians and insurance companies to view and treat severe forms of mental illness as many other biological disease.

It's a tough fight.

A wall separates mental and physical health in most people's perceptions. It is assumed a person suffering a stroke will receive immediate comprehensive care and full insurance coverage. But few people question a system that allows a person suffering from depression to go years before the condition is accurately diagnosed and then cuts off benefits at ridiculously low amounts.

This anti-mental illness bias discourages people from seeking help and leaves them and their families to suffer needlessly, sometimes for many years.

That could change in New Hampshire if legislation proposed by Sen. Jeanne Shaheen, D-Madbury, passes. It would require that insurance companies provide coverage for several clinical mental illnesses as they do for any other disease.

This does not mean that someone feeling blue at the loss of a pet could collect unlimited insurance benefits. The scope of the law is limited to covering patients who suffer from severe medical illnesses that can be clinically diagnosed. They include schizophrenia, bipolar disorder, panic [illegible] and autism, to name four.

It is important to note that opposition to the bill centers not on its merits, but on its cost. Even opponents recognize that these severe mental disorders are diseases. The argument against the bill rests on the premise that it will drive medical costs much higher.

That premise is debatable. Surely, until the coverage is provided over an extended period of time, there is no way to accurately determine what the cost of such coverage will be. A few states already have expanded insurance coverage to several mental illnesses, but the track record is much too short to draw meaningful cost conclusions.

But this isn't an argument that should turn on costs. How many billions does it cost to treat heart disease in the country every year? We don't hear anyone calling for an end to insurance coverage for heart bypass surgery — and this when some studies have suggested the procedure is overused and may be less beneficial than originally believed.

The question should be this: In society's slow march toward enlightened mental health care, should severe mental illnesses be treated as diseases? If the answer is yes, then Sen. Shaheen bill's is a moral imperative.

This is not to say the cost of such coverage isn't important. But the solution to that problem is stringent management, not neglect. The cost of mental health services can be contained just as the costs for other health care services are now being contained.

Will mental health care coverage push up medical insurance costs? Yes, but consider the potential societal benefits if people who aren't getting help now are encouraged to do so. Not to blame all of society's ills on the mentally ill, but more effective treatment would no doubt mean a lower crime rate, fewer instances of domestic violence, and increased worker productivity — to scratch the surface.

Not so long ago, the mentally ill were heavily sedated and locked away in state hospitals. The appalling inhumanity of that manipulation finally hit home in the late 1960s and led to reforms in the 1970s and 1980s.

Isn't it time we take the next step toward the humane treatment of mental illness?

LEGISLATIVE ALERT

MARCH 24, 1994

Senate Bill 767: Insurance coverage for mental illness
PASSED IN THE NH SENATE
HEARING BY HOUSE COMMERCE COMMITTEE ON WEDNESDAY, APRIL 6TH 11AM - *PLEASE ATTEND!!*
Legislative Office Bldg. Room 207
(the LOB is directly behind the NH State House)

Senate Bill 767 was heard by the Senate Insurance Committee on February 17th. Thanks to all of you who wrote to your Senator, wrote a letter to the editor, or appeared at the hearing in support of this bill. SB 767 passed the Senate and now goes to the House, where it will be heard by the House Committee on Commerce, Small Business, and Consumer Affairs and later by the House Appropriations Committee. SB767 may face *opposition* in the House .

YOUR LETTERS TO COMMITTEE MEMBERS AND ATTENDANCE AT THE HEARING ON APRIL 6TH IS EXTREMELY IMPORTANT!!!!

1. Contact your Representative *and* the Committee members personally and in writing. Call and write the Committee members. If your representative is not on these Committees, write to your representative and *send a copy to these Committee Chairs . Get their committment to support SB767.* Ask them to share your letter or call with the other committee members. You may wish to bring paper, pens, and stamped envelopes to your group meeting to have all attendees write to their representative *and* to the Chair of the Appropriations and Commerce Committees. Because time is short you must do this immediately.

2. IF YOU HAVE WRITTEN ONCE ALREADY - THEN WRITE AGAIN. YOUR CALLS AND LETTERS DO MAKE A DIFFERENCE. THE REPRESENTATIVES LIKE TO HEAR WHAT "REAL PEOPLE" ARE THINKING ABOUT THE ISSUES.

*LIST OF COMMITTEE MEMBERS IS ATTACHED.

* BRIEF "TALKING POINTS" IS ALSO ATTACHED.

Share this Alert with your friends, family and support group members. Every call and letter counts. Make sure *you* are counted!!

Alliance for the Mentally Ill of New Hampshire
10 Ferry St. Unit 314, Concord, NH 03301 tel: 603-225-5359

TALKING POINTS FOR SB767
Use these as a guide when talking to legislators.

Senate Bill 767 will require that NH insurance companies, HMO, etc. provide coverage for biologically based mental illness to the same extent that they cover other physical illness.

• **This is a mental *illness* bill. It is *not* a mental *health* bill.** Mental illnesses are low incidence biological brain disorders experienced by 2.8% of the adult population in any given year. On the other hand, "mental health" problems are experienced by many people. This is not to suggest that mental health problems aren't significant and often painful - but this bill proposes expanded coverage only for that 2.8% of the population who experience biologically based disorders of the brain. (1)

• **It is time that we treated the brain as a part of the body.** Serious mental illnesses are disorders of the brain - not unlike Alzheimer's or Parkinson's disease. They are not the result of unhealthy lifestyles, or choice, or personal weakness, or poor parenting.

• **It is time for the discrimination in insurance coverage to stop.** Insurance that covers biologically based mental illness at lesser amounts than other physical illness unfairly discriminates.

• **Serious mental illness is diagnosable and treatable, like other physical illnesses.** While mental illness is not curable - it is treatable, like severe diabetes. Treatments for mental illness are effective. Early treatment of schizophrenia is 60% effective in reducing symptoms and 80% effective for bipolar disorder -- as compared with a 41% success rate in treating cardiovascular disease through angioplasty. The accuracy of diagnosing serious mental illness is also similar to other physical illness.(2)

There is nothing as powerful and persuasive as your personal story. If you are a family member of a person with mental illness -- tell you r story in a way that is always sensitive to your family member's need for personal dignity and privacy. You family comes first.

Remember that you don't have to be an expert to be persuasive in getting legislators to support this bill. **The basic reason for them to support ending insurance discrimination is that it is the right thing to do -- it is a basic issue of fairness.**

REFERENCES:

(1) National Institute of Mental Health, Epidemiological Catchment Area Study cited in "Health Care Rform for Americans With Serious Mental Illness: Report of the National Mentla Health Advisory Council," U.S.Dept. of Health and Human Services, Public Health Service, 1992.

(2) Scientific reports on treatment effectiveness are many and are reprinted in a special seciton of the report mentioned above available from the AMI of NH lending library.

AMI of New Hampshire
NEWS

VOLUME V, Issue 2 *InfoLine 1-800-242-NAMI* FALL 1994

Hold the Date
Saturday October 22nd
AMI of NH ANNUAL CONFERENCE
details on page 5

Parity Passes!

After months of advocacy by families and consumers, Governor Merrill signed Senate Bill 767 into law in early July. SB 767 requires all health insurance policies in NH to provide coverage for certain biologically based mental illness at the same level as coverage for other illness. The law will go into effect for any policy issued or renewed beginning January 1, 1995. The Governor waited until the last minute before signing the bill, but signed after realizing that the so-called "small business" opposition to the bill was really an organized campaign by the Church of Scientology, which opposes all types of psychiatric treatment.

Supporters - including business owners - argued that parity makes economic sense, and that premiums would rise less than 2%. "Fair coverage has an economic benefit to New Hampshire," said Rick Sherman, President of the Alliance. "The costs for not treating mental illness far outweigh the costs of providing adequate treatment."

The cost of untreated mental illness is high. According to the National Advisory Mental Health Council's 1992 report, the annual indirect costs for serious mental illness are $48 billion. Additionally, about 25% of all Social Security Disability payments are for persons with severe mental illness.

NH Business Supports SB767

David Foote, a partner at CFX Bank in Keene supported SB767. "We have over 300 employees in 19 branches. The mental illness coverage legislation says that mental illness is an illness like heart disease or diabetes. Finally it's getting treated in the same manner. When I look across the broad spectrum of our employees there would be very few people with serious mental illness, but, when it happens, the person does need the insurance coverage. We believe

(see Parity, page 3)

Rick Sherman accepts National Advocacy Award from NAMI President Warren Adams

AMI of NH Recognized at San Antonio Convention

AMI New Hampshire received national recognition during the NAMI Annual Convention held in San Antonio, Texas in July. AMI received the NAMI Outstanding State Advocacy Award for passage of NH's Insurance Parity legislation. This marks the second time in four years that AMI of NH has received the Advocacy Award. AMI-NH also received the NAMI Award for Outstanding Public Education through the Media for our work with the NH media during the parity legislation effort.

And special congratulations to AMI of NH Board member Rona Purdy on her election to be President of NAMI. Much will be accomplished under her leadership.

New CEO at Central NH

Central New Hampshire Community Mental Health Services, Inc. has a new President and Chief Executive Officer, Dale K. Klatzker, PhD. Dr. Klatzker comes to New Hampshire from Eastern Middlesex Human Services in Wakefield, Massachusetts. Dr. Klatzker obtained a Masters degree in Social Work at Boston University and a Ph.D. at the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University.

The task of a CEO in a community mental health system is extraordinarily challenging at this time. Tightening budgets, changing models of care, political uncertainties, and increasing expectations and needs in the community present a complex and difficult task. Dr. Klatzker has described his management style as "an inclusive one that values partnership and teamwork at all levels". He is currently holding a series of weekly meetings, for staff and other interested individuals, at which he seeks input and presents his plans for addressing the Agency's fiscal and programmatic problems. He is also meeting with staff and consumers in all programs.

Central NH Mental Health Center's new chief executive, Dale Klatzker.

"Our consumers must always be at the focus of our efforts," Dale Klatzker states, and he has stressed that in seeking fiscal stability, "We will not be sacrificing direct services. There will be changes but we will not be offering fewer services or diminished levels of care."

(Party, continued from page 1)

that keeping the good mental health of employees is good business."

Marje Iafolla, of Iafolla Industries, a road construction and paving company in Portsmouth, praised Governor Merrill for signing SB767. "It is really important that the Governor signed this bill. We have had employees who needed mental health services. When they are treated they can return to work and have done very well. I can't imagine why any business would be against this."

Judith Bezler, owner of Judith Bezler Insurance Associates, Merrimack agrees. "This bill and the small business insurance reforms will be excellent changes for small business. If I had employees with mental illness that was not being treated like any other medical concern, this would be a major productivity problem. Insurance companies found that Employee Assistance Programs cost money at the beginning but have ended up reducing claims. Now that we have a way of covering mental illness, I expect we will see savings in other medical claims. SB767 makes good business sense."

Book Review:
Girl Interrupted

by Susannah Kaysen

What's it like to be labeled "crazy"? To find yourself locked up in a psychiatric ward at age 18? To be removed from the outside world for two years?

In sparse, insightful prose, Susannah Kaysen recreates the essence of this disruption. The title of this book comes from the title of a painting by Vermeer: Girl Interrupted at Her Music. "Interrupted at her music: [illegible] life had been, interrupted in the music of being seventeen," reflects Kaysen.

In a series of bittersweet vignettes, she highlights perceptions of the other adolescent girls in the ward, the staff, the essence of her residence at McLean Hospital from 1967 - 1969.

There is humor mixed with pathos as this world within walls is opened. Of the student nurses she writes "When we looked at them, we saw alternative versions of ourselves. They were living out lives we might have been living, if we hadn't been occupied with being mental patients."

The book is interspersed with the brief medical and staff records of her stay, from admission to the final terse page which states, "Borderline Personality — Recovered. Drug: Chlorpromazine."

Now 44, Kaysen lives in Cambridge, MA and has had two other books published. The hardcover edition of this book was so widely read when it was released last year, that it has been reissued in paperback. A film version is planned.

(A copy of this book has been donated to the AMI of NH Library.)

NEED INFORMATION OR SUPPORT? CALL AMI of NH Information Line 1-800-242-6264

VERMONT

VERMONT Legislation

Two Copies

1 is AM1 of VT reprint and is easier to read.

2 is official version - same thing but harder to read.

Alliance for the Mentally Ill of Vermont
230 MAIN STREET • MUNICIPAL CENTER • BRATTLEBORO, VT 05301
IN VERMONT 800-639-6480 • 802-257-5546

State of Vermont
Legislative Bill Tracking System
1997-1998 Legislative Session

NO. 25. AN ACT RELATING TO HEALTH INSURANCE FOR MENTAL HEALTH AND
SUBSTANCE ABUSE DISORDERS.

(H.57)

Sec. 2. 8 V.S.A. § 4089b is added to read:

§ 4089b. HEALTH INSURANCE COVERAGE; MENTAL HEALTH AND

SUBSTANCE ABUSE

(a) As used in this section,

(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402(7). Health insurance plan includes any health benefit plan offered or administered by the state, or any subdivision or instrumentality of the state.

(2) "Mental health condition" means any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised.

(3) "Rate, term or condition" means any lifetime or annual payment

limits, deductibles, copayments, coinsurance and any other cost-sharing requirements, out-of-pocket limits, visit limits and any other financial component of health insurance coverage that affects the insured.

(b) A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for accessto treatment for a physical health condition. Any deductible or out-of-pocket limits required under a health insurance plan shall be comprehensive for coverage of both mental health and physical health conditions.

(c) A health insurance plan that does not otherwise provide for management of care under the plan, or that does not provide for the same degree of management of care for all health conditions, may provide coverage for treatment of mental health conditions through a managed care organization provided that the managed care organization is in compliance with the rules adopted by the commissioner that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the commissioner shall assure that timely and appropriate access to care is available; that the quantity, location and specialty distribution of health care providers is adequate and that administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured.

(d) A health insurance plan shall be construed to be in compliance with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms and conditions that place no greater financial burden on the insured than for access to treatment of physical conditions. The commissioner may disapprove any plan that the commissioner determines to be inconsistent with the purposes of this section.

(e) To be eligible for coverage under this section the service shall be rendered:

(1) For treatment of mental illness,

(A) by a licensed or certified mental health professional, or (B) in a mental health facility qualified pursuant to rules adopted by the secretary of human services or in an institution, approved by the

secretary of human services, that provides a program for the treatment of a mental health condition pursuant to a written plan. A nonprofit hospital or a medical service corporation may require a mental health facility or licensed or certified mental health professional to enter into a contract as a condition of providing benefits.

(2) For treatment of alcohol or substance abuse,

(A) by a substance abuse counselor or other person approved by the secretary of human services based on rules adopted by the secretary that establish standards and criteria for determining eligibility under this subdivision, or

(B) in an institution, approved by the secretary of human services, that provides a program for the treatment of alcohol or substance dependency pursuant to a written plan.

Sec. 3. REPORT

On or before January 15, 1999, the Department of Banking, Insurance, Securities, and Health Care Administration shall report to the general assembly on the following:

(1) An estimate of the impact of this act on health insurance costs.

(2) Actions taken by the department to assure that health insurance plans are in compliance with this act and that quality and access to treatment for mental health conditions provided by the plans are not compromised by providing financial parity for such coverage.

(3) When a health insurance plan offers choices for treatment of mental health and substance abuse conditions as provided by 8 V.S.A. § 4089b(d), an analysis and comparison of those choices in regard to level of access, choice and financial burden.

(4) Identification of any segments of the population of Vermont that may be excluded from access to treatment for mental health and substance abuse conditions at the level provided by this act, including an estimate of the number of Vermonters excluded from such access under health benefit plans offered or administered by employers who receive the majority of their annual revenues from contract, grants or other expenditures by state agencies.

Sec. 4. CONSTRUCTION; TRANSITIONAL PROVISIONS

(a) The provisions of this bill shall not be construed to:

(1) Limit the provision of specialized Medicaid covered services for individuals with mental health or substance disorders.

(2) Supersede the provisions of federal law, federal or state Medicaid policy or the terms and conditions imposed on any Medicaid waiver granted to the state with respect tothe provision of services to individuals with mental health or substance abuse disorders.

(3) Affect any annual health insurance plan until its date of renewal or any health insurance plan governed by a collective bargaining agreement or employment contract until the expiration of that contract.

(b) The rules of the secretary of human services adopted under 8 V.S.A. § 4089, relating to eligibility for payment for treatment of mental illness, and adopted under 8 V.S.A. § 4099, relating to eligibility for payment for treatment of alcoholism, shall remain in effect until the effective date of this act and thereafter shall be deemed to be the rules adopted by the secretary under 8 V.S.A. § 4089b(e), to the extent that they are consistent with the provisions of this act and until amended or repealed by the secretary.

Sec. 5. REPEAL

8 V.S.A. § 4089 (mental illness) and §§ 4097-4099b (alcoholism) are repealed in regard to any health insurance plan only after the provisions of this act take effect in accordance with Sec. 6 of this act.

Sec. 6. EFFECTIVE DATE

This act shall take effect on passage and shall apply to any health insurance plan offered or renewed on and after January 1, 1998.

Approved: May 28, 1997

Vermont

NO. 25. AN ACT RELATING TO HEALTH INSURANCE FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.

(H.57)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 8 V.S.A. § 4089a(g) and (h) are added to read:

(g) Members of the independent panel of mental health care providers shall be compensated as provided in 32 V.S.A. § 1010(b) and (c).

(h) A review agent shall pay a license fee for the year of registration and a renewal fee for each year thereafter of $200.00. In addition, a review agent shall pay any additional expenses incurred by the commissioner to examine and investigate an application or an amendment to an application.

Sec. 2. 8 V.S.A. § 4089b is added to read:

§ 4089b. HEALTH INSURANCE COVERAGE: MENTAL HEALTH AND SUBSTANCE ABUSE

(a) As used in this section,

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(2) "Mental health condition" means any condition or disorder involving mental illness or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease, as periodically revised.

(3) "Rate, term or condition" means any lifetime or annual payment limits, deductibles, copayments, coinsurance and any other cost-sharing requirements, out-of-pocket limits, visit limits and any other financial component of health insurance coverage that affects the insured.

(b) A health insurance plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for accessto treatment for a physical health condition. Any deductible or out-of-pocket limits required under a health insurance plan shall be comprehensive for coverage of both mental health and physical health conditions.

(c) A health insurance plan that does not otherwise provide for management of care under the plan, or that does not provide for the same degree of management of care for all health conditions, may provide coverage for treatment of mental health conditions through a managed care organization provided that the managed care organization is in compliance with the rules adopted by the commissioner that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the commissioner shall assure that timely and appropriate access to care is available; that the quantity, location and specialty distribution of health care providers is adequate and that administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured.

(d) A health insurance plan shall be construed to be in compliance with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms and

conditions that place no greater financial burden on the insured than for access to treatment of physical conditions. The commissioner may disapprove any plan that the commissioner determines to be inconsistent with the purposes of this section.

(e) To be eligible for coverage under this section the service shall be rendered:

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(A) by a licensed or certified mental health professional, or (B) in a mental health facility qualified pursuant to rules adopted by the secretary of human services or in an institution, approved by the secretary of human services, that provides a program for the treatment of a mental health condition pursuant to a written plan. A nonprofit hospital or a medical service corporation may require a mental health facility or licensed or certified mental health professional to enter into a contract as a condition of providing benefits.

(2) For treatment of alcohol or substance abuse,

(A) by a substance abuse counselor or other person approved by the secretary of human services based on rules adopted by the secretary that establish standards and criteria for determining eligibility under this subdivision, or

(B) in an institution, approved by the secretary of human services, that provides a program for the treatment of alcohol or substance dependency pursuant to a written plan.

Sec. 3. REPORT

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(1) An estimate of the impact of this act on health insurance costs,

(2) Actions taken by the department to assure that health insurance plans are in compliance with this act and that quality and access to treatment for mental health conditions provided by the plans are not compromised by providing financial parity for such coverage.

(3) When a health insurance plan offers choices for treatment of mental health and substance abuse conditions as provided by 8 V.S.A. § 4089b(d), an analysis and comparison of those choices in regard to level of access, choice and financial burden.

(4) Identification of any segments of the population of Vermont that may be excluded from access to treatment for mental health and substance abuse conditions at the level provided by this act, including an estimate of the number of Vermonters excluded from such access under health benefit plans offered or administered by employers who receive the majority of their annual revenues from contract, grants or other expenditures by state agencies.

Sec. 4. CONSTRUCTION; TRANSITIONAL PROVISIONS

(a) The provisions of this bill shall not be construed to:

(1) Limit the provision of specialized Medicaid covered services for individuals with mental health or substance disorders,

(2) Supersede the provisions of federal law, federal or state Medicaid policy or the terms and conditions imposed on any Medicaid waiver granted to the state with respect tothe provision of services to individuals with mental health or substance abuse disorders,

(3) Affect any annual health insurance plan until its date of renewal or any health insurance plan

governed by a collective bargaining agreement or employment contract until the expiration of that contract.

(b) The rules of the secretary of human services adopted under 8 V.S.A. § 4089, relating to eligibility for payment for treatment of mental illness, and adopted under 8 V.S.A. § 4099, relating to eligibility for payment for treatment of alcoholism, shall remain in effect until the effective date of this act and thereafter shall be deemed to be the rules adopted by the secretary under 8 V.S.A. § 4089b(e), to the extent that they are consistent with the provisions of this act and until amended or repealed by the secretary.

Sec. 5. REPEAL

8 V.S.A. § 4089 (mental illness) and §§ 4097-4099b (alcoholism) are repealed in regard to any health insurance plan only after the provisions of this act take effect in accordance with Sec. 6 of this act.

Sec. 6. EFFECTIVE DATE

This act shall take effect on passage and shall apply to any health insurance plan offered or renewed on and after January 1, 1998.

Approved: May 28, 1997

ANSWERS TO COMMONLY ASKED QUESTIONS ABOUT MENTAL HEALTH PARITY

What is mental health parity?

In Vermont mental health parity refers to the law that requires your health insurance to cover mental health and substance abuse services at no greater cost to you than insurance for other health services.

So what does "parity" really mean?

The law eliminates separate and unequal deductibles and out-of-pocket costs for mental health and substance abuse services. Instead, it requires comprehensive combined deductibles and out-of-pocket costs for mental health, substance abuse and all other health care services. It also eliminates arbitrary visit limits and dollar maximums.

Why is parity important to me?

Before the parity law, insurance for mental health and substance abuse services often provided very limited coverage and cost considerably more than insurance for other health conditions. As a result, persons with serious mental health or substance abuse conditions often found themselves in need of treatment but without the means to pay for it, even if they had health insurance. Under the new law these services must be available, and at no greater cost to you than any other kind of health care service.

Does this law apply to all health insurance plans?

Yes. It applies to all health plans offered by Vermont insurance companies, including HMOs. The Vermont law does not, however, apply to employers who pay their employees' health care costs themselves (self-insured companies). The state cannot regulate self-insured companies because they are regulated by the federal government.

Does this mean that if I work for a self-insured employer I won't get parity in mental health insurance?

Not entirely. First, some self-insured companies may choose to offer financial parity voluntarily. In addition, there is a federal parity law that applies to self-insured companies that employ 50 or more people. This law provides partial parity by prohibiting lifetime and annual dollar limits for mental health services. But the federal law applies only to mental health services. It does not cover treatment services for substance abuse.

Are plans allowed to sell different types of mental health benefit packages?

The law requires your insurance plan to cover mental health and substance abuse services in a way that is financially equal to what the company pays for your other health services. Plans are also allowed to offer other treatment choices at different out-of-pocket costs than parity, however, so long as at least one of your options meets the financial parity test. For example, plans may offer a "point of service" option, allowing you to use a provider who is not on your plan's list, but you may have to pay more for this.

What about managed care? I have heard that the insurance company can require me to go throughmanaged care for my mental health services.

The law permits the plans to use managed care for mental health services. This is true even if the plan does not require managed care for other health services.

So, how do I know I will be able to get the services I need when I need them?

Vermont laws and regulations set strict consumer safeguards to prevent you from having to deal with unnecessary delays or barriers to getting appointments for the services you need, at the right time and with the right professional or treatment program. The health plans that use managed care for their mental health services are required to have enough network providers so that you can get appointments in your area in a reasonable time.

When does the law go into effect?

On January 1, 1998 for all new insurance policies. If you had a health insurance policy before January 1, parity is required when your policy is renewed. If you receive your insurance through a collective bargaining agreement or an employment contract, parity must be provided when the agreement or contract is renewed.

What if I have Medicaid or Medicare? Does parity apply?

The Office of Vermont Health Access (formerly Medicaid) provides for mental health and substance abuse parity in its health benefit packages. However, neither the Vermont parity law nor the federal parity law applies to Medicare.

How do I find out if I'm entitled to parity?

If your insurance is provided through your employer, talk with the person at your work who is most familiar with your health insurance plan. Ask what date the health insurance contract is renewed. Ask that the insurance company verify when parity will apply to you. Remember, parity applies in most cases, except when your employer is self-insured.

If you pay for your own insurance, or are insured through the Office of Vermont Health Access, call your insurance company and ask them to explain how parity will work in your case. If you have any questions, you can always call the Division of Health Care Administration's toll-free consumer help line at *1-800-631-7788*.

What if I have been denied coverage for mental health or substance abuse services that I think are necessary?

FIRST, talk with your mental health or substance abuse treatment professional. Ask him or her to help you understand the plan's decision. If you receive mental health or substance abuse services through a managed care plan, Vermont rules permit your health care professional to talk freely with you about your health care needs and treatment options. You may also ask your health care professional to advocate on your behalf. You always have the right to know why payment for a service has been denied.

SECOND, call your insurer or managed care plan and ask that the decision be reviewed through its complaint (grievance) system. You always have the right to appeal a decision to deny coverage. State rules require all health insurance plans to make decisions on appeals relating to mental health or substance abuse services within 24 hours (for emergencies) or within 10 days (all other

appeals).

***THIRD,* if you are unhappy with the company's final decision, you have the right to ask the Independent Panel of Mental Health Providers to review your case. Their number is 802-828-3301. This is a group of mental health professionals who will review your case. If the Independent Panel members agree that the services you are asking for are medically necessary, they will require your plan to pay for the services.**

Need more information? Need help?
Call the Division of Health Care Administration's Consumer Help Line anytime: 1-800-631-7788

If you need this flyer in an alternative format please call 1-800-631-7788.

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RHODE ISLAND

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STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

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June 4, 1997

Ms. Susan Dore
National Alliance for the Mentally Ill
2101 Wilson Boulevard - Suite 302
Arlington, Virginia 22201

Dear Susan:

This letter is in response to the questions posed of participants in the discussion of parity in coverage of mental health services to take place on June 17, 1997. These responses are given in the order of the questions posed.

Sincerely,

Donald P. Galamaga
Executive Director,
Division of Integrated
Mental Health Services

DPG:db

enclosure

Rhode Island Response to Parity Coverage of Mental Health Services Questions Posed by the Milbank Memorial Fund and the National Alliance for the Mentally Ill

1. A copy of the Rhode Island Statute 27-38.2 entitled Insurance Coverage for Serious Mental Illness is enclosed herewith.

2. The scope of the Rhode Island Law is as follows:

   a. All persons with serious mental illness are covered regardless of income.

   b. If an employer provides insurance coverage for physical health care, mental health care must be provided for persons with serious mental illness at a cost parallel to that of physical health.

   c. As far as insurance coverage is concerned, the Rhode Island Law provides for inpatient hospitalization and outpatient medication visits.

   d. There are no limits on outpatient medication visits. Inpatient coverage in cases where continuous hospitalization is medically necessary shall be limited to 90 consecutive days.

   e. Coverage which includes medication visits generally falls under the rubric of an outpatient visit in most insurance policies in the state and is treated as such. Hospitalization is subject to determination of medical necessity and appropriate treatment consistent with the treatment of other diseases or injuries covered under the health insurance policy or agreement.

   f. The law specifically requires that the treatment of serious mental illness must be done under the same terms and conditions as such coverage is provided for other illnesses and diseases.

   g. Insurance coverage offered pursuant to this statute must include the same durational limits, amount limits, deductibles and co-insurer factors for serious mental illness as for other illnesses and diseases.

3. In Rhode Island the Department of Business Regulations has the primary responsibility for regulating insurance carriers. This is a separate cabinet level agency, and it is currently involved in writing regulations for the Rhode Island parity bill. The Health Department, a separate cabinet level agency and the state public health authority, issues a certificate of compliance with health maintenance organization laws and regulations in the state to the Department of Business Regulations, who in turn licenses the HMO. The Health

Department also issues certificates to utilization review agencies in Rhode Island pursuant to legislation adopted in 1992.

4. Primary insurance carriers in the state that recognize parity legislation include Blue Cross & Blue Shield of Rhode Island, Harvard and Pilgrim Community Health of New England, and United Health plans. The parity legislation went into effect on January 1, 1995. Although all principal carriers had been involved either directly or indirectly with discussions concerning the legislation in 1994, implementation was uneven due to the fact that many policies were in effect already on the effective date of the legislation, and an uneven response ensued over the first 6 months of 1995 as companies altered their coverage to reflect the requirements of the law which is fairly clear on its own merits.

COMMENTARY

1. The general public perception of mental health treatment in the State of Rhode Island as being efficient and effectively managed in the public sector, especially with respect to the management of inpatient hospitalization, was a significant factor in setting the tone for discussions by advocacy groups with insurance carriers and providers about parity starting as early as 1992. Beyond that, the Alliance for the Mentally Ill, along with the Coalition of Consumer Self Advocates in Rhode Island, were able to get legislation sponsored in 1992 that raised the issue of parity coverage and which resulted in a legislative commission to study this issue. The Alliance for the Mentally Ill was a major factor here with the support of the Department of Mental Health, Retardation and Hospitals, the Mental Health Association, the consumers' organization and others to press the case for coverage for persons with mental illness. It was also extremely helpful to have a representative from Greensprings, Carl Young, Ph.D., who had looked at the hospitalization data very carefully and was convinced that parity coverage was a positive investment from the insurer's point of view. Add to this the fact that the Rhode Island General Assembly has always looked favorably on programs for persons with disabilities and the fact that the past 11 or 12 years of general elections have seen all mental health related bond issues passed by the general public overwhelmingly, and you have a framework for support of the parity concept.

2. It is clear that more persons are being served in the private sector as a result of parity coverage, if only based upon the anecdotal issue of benefits not being comprehensive enough in the private sector with some persons seeking additional support from the public sector to supplement private coverage. It is clear that a service enhancement has taken place, although it is early to measure it specifically.

3. There have been no effects of the parity law on organizational structure resources and other areas that are measurable and discernible at this point, with the possible exception of the fact that it has become apparent to the insurers that the cost of coverage, thus far, has been minimal in Rhode Island and that the development of a continuum of care is a likely outcome in the private sector.

4. Parity legislation will probably give added emphasis to the accountable management of resources in the area of mental health treatment, hopefully resulting in an enlightened form of managed care for serious mental illness. As far as mental illness is concerned, in Rhode Island the RIte Care waiver which is planned to serve children up to the age of 18 in the former AFDC population, provides an unlimited mental health benefit to persons in the general population with people with serious mental illness being carved out to the public mental health system at the present time. In the public sector a design is underway for a complementary program called RIcover which will provide both mental health coverage and physical health coverage to persons for whom behavioral health issues are the major issues in their lives.

5. Parity monitoring can be effective if responsibility is located in one agency and if an effective advocacy organization exists to provide a vehicle for system complaints to be forwarded both to the insurance monitor and to the state mental health or public health agency. As was mentioned, the public health authority has a role in the licensing of health maintenance organization and utilization review agencies. Under that authority, public hearings were held in 1995 concerning inappropriate responses by one insurer, United Behavioral Health, to the needs of persons with mental illness, resulting in a $100,000 fine by the public health agency, half of which was directed to the development of practice standards for the treatment of specific forms of mental illness to be shared with all insurers in the state.

6. In the private sector, the concept of flexible benefits is currently being explored by Blue Cross & Blue Shield of Rhode Island through Greensprings. Essentially, private insurers are looking to develop a range of services similar to those offered in the public sector that would avoid more intense levels of care than are required. This seems to be a normal and cost effective outgrowth of parity legislation. In addition, the concept of medical necessity needs to be clarified for persons who have serious mental illness. The paper developed by the Bazelon Center in 1996 makes some significant recommendations for medical necessity determinations for mental illness that are clearly indicated since we are dealing with a very vulnerable population. Serious consideration ought to be given to incorporation of some of the goals, principles and service issues found in that paper in either state or federal law or regulation.

Rhode Island copy of bill

of charge by the state of Rhode Island. Benefits need not be provided for the cost of biologicals used for vaccinations.

History of Section.
P.L. 1988, ch. 488, § 1.
Reenactments. The 1994 Reenactment (P.L. 1994, ch. 134, § 1) substituted "that care" for "such care" in subsection (b).

27-38.1-3. Benefits to be included in basic coverage. — The benefits mandated by this chapter shall be included in all benefit plans offered by every health insurer and health maintenance organization. Benefit plans offered by health insurers and health maintenance organizations may impose copayment charges for the benefits mandated by this chapter; however, in no instance shall the copayment amounts be greater than copayment charges imposed for other physician office visits, nor shall the copayment charges pose a barrier to obtaining pediatric preventive care. Benefits for pediatric services shall be reimbursed in accordance with each health insurer's respective principles and mechanisms of reimbursement. The provisions of this benefit will supersede any deductible requirements.

History of Section.
P.L. 1988, ch. 488, § 1.
Reenactments. The 1989 Reenactment (P.L. 1989, ch. 542, § 1) made several substitutions for the word "such" in the second sentence, and made a minor stylistic change in the fourth sentence.
The 1994 Reenactment (P.L. 1994, ch. 134, § 1) made stylistic changes throughout the section.

CHAPTER 38.2

INSURANCE COVERAGE FOR SERIOUS MENTAL ILLNESS

SECTION.
27-38.2-1. Mental illness coverage.
27-38.2-2. Definitions.
27-38.2-3. Medical necessity and appropriateness of treatment.
27-38.2-4. Limitations of coverage.

Delayed Effective Dates. Section 2 of P.L. 1994, ch. 225 provides that the enactment of this chapter by that act shall take effect January 1, 1995 and shall apply to policies issued, renewed or in effect on or after January 1, 1995.

Section 2 of P.L. 1994, ch. 336 provides that the enactment of this chapter by that act shall take effect January 1, 1995 and shall apply to policies issued, renewed or in effect on or after January 1, 1995.

27-38.2-1. Mental illness coverage. [Effective January 1, 1995.] — Every health care insurer shall provide coverage for the medical treatment of serious mental illness under the same terms and conditions as such coverage is provided for other illnesses and diseases. Insurance coverage offered pursuant to this statute must include the same durational limits, amount limits, deductibles, and co-insurance factors for serious mental illness as for other illnesses and diseases.

COLLEGE RELATION 003

History of Section.
P.L. 1994, ch. 225, § 1; P.L. 1994, ch. 336, § 1.
Delayed Effective Dates. For the effective date of this section, see the note under this same heading following the chapter analysis.

27-38.2-2. Definitions. [Effective January 1, 1995.] — For the purposes of this chapter, the following words and terms shall have the following meanings:

(a) "Health insurers" means all persons, firms, corporations, or other organizations offering and assuring health services on a prepaid or primarily expense-incurred basis, including but not limited to policies of accident or sickness insurance, as defined by chapter 18 of this title, nonprofit hospital or medical service plans, whether organized under chapter 19 or 20 of this title or under any public law or by special act of the general assembly, health maintenance organizations, or any other entity which insures or reimburses for diagnostic, therapeutic, or preventive services to a determined population on the basis of a periodic premium, except for supplemental policies which only provide coverage for specified diseases.

(b) "Serious mental illness" means any mental disorder that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the illness. Ther term includes, but is not limited to:

(1) schizophrenia
(2) schizoaffective disorder
(3) delusional disorder
(4) bipolar affective disorders
(5) major depression
(6) obsessive compulsive disorder.

(c) "Medical coverage" means inpatient hospitalization and outpatient medication visits.

History of Section.
P.L. 1994, ch. 225, § 1; P.L. 1994, ch. 336, § 1.
Delayed Effective Dates. For the effective date of this section, see the note under this same heading following the chapter analysis.

27-38.2-3. Medical necessity and appropriateness of treatment. [Effective January 1, 1995.] — Upon request of the reimbursing health insurers, all providers of treatment of serious mental illness shall furnish medical records or other necessary data which substantiates that initial or continued treatment is at all times medically necessary and appropriate. When the provider cannot so establish the medical necessity and/or appropriateness of the treatment modality being provided, neither the health insurer nor the patient shall be obligated to reimburse for that period or type of care which was not so established. The exception to the preceding can only be made if the patient has been informed of the above and has agreed in writing to continue to receive treatment at his or her own expense.

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The health insurers, when maki: the above determination of medically necessary and appropriat. treatment, must do so in a manner consistent with that used to make the determination for the treatment of other diseases or injuries covered under the health insurance policy or agreement.

History of Section.
P.L. 1994, ch. 225, § 1; P.L. 1994, ch. 336, § 1.

Delayed Effective Dates. For the effective date of this section, see the note under this same heading following the chapter analysis.

27-38.2-4. Limitations of coverage. [Effective January 1, 1995.] — The health care benefits outlined in this chapter apply only to services delivered within the state of Rhode Island.

Inpatient coverage in cases where continuous hospitalization is medically necessary shall be limited to ninety (90) consecutive days.

History of Section.
P.L. 1994, ch. 225, § 1; P.L. 1994, ch. 336, § 1.

Delayed Effective Dates. For the effective date of this section, see the note under this same heading following the chapter analysis.

CHAPTER 39

SECOND MEDICAL OPINION

SECTION.
27-39-1. Definitions.
27-39-2. Insurance benefits for second opinion.
27-39-3. Insurance benefits for third opinion.
27-39-4. Exclusions.
27-39-5. Severability.

27-39-1. Definitions. — As used in this chapter:

(1) "Elective surgical procedure" means any nonemergency surgical procedure which may be scheduled at the convenience of the patient or the surgeon without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions;

(2) "Eligible physician" means a physician licensed to practice medicine and surgery who holds the rank of diplomate of an American board (M.D.) or certified specialist (D.O.) in the surgical or medical specialty for which surgery is proposed; and

(3) "Second surgical opinion" means an opinion of an eligible physician based on that physician's examination of a person for the purpose of evaluating the medical advisability of that person undergoing an elective surgical procedure. The examinations must be performed after another physician licensed to practice medicine and surgery has proposed to perform the surgical procedure on the person but prior to the performance of the surgical procedure.

ALASKA

Steve Frew MH 9-1667

under this subsection only if the advanced nurse practitioner is certified to practice as a nurse midwife in accordance with regulations adopted under AS 08.68.100(a), and the services provided are within the scope of practice authorized by that certification.

(b) If an individual or group health insurance policy, subscriber's contract, enrollee contract, or fraternal benefit society certificate provides for furnishing those services required of a physician in the care of women during pregnancy, childbirth, and the period after childbirth, the contract shall also provide that an advanced nurse practitioner may furnish those same services instead of a physician. Services may be provided under this subsection only if the advanced nurse practitioner is certified to practice as a nurse midwife in accordance with regulations adopted under AS 08.68.100(a), and the services provided are within the scope of practice authorized by that certification. (§ 1 ch 40 SLA 1981; am § 75 ch 62 SLA 1995; am § 46 ch 56 SLA 1996)

Revisor's notes. — Enacted as AS 21.42.347. Renumbered in 1981. In 1984, the internal references were changed from AS 08.68.410(5) to AS 08.68.100(a) to correct a manifest error.

Cross references. — For applicability of this section, see § 27, ch. 40, SLA 1981 in the Temporary and Special Acts.

Effect of amendments. — The 1995 amendment, effective July 1, 1995, in subsection (a), inserted "enrollee contract," in the first sentence and, in subsection (b), inserted "an individual or group disability insurance policy," and ", enrollee contract, or fraternal benefit society certificate" near the beginning of the first sentence.

The 1996 amendment, effective September 9, 1996, substituted "health" for "disability" near the beginning of subsections (a) and (b).

Sec. 21.42.360. Definitions. [Repealed, § 11 ch 163 SLA 1976. For current law see AS 21.90.]

Sec. 21.42.365. Coverage for treatment of alcoholism or drug abuse. (a) An insurer authorized under AS 21.09 to offer, issue for delivery, deliver, or renew a group health insurance policy for major medical coverage on an expense incurred basis in the state, or a hospital or medical service corporation authorized under AS 21.87 to offer or renew a group subscriber's contract for medical coverage in the state, shall provide the covered person the following coverage for treatment of alcoholism or drug abuse:

(1) benefits of at least $7,000 over two consecutive benefit years; and

(2) lifetime benefits of at least $14,000.

(b) The benefits specified in (a)(1) and (2) of this section shall be adjusted every three years, by the director, to correspond with the change in the medical care component of the consumer price index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor Statistics, United States Department of Labor. The base year for the computation shall be the first full calendar year for which insurance is obtained under this section.

(c) The insurer or hospital or medical service corporation providing coverage under this section may not

(1) require that the covered person be responsible for a deductible or copayment that is different for the determination of benefits relating to treating alcoholism or drug abuse than for the determination of benefits for treating another covered illness;

(2) use a different claim payment methodology in determining the benefits relating to treating alcoholism or drug abuse than that used in determining the benefits for treating another covered illness;

(3) require prenotification of treatment or a second opinion unless the requirement is applicable to other covered major illnesses;

(4) limit coverage by provisions of the insurance contract that are not applicable to other covered major illnesses, including but not limited to provisions concerning preexisting illnesses or provisions requiring that the exact date of onset be known;

(5) limit treatment services under the insurance contract to either an inpatient or outpatient service;

(6) exclude from coverage the cost of medically necessary treatment, including medical or psychiatric evaluation, activity or family therapy, counseling, or prescription drugs or supplies received at an approved treatment facility; or

(7) deny reimbursement for actual services rendered solely because treatment was interrupted or not completed.

(d) Notwithstanding (a) of this section, if the insured or subscriber is an employer who employs fewer than 20 permanent, full-time employees for each working day during each of at least 20 calendar workweeks in either the current calendar year or the preceding calendar year, the insurer, hospital, or medical service corporation is not required to provide the coverage specified in (a) of this section to the insured or subscriber but shall offer that coverage to the insured or subscriber as optional coverage.

(e) In this section

(1) "alcoholism or drug abuse" means an illness characterized by

(A) a physiological or psychological dependency, or both, on alcoholic beverages or controlled substances as defined in AS 11.71.900; or

(B) habitual lack of self control in using alcoholic beverages or controlled substances to the extent that the person's health is substantially impaired or the person's social or economic function is substantially disrupted;

(2) "approved treatment facility" means treatment in a facility that is either approved under AS 47.37.140 or located and licensed for treatment of alcoholism or drug abuse in another state;

(3) "catastrophic illness insurance" means a major medical insurance contract or subscriber contract that provides benefits for hospital and medical care with potential lifetime maximum benefits per insured of at least $250,000 and that has a deductible of at least $5,000;

(4) "copayment" means the portion of the eligible expenses in excess of the deductible to be paid by the covered person;

(5) "cost" means the least of the following:

(A) the actual charge for the treatment received for alcoholism or drug abuse;

(B) the usual, customary, and reasonable charge for the treatment; or

(C) the charge agreed to by contract between the treatment provider and the insurer, hospital, or medical service corporation;

(6) "covered person" means the insured or subscriber or the insured or subscriber's covered spouse or dependent child;

(7) "deductible" means the portion of eligible expenses for which the covered person is responsible;

(8) "group health insurance" means a major medical insurance contract or subscriber contract that provides major medical coverage for five or more employees of the employer, but does not include catastrophic illness insurance;

(9) "major medical" means a health insurance contract, or subscriber contract that provides benefits for hospital and medical care with potential lifetime maximum benefits per insured of at least $10,000;

(10) "treatment" means medical care, including detoxification, as an inpatient or outpatient at an approved treatment facility. (§ 2 ch 150 SLA 1988; am §§ 47, 48, 49 ch 56 SLA 1996)

Effect of amendments. — The 1996 amendment, effective September 9, 1996, substituted "health" for "disability" in subsection (a) and in paragraphs (e)(8) and (e)(9).

Editor's notes. — Section 4, ch. 150, SLA 1988 provides: "AS 21.42.365, enacted by sec. 2 of this Act, applies to group disability insurance policies and hospital or medical service group subscriber contracts entered into or renewed on or after January 1, 1989."

Sec. 21.42.370. Separate accounts. (a) A domestic life insurance company may establish one or more separate accounts, and may allocate to an account amounts,

FEDERAL

THE MENTAL HEALTH PARITY ACT OF 1996
SUMMARY OF THE LAW

President Clinton signed the Mental Health Parity Act of 1996 (P.L. 104-204) into law on September 26, 1997. This landmark law, which received unprecedented bipartisan support, begins the process of ending the long-held practice of providing less insurance coverage for mental illnesses, or brain disorders, than is provided for equally serious physical disorders.

Key Provisions

- ⇒ The law takes effect on January 1, 1998, and expires on September 30, 2001.
- ⇒ The law equates aggregate lifetime limits and annual limits for mental health benefits with aggregate lifetime limits and annual limits for medical and surgical benefits. *(Typical caps for mental illness coverage are $50,000 for lifetime and $5,000 for annual, as compared with $1 million lifetime and no annual cap for other physical disorders.)*
- ⇒ The law covers mental illnesses (i.e., "mental health services," as defined under the terms of individual plans); it does not cover treatment of substance abuse or chemical dependency.
- ⇒ Existing state parity laws are not preempted by the federal law *(i.e., a state law requiring more comprehensive coverage would not be weakened by the federal law, nor does it preclude a state from enacting stronger parity legislation).*
- ⇒ The law applies only to employers that offer mental health benefits; it does not mandate such coverage.
- ⇒ The law allows for many cost-shifting mechanisms, such as adjusting limits on mental illness inpatient days, prescription drugs, outpatient visits, raising co-insurance and deductibles, and modifying the definition of medical necessity. *(Therefore, lower limits for inpatient and outpatient mental illness treatments are expected to continue, and in some cases, actually expand to help keep costs down.)*
- ⇒ The law applies to both fully insured state-regulated health plans and self-insured plans that are exempt from state laws under the Employee Retirement Income Security Act (ERISA), which are regulated by the Department of Labor.
- ⇒ The law has a small business exemption which excludes businesses with 50 employees or less.
- ⇒ The law allows an increased cost exemption; employers that can demonstrate a one percent or more rise in costs due to parity implementation will be allowed to exempt themselves from the law.

What's Not Covered

The Mental Health Parity Act of 1996 does not provide:

- ⇒ A mandate for mental health benefits to be offered in health insurance plans;
- ⇒ Coverage for treatment of substance abuse or chemical dependency;
- ⇒ Rules for service charges, such as co-payments, deductibles, out-of-pocket payment limits, etc.;
- ⇒ Designations for the number of inpatient hospital days or outpatient visits that must be covered;
- ⇒ Coverage in connection with Medicare or Medicaid;
- ⇒ Restrictions on a health insurance plan's ability to manage care; or
- ⇒ Provisions for business with 50 or fewer employees.

Federal Regulations

The Clinton Administration issued interim final regulations in the *Federal Register* (December 22, 1997) that set forth the guidelines for implementing the Mental Health Parity Act. The White House and the Office of Management and Budget (OMB) ruled that employers must first comply with the law in 1998 and develop a cost history of at least six months (retrospective data) before seeking an exemption. By contrast, some business groups had argued that firms be allowed to use the exemption based on estimates of higher costs (prospective data), thereby relieving them of the responsibility to ever comply. Those employers who had planned on using the prospective formula have been given a three-month grace period and must comply with the law by March 31, 1998, if they reasonably believed that the one percent cost increase would have been available to them on a prospective basis.

The regulations require employers using the exemption to notify all plan participants and the appropriate enforcement authority (e.g., state insurance commissioner, U.S. Department of Labor, U.S. Department of Health and Human Services, and the U.S. Department of Treasury). While neither the government, nor plan participants, will be able to see the "proprietary" data upon which the exemption is based, employers must provide a summary of the data upon which their one percent cost increase claim is based. This summary must include overall plan expenditures, the dollar value of claims that would have been denied if parity were not in place, and administrative costs attributable to compliance with the law. Plan sponsors will be specifically barred from including any individually identifiable information in a data summary. Once an employer submits a notice under the one percent exemption, they will have to wait 30 days before the exemption becomes effective. However, this notice is not a formal application and employers do not have to wait for approval from the government before proceeding.

The notices that employers provide to the government under the one percent exemption will be part of the public record and will allow third parties, including NAMI and its state and local affiliates, to access the names of these employers.

Benefits for American Families

The principle beneficiaries of the Mental Health Parity Act will be persons with the most severe, persistent and disabling of brain disorders because they are, on average, more likely to exceed annual and lifetime benefits.

Mental Health Insurance Parity

Why Consider it?

- Nine out of 10 insurance companies treat mental illnesses differently from other physical illnesses
- Mental illnesses are biological brain disorders & should be treated like other illnesses
- Mental Illness is treatable and treatment costs less then treatment of many other common physical illnesses
- The ***cost*** of mental health parity is ***minimal*** to non-existent! Based on ***actual*** data from states that have passed parity legislation

Mental Health Insurance Parity

Fact Sheet

General

- Nine out of 10 insurance policies treat mental health differently from physical health problems.
- In 1996 the federal government passed the Mental Health Parity Act, otherwise known as the Dominici Wellstone Law, which goes into effect in January 1998. This law provides partial parity regarding lifetime and annual limits, but there are significant loopholes. It does not provide true parity.
- Fifteen states have passed parity legislation, these states include: Texas, Maine, New Hampshire, Maryland, Rhode Island, Minnesota, Maine, Arkansas, Arizona, Colorado, Connecticut, Indiana, Missouri, South Carolina, and Vermont.
- In 1997, 34 states considered parity legislation, nine states passed legislation while additional states passed legislation in one body and will seek passage in the other body in 1998.

Mental Illnesses *are* Treatable

- Treatment for bipolar disorder has an 80-90% success rate, treatment of major depression 70-80% successful, and treatment of acute schizophrenia is 60% successful. Treatment of heart disease has just a 45-50% success rate and often requires expensive, dangerous surgery. (1)
- Treatment of mental illness is more affordable now then in the past. With new generations of medications continually being developed, there is increased precision in relieving symptoms and eliminating side effects associated with past treatments.
- The annual cost of treating a person with severe diabetes has been found to be more expensive then treating a person with schizophrenia. (1) In Texas, the total cost of treating state employees and family members with brain disorders was one-fifth the cost of treating cardiovascular disease. (2)
- About 2.8% of all adult Americans, some 5 million people, suffer from a brain disorder. Approximately 40% of those people do not or can not seek treatment, in part, due to a lack of adequate insurance coverage. (3)
- It is estimated that 90% of insurance companies offer less benefits for treatment of mental illness then other physical conditions.

Costs of Mental Health Parity

- A study by the Rand Corporation, published in the *Journal of the American Medical Association,* showed that equalizing annual limits - a key to the provision of the federal Mental Health Parity Act - will only increase costs by only $1 per employee per year. (4)
- The same study showed that more comprehensive change required by some state laws (i.e. removing limits on inpatient days and outpatient visits) will increase costs by less than $7 per enrollee per year. (4)
- Since the 1994 passage of the Rhode Island parity bill, premium costs have only increased by 30 cents per person per month. (5)
- In North Carolina, where they passed a parity bill 1992, total mental health costs have actually *declined* 3.4%. (6)
- Persons who have inadequate mental health coverage and need extensive mental health treatment often end up using public resources such as Medicaid and Medicare.
  A total of $26.6 billion was spent on treating severe mental illness in the US in 1990. 57% of all treatment costs for severe mental illness was paid by federal and state entitlement programs at tax-payers expense, whereas, Tax-payers pay only 43% of the costs of all other illnesses. (3)

Alaska

- Prior to the enactment of the federal legislation, the state of Alaska limited the mental health benefits available for their own employees to a $25,000 *lifetime* maximum cost cap, while other medical services were covered up to a $1,000,000 lifetime benefit.
- Many private insurance plan in Alaska have low annual limits on mental health benefits or require larger co-payment for mental health services (such as paying 50% of the cost for mental health services, while paying 70% to 90% for other medical services).

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1.) National Advisory Mental Health Council, Health care reform for Americans with severe mental illness; report of the National Advisory Mental Health Council, American Journal of Psychiatry, 1993; 150: 1447-1465
2.) FY 94-96, HealthSelect of Texas, administered by Blue Cross-Blue Shield of Texas.
3.) National Institute of Mental Health
4.) Sturm, R. (1997). How Expensive is Unlimited Mental Health Care Coverage Under Managed Care? . *Journal of the American Medical Association*. 278:18, p.1533-1537
5.) Emmet, W., Alliance for the Mentally Ill, Rhode Island, April 1996
6.) Cameron, S., Executive Director, North Carolina Psychological Association, "State Health Plan Data on the Mental Health Benefit," April 30, 1996.

States that have Passed Parity

State	Enactment	Type of Bill	Effective On
Texas	1990	Diagnosis-Based; covers all state employees, including local, county, municipal, public higher education and public school employees.	09/01/91
Maine	1993	Diagnosis-Based; covers all groups of 20 plus employees; raised minimum benefits to 100K lifetime; 60 days annual inpatient; 2K outpatient	01/01/94
New Hampshire	1994	Diagnosis-based; applies only to groups & HMOs regardless of size	01/01/95
Maryland	1994	All mental health and substance abuse; medical treatment only	08/01/94
Rhode Island	1994	Diagnosis-based; all health care and HMO policies; in and outpatient equal	01/01/95
Minnesota	1995	All mental Health and chemical Dependency Services equal to in-patient and outpatient medical services	08/01/95
Maine	1995	Diagnosis-based; groups of 20 plus employees; all co-pays and caps, both annual and lifetime equal to all other medical coverage	07/01/96
Arkansas	1997	Equal coverage for mental health and developmental disorders; limitations are cost increase may not exceed 1.5%; only groups of 50 plus employees	06/01/97
Arizona	1997	Mental Illness, mirrors Federal Domenici-Wellstone law, no substance abuse	
Colorado	1997	Diagnosis-based; all co-payment and caps both annual and lifetime are equal to all other medical coverage	
Connecticut	1997	Diagnosis-based; all insurance and HMOs; coverage equal to medical / surgical	10/01/97
Indiana	1997	Mental illness, mirrors Federal Domenici-Wellstone law, no substance abuse and full parity for state employees; including co-pays, caps and lifetime limits	
Missouri	1997	All DSM-VI in managed care plans only; part of larger managed-care regulatory bill	09/01/97
South Carolina	1997	Mental illness, mirrors Federal Domenici-Wellstone law. no substance abuse	
Texas	1997	Diagnosis-based; employee groups of 50 plus; limitations: 60 outpatient visits & 45 inpatient days annually.	01/01/98
Vermont	1997	All mental health and substance abuse	01/01/98

Mental Health Parity Task Force
Draft Work Plan/Time Line
July 9, 1998

Prior to First Meeting

- Finalize Task Force Membership
- Draft guiding principles for Task Force
- Initial research on information available from other states
- Arrange first face-to-face Task Force meeting

August

- Hold first in-person Task Force meeting. Agenda to include
  - review mission from legislation
  - provide background information on parity (federal legislation, etc.)
  - review/approve guiding principles
  - review work plan and time line
  - discuss budget and staffing
  - discuss opportunities for public testimony
- Develop specifications for contract(s) and/or staffing

September

- Selection of contractor(s) and/or staff
- Hold teleconference meeting (one or two). Agenda to include:
  - review definitions of "mental illness", "serious mental illness", "mental injury" and "mental health consumer"
  - review summary information from other states
  - select options for further consideration
  - public testimony?

October

- Hold teleconference meeting (one or two). Agenda to include:
  - summary information from contractor on various approaches to parity
  - begin to formulate potential actions/recommendations to Legislature
  - review outline/table of contents for final report
  - clarify additional information needed

November

- Hold in-person meeting. Agenda to include:
  - Review draft recommendations/actions for inclusion in final report
- Discuss menu of parity options and prioritize options for inclusion in final report

December

- Hold in-person or teleconference meeting(s) to review/adopt final report

Elmer
talk ab sub ab.
early on

Pat
- pub testimony imp.

Thelma
- diff betw indemnity & self-insured plans. Would be elim. self must follow by self-insured
- Juv other exclusions also

W/C & disability insurance cover?
Juv
- put diff legal framework

- budget for next time
Torgerson

- pub test:
- Very more meaningful in person

- 2nd public testimony once recs. before session

Draft Guiding Principles
for the
Mental Health Parity Task Force
August, 1998

1. Achieving greater parity between mental health and physical health care coverage is an important public policy objective.
2. There needs to be a balance between private and public health care coverage for persons with mental disorders.
3. Whenever possible, mental health coverage should be included as part of comprehensive health care coverage in the public and private sectors.
4. Cost of mental health parity is an important consideration; mental health parity should not place an undue economic burden on employers.
5. Cost of mental health parity should be considered in comparison to costs for physical care coverage.
6. Lack of mental health insurance options needs to be recognized as an impediment to employment for persons with mental disorders.
7. A variety of options should be considered in developing recommendations for addressing mental health parity in Alaska.
8. Mental health parity should be recognized as a mechanism to help reduce reliance on Medicaid and Adult Public Assistance for persons with mental disorders.

Others?

#9 Tom ~~ok on sub ab. clause~~
Alcohol & substance abuse must be considered as part of the research related to mh parity

#10 ~~The MH Parity~~
The Task Force recognizes that substantial education is necessary to eliminate stigma associated w/ MI sub abuse & alcoholism

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Parity

Mental Health Parity Act Summary

STATUS

On December 22, 1997, the Departments of the Treasury, Labor, and Health and Human Services published in the Federal Register an interim final regulation implementing the provisions of the Mental Health Parity Act of 1996 (MHPA). The provisions of the law and regulation are effective for group health plans for plan years beginning on or after January 1, 1998. There are no special effective date provisions for collectively bargained plans. Comments on the interim final regulations will be accepted through March 23, 1998.

BRIEF SUMMARY

MHPA provides that a group health plan or insurance offered in connection with a plan, providing both medical/surgical benefits and mental health benefits, may not impose an aggregate lifetime dollar limit or annual dollar limit on mental health benefits that is less than such a limit on medical/surgical benefits.

Group health plans and health insurance are not required by MHPA to provide mental health benefits. In addition, the law does not affect the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits.

The MHPA provides two exemptions from the parity requirements. The first exemption is for small employers (defined as an employer with at least 2 but not more than 50 employees). The second exemption is for group health plans if the application of these provisions results in an increase in the cost under the plan or coverage of at least 1 percent. The regulation requires all plans to implement parity for at least six months. For most plans this will be the first six months of the first plan year beginning on or after January 1, 1998. However, a plan may claim an exemption from parity if, based on at least six months actual data with parity in place, a plan has experienced a one percent or more cost increase attributable to the application of the parity provisions. (Six months of actual data includes all claims incurred during the six months period and reported within eight months after implementation of parity.) Increased costs do not include premium payments. The exemption is not effective until 30 days after the plan notifies participants and beneficiaries of the plan's decision to claim the one percent increased cost exemption. Plans also must send a copy of the notice to the government. MHPA provisions are effective for plan years beginning on or after January 1, 1998. MHPA includes a sunset provision under which the MHPA requirements do not apply to benefits for services furnished on or after September 30, 2001.

DETAILED SUMMARY OF THE LAW

The Mental Health Parity Act of 1996 (MHPA) amended the Public Health Service Act (PHSA) and the Employee Retirement Income Security Act of 1974 (ERISA) to provide for parity in the application of dollar limits on certain mental health benefits when limits are placed on medical and surgical benefits.

Substantially similar provisions implementing MHPA were later added to the Internal Revenue Code of 1986 (Code) under the Taxpayer Relief Act of 1997. Health coverage is regulated, in part, by the Federal government, under ERISA and the PHS Act, and other Federal provisions including the Code, and, in part, by the States.

MHPA provides that a group health plan, or health insurance coverage offered in connection with a group health plan, providing both medical and surgical benefits and mental health benefits may not impose an aggregate lifetime dollar limit or annual dollar limit on mental health benefits if it does not also impose such a limit on substantially all of the medical and surgical benefits.

> If the plan does impose an aggregate lifetime dollar limit or annual dollar limit on substantially all medical and surgical benefits, the plan cannot impose a limit on mental health benefits that is less than that applied to the medical and surgical benefits.
>
> If a group health plan offers two or more benefit package options under the plan, the requirements of the MHPA apply separately to each option.
>
> The MHPA makes clear that the requirements of the law apply to group health plans and health insurance issuers offering coverage under such plans regardless of whether the mental health benefits are separately administered under the plan.

There are many ways under the law that plans and issuers are permitted to use to control plan costs.

> Group health plans and health insurance coverage offered in connection with group health plans are not required by MHPA to provide mental health benefits.
>
> In addition, the law does not affect the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under a plan or coverage except as specifically provided in regard to parity of aggregate lifetime limits and annual limits.
>
> MHPA protections do not extend to benefits for substance abuse or chemical dependency.

The MHPA also provides two exemptions from these requirements.

> The first exemption is for small employers (defined as an employer with at least 2 but not more than 50 employees).
>
> The second exemption is for group health plans if the application of these provisions results in an increase in the cost under the plan or coverage of at least 1 percent. The statute is very brief and general, and does not prescribe what costs must be considered, or how the exemption is to be administered.

MHPA provisions for group health plans are effective beginning on or after January 1, 1998. MHPA includes a sunset provision under which the MHPA requirements do not apply to benefits for services furnished on or after September 30, 2001.

PROVISIONS OF THE REGULATIONS

Weighted Average

If a plan has no or different aggregate lifetime limits or annual limits on different categories of medical and surgical benefits, the interim rule establishes rules to calculate an average aggregate lifetime limit or annual limit for mental health benefits that is computed taking into account the weighted average of such limits applicable to the different categories.

Definition of "Substantially All"

The law provides that a plan or coverage that includes an annual dollar limit on substantially all medical and surgical benefits must either apply the annual dollar limit both to the medical and surgical benefits and to the mental health benefits and not distinguish in the application of the limit between these benefits; or not include any annual limit on mental health benefits that is less than the applicable annual limit on medical and surgical benefits.

The regulation interprets "substantially all medical and surgical benefits" as at least two-thirds of the dollar amount of all plan payments for medical and surgical benefits covered under the plan=s benefit package. A plan or coverage that includes either no annual dollar limits or different annual dollar limits on different categories of medical and surgical benefits must comply by substituting, for the aggregate lifetime or annual limits, an average limit that is computed by taking into account the weighted average of the aggregate lifetime or annual limit, as appropriate, that is applicable to the categories of benefits. An unlimited benefit is valued as a reasonable estimate of the upper limit on the dollar amount a plan may incur with respect to that benefit.

Increased Cost Exemption

The interim rule also describes the exemption from MHPA=s requirements if the application of MHPA results in an increase in the cost under the plan or coverage of at least one percent.

Generally, plans must implement parity for the first plan year beginning on or after January 1, 1998, but may claim an exemption from parity if, based on at least six months actual data, a plan has experienced a one percent or more cost increase.

A plan that complied with parity after the date of enactment of the law, but before the date that the plan becomes subject to the requirements of the interim rule, may use data from that period to show a cost increase justifying an exemption.

Increased costs do not include premium payments.

The exemption is not effective until 30 days after the plan notifies participants and beneficiaries of the plan's decision to claim the one percent increased cost exemption. Plans also must send a copy of the notice to the government. (See copy below.)

To claim the one percent increased cost exemption:

- A group health plan that is a church plan must furnish the notice to the

Department of the Treasury.

- A group health plan subject to Part 7 of Subtitle B of Title I of ERISA must furnish the notice to the Department of Labor.
- A group health plan that is a nonfederal governmental plan must furnish the notice to the Department of Health and Human Services.

See below for addresses.

Any notice submitted to the Department of Labor or Health and Human Services will be available for public inspection.

Finally, to claim the one percent increased cost exemption, a plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information required to support the exemption. An individual who is not a participant or beneficiary and who presents a notice is considered to be a representative. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with parity, and the administrative expenses attributable to complying with the parity requirements. In no event should a summary of information include individually identifiable information.

Issuers

An issuer (that is, an insurer or a managed care organization) that provides group health insurance coverage to group health plans may sell a policy without parity only to a group health plan that meets the requirements of one of the exemptions under the regulations.

After a plan meets the one percent cost exemption requirements, it may change issuers without having to meet those requirements again before the sunset of the MHPA, September, 30, 2001.

Jurisdiction

The provisions of MHPA are set forth in Chapter 100 of Subtitle K of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act. The Secretaries of the Treasury, Labor, and Health and Human Services share jurisdiction over the MHPA provisions. These provisions are substantially similar, except as follows:

The MHPA provisions in the Code generally apply to all group health plans other than governmental plans, but they do not apply to health insurance issuers. A taxpayer that fails to comply with these provisions may be subject to an excise tax under section 4980D of the Code.

The MHPA provisions in ERISA generally apply to all group health plans other than governmental plans, church plans, and certain other plans. These provisions also apply to health insurance issuers that offer health insurance coverage in connection with such group health plans. Generally, the Secretary of Labor enforces the MHPA provisions in ERISA, except that no enforcement action may be taken by the Secretary against issuers. However, individuals may generally pursue actions against issuers under ERISA and, in some circumstances, under State law.

The MHPA provisions in the PHS Act generally apply to health insurance issuers that offer health insurance coverage in connection with group health plans and to certain State and local governmental plans. States, in the first instance, enforce the PHS Act with respect to issuers. Only if a State does not substantially enforce any provisions that apply to issuers under its insurance laws will the Department of Health and Human Services enforce the provisions, through the imposition of civil money penalties. Moreover, no enforcement action may be taken by the Secretary of Health and Human Services against any group health plan except certain State and local governmental plans.

Transition Provisions

The interim rules provide a limitation on enforcement actions for requirements other than the one percent increased cost exemption. No enforcement action can be taken by any of the Secretaries against a group health plan (or issuer) that has sought to comply in good faith with the requirements of the law before the earlier of: (a) the first day of the first plan year beginning on or after April 1, 1998, or (b) January 1, 1999. Compliance with the requirements of the interim rules is deemed to be good faith compliance.

With respect to the increased cost exemption, the interim rules provide a transition period for compliance with the requirements. No enforcement action will be taken against a group health plan (or issuer) that is subject to the MHPA requirements prior to April 1, 1998 solely because the plan has claimed the increased cost exemption based on assumptions inconsistent with the interim rules, provided that the plan is amended to comply with the parity requirements no later than March 31, 1998 and the plan complies with certain notice requirements.

A group health plan utilizing the transition provision must provide notice to the applicable federal agency and post notice at the location(s) where documents must be made available for examination under ERISA regulations. (See model and addresses, below.)

The notice must indicate the plan's intent to use the transition period by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. In all cases, the notice must include: the date; the name of the plan and the plan number; the name, address, and telephone number of the plan sponsor or plan administrator; the employer identification number (in the case of single-employer plans only); the individual to contact for further information; the signature of the plan administrator; and the date signed. In addition, the notice must be provided at no charge to participants and beneficiaries (or their representatives) within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

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Parity

Mental Health Parity Act of 1996

Federal Parity Amendment PL 104-204 as finally enacted PUBLIC LAW 104-204
104th Congress -- 2nd Session
H.R. 3666
104 P.L. 204, *; 110 Stat. 2874,*;
1996 Enacted H.R. 3666, *; 104 Enacted H.R. 3666, *;

DATE: SEPT. 26, 1996 -- PUBLIC LAW 104-204
SYNOPSIS: An Act

Making appropriations for the Departments of Veterans Affairs and Housing and Urban Development, and for sundry independent agencies, boards, commissions, corporations, and offices for the fiscal year ending September 30, 1997, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the Departments of Veterans Affairs and Housing and Urban Development, and for sundry independent agencies, boards, commissions, corporations, and offices for the fiscal year ending September 30, 1997, and for other purposes, namely:

[The Mental Health Parity Amendment came at the end of the bill, after the following: Title1 - Department Of Veterans Affairs - Veterans Benefits Administration , compensation and pensions, (including transfers of funds) ; Title II -- Department Of Housing And Urban Development - Housing Programs, Development of Additional New Subsidized Housing ; Title III -- Independent Agencies - American Battle Monuments Commission , Salaries And Expenses; Title IV--general Provisions; Title V --supplemental Department Of Veterans Affairs -- Veterans Benefits Administration, Compensation And Pensions ; Title VI-- Newborns' And Mothers' Health Protection Act Of 1996]

TITLE VII--PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS

{*701} Sec. 701. Short Title.-- This title may be cited as the "Mental Health Parity Act of 1996".

{*702} Sec. 702. Amendments to the Employee Retirement Income Security Act of 1974.--(a) In General.--Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by section 603(a)) is amended by adding at the end the following new section:

712 " Sec. 712. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

"(a) In General.--

"(1) Aggregate lifetime limits.-- In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both

medical and surgical benefits and mental health benefits--

"(A) No lifetime limit.--If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

"(B) Lifetime limit.--If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable lifetime limit'), the plan or coverage shall either--

"(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

"(C) Rule in case of different limits.--In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

"(2) Annual limits.-- In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits--

"(A) No annual limit.--If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

"(B) Annual limit.--If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable annual limit'), the plan or coverage shall either--

"(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

"(C) Rule in case of different limits.--In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

"(b) Construction.--Nothing in this section shall be construed--

"(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

"(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

"(c) Exemptions.--

"(1) Small employer exemption.----

"(A) In general.--This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

"(B) Small employer.--For purposes of subparagraph (A), the term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

"(C) Application of certain rules in determination of employer size.-- For purposes of this paragraph--

"(i) Application of aggregation rule for employers.--Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

"(ii) Employers not in existence in preceding year.--In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(iii) Predecessors.--Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

"(2) Increased cost exemption.-- This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

"(d) Separate Application to Each Option Offered.-- In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

"(e) Definitions.--For purposes of this section--

"(1) Aggregate lifetime limit.-- The term 'aggregate lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(2) Annual limit.-- The term 'annual limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(3) Medical or surgical benefits.-- The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be) , but does not include mental health benefits.

"(4) Mental health benefits.-- The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

"(f) Sunset.--This section shall not apply to benefits for services furnished on or after September 30, 2001.".

(b) Clerical Amendment. --The table of contents in section 1 of such Act, as amended by section 603 of this Act, is amended by inserting after the item relating to section 711 the following new item: "Sec. 712. Parity in the application of certain limits to mental health benefits.".

(c) Effective Date.--The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

{*703} Sec. 703. Amendments to the Public Health Service Act Relating to the Group Market.--(a) In General.- -Subpart 2 of part A of title XXVII of the Public Health Service Act (as added by section 604(a)) is amended by adding at the end the following new section:

2705 "Sec. 2705. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

"(a) In General.--

"(1) Aggregate lifetime limits.- - In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits--

"(A) No lifetime limit.--If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

"(B) Lifetime limit.--If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable lifetime limit') , the plan or coverage shall either--

"(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

"(C) Rule in case of different limits.--In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

"(2) Annual limits.-- In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits--

"(A) No annual limit.- -If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

"(B) Annual limit.--If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the 'applicable annual limit'), the plan or coverage shall either --

"(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

"(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

"(C) Rule in case of different limits.--In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

"(b) Construction.--Nothing in this section shall be construed--

"(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

"(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the

imposition of aggregate lifetime limits and annual limits for mental health benefits).

"(c) Exemptions.--

"(1) Small employer exemption.-- This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

"(2) Increased cost exemption.-- This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

"(d) Separate Application to Each Option Offered.--In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

"(e) Definitions.--For purposes of this section--

"(1) Aggregate lifetime limit.-- The term 'aggregate lifetime limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(2) Annual limit.- - The term 'annual limit' means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

"(3) Medical or surgical benefits.-- The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

"(4) Mental health benefits. -- The term 'mental health benefits' means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

"(f) Sunset. --This section shall not apply to benefits for services furnished on or after September 30, 2001.".

(b) Effective Date.-- The amendments made by this section shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.

This Act may be cited as the "Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act, 1997".

There were eight versions of this bill considered during the Congressional

session in 1996. The dates were June 19, 27, and 28; July 2 and 12; September 9 (2 versions considered that day), and September 26.

DEBATE: 142 Congressional Record, 104th Congress, 2nd Session - 1996
Apr. 18, Senate consideration and adoption of Domenici/Wellstone Amendment No. 3681 to S. 1028, p. S3588.
June 25, House consideration of H.R. 3666, p. H6799.
June 26, House consideration and passage of H.R. 3666, p. H6856.
Aug. 1, Senate consideration of H.R. 3666, p. S9416.
Sept. 3, Senate consideration of H.R. 3666, p. S9691.
Sept. 4, Senate consideration of H.R. 3666, p. S9821.
Sept. 5, Senate consideration and passage of H.R. 3666 with amendments, p. S9875.
Sept. 20, Submission in the House of the conference report on H.R. 3666, p. H10733.
Sept. 24, House agreement to the conference report on H.R. 3666, p. H10951.

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Part V

Department of the Treasury
Internal Revenue Service
26 CFR Part 54

Department of Labor
Pension Welfare Benefits Administration
29 CFR Part 2590

Department of Health and Human Services
Health Care Financing Administration
45 CFR Part 146

Mental Health Parity; Interim Rules
HIPAA Mental Health Parity Act; Proposed Rule

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 54
[T.D. 8741]
RIN 1545-AV53

DEPARTMENT OF LABOR
Pension and Welfare Benefits Administration
29 CFR Part 2590
RIN 1210-AA62

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
45 CFR Part 146
RIN 0938-AI05

Interim Rules for Mental Health Parity

AGENCIES: Internal Revenue Service, Department of the Treasury; Pension and Welfare Benefits Administration, Department of Labor; Health Care Financing Administration, Department of Health and Human Services.

ACTION: Interim rules with request for comments.

SUMMARY: This document contains interim rules governing parity between medical/surgical benefits and mental health benefits in group health plans and health insurance coverage offered by issuers in connection with a group health plan. The rules contained in this document implement changes made to certain provisions of the Internal Revenue Code of 1986 (Code), the Employee

Retirement Income Security Act of 1974 (ERISA or Act), and the Public Health Service Act (PHS Act) enacted as part of the Mental Health Parity Act of 1996 (MHPA) and the Taxpayer Relief Act of 1997. Interested persons are invited to submit comments on the interim rules for consideration by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (Departments) in developing final rules. The rules contained in this document are being adopted on an interim basis to ensure that sponsors and administrators of group health plans, participants and beneficiaries, States, and issuers of group health insurance coverage have timely guidance concerning compliance with the requirements of MHPA.

DATES: *Effective date.* The interim rules are effective January 1, 1998.

Applicability dates. The requirements of MHPA and the interim rules apply to group health plans and health insurance issuers offering health insurance coverage in connection with a group health plan for plan years beginning on or after January 1, 1998. MHPA includes a sunset provision under which the MHPA requirements do not apply to benefits for services furnished on or after September 30, 2001.

Information collection. Affected parties are not required to comply with the information collection requirements in these interim rules until the Departments publish in the Federal Register the control numbers assigned to these information collection requirements by the Office of Management and Budget (OMB). Publication of the control numbers notifies the public that OMB has approved these information collection requirements under the Paperwork Reduction Act of 1995. The Departments have submitted a copy of this rule to OMB for its review of the information collections. Interested persons are invited to send comments regarding these burdens or any other aspect of these collections of information on or before February 20, 1998.

Comments. Written comments on these interim rules are invited and must be received by the Departments on or before March 23, 1998.

ADDRESSES: Comments on the information collection requirements should be sent directly to:

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attention: HCFA Desk Officer.

Health Care Financing Administration, Office of Financial and Human Resources, Management Planning and Analysis Staff, Room C2-26-17, 7500 Security Boulevard, Baltimore, MD 21244-1850; Attention: John Burke

Written comments on other aspects of the interim rules should be submitted with a signed original and three copies (except for electronic submissions sent to the Internal Revenue Service (IRS)) to any of the addresses specified below. For convenience, comments may be addressed to any of the Departments. Comments addressed to any Department will be shared with the other Departments. Comments to the IRS can be addressed to: CC:DOM:CORP:R (REG-109704-97), Room 5228, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044.

In the alternative, comments may be hand-delivered between the hours of 8 a.m. and 5 p.m. to: CC:DOM:CORP:R (REG-109704-97), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC 20224.

Alternatively, taxpayers may transmit comments electronically via the IRS Internet site at: http://www.irs.ustreas.gov/prod/tax_reg/comments.html.

Comments to the Department of Labor can be addressed to: U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, NW., Room N-5669, Washington, DC 20210; Attention: MHPA Comments.

Alternatively, comments may be hand-delivered between the hours of 9 a.m. and 5 p.m. to the same address.

Comments to the Department of Health and Human Services can be addressed to: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-2891-IFC, P.O. Box 26688, Baltimore, MD 21207.

In the alternative, comments may be hand-delivered between the hours of 8:30 a.m. and 5:00 p.m. to either:

Room 309-G, Hubert Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201
or
Room C5-09-26, 7500 Security Boulevard, Baltimore, MD 21244-1850

All submissions to the Internal Revenue Service will be open to public inspection and copying in Room 1621, 1111 Constitution Avenue, NW, Washington, DC from 9:00 a.m. to 4:00 p.m.

All submissions to the Department of Labor will be open to public inspection and copying in the Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5638, 200 Constitution Avenue, NW, Washington, DC from 8:30 a.m. to 5:30 p.m.

All submissions to the Department of Health and Human Services will be open to public inspection and copying in Room 309-G of the Department of Health and Human Services offices at 200 Independence Avenue, SW, Washington, DC from 8:30 a.m. to 5:00 p.m.

FOR FURTHER INFORMATION CONTACT: Terese Klitenic, Health Care Financing Administration, Department of Health and Human Services, at (410) 786-1565; Mark Connor, Pension and Welfare Benefits Administration, Department of Labor, at (202) 219-4377; or Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-4695.

Customer service information. Individuals interested in obtaining a copy of the Department of Labor's booklet entitled "Questions and Answers: Recent Changes in Health Care Law," which includes information on MHPA, may call the following toll-free number: 1-800-998-7542.

SUPPLEMENTARY INFORMATION:

A. Background

The Mental Health Parity Act of 1996 (MHPA) was enacted on September 26, 1996 (Pub. L. 104-204, 110 Stat. 2944). MHPA amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) to provide for parity in the application of certain dollar limits on

mental health benefits with dollar limits on medical/surgical benefits. Provisions implementing MHPA were later added to the Internal Revenue Code of 1986 (Code) under the Taxpayer Relief Act of 1997 (Pub. L. 105-34).

1. Regulatory Responsibility

The provisions of MHPA are set forth in Chapter 100 of Subtitle K of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act.The Secretaries of the Treasury, Labor, and Health and Human Services share jurisdiction over the MHPA provisions. These provisions are substantially similar, except as follows:

- The MHPA provisions in the Code generally apply to all group health plans other than governmental plans, but they do not apply to health insurance issuers. A taxpayer that fails to comply with these provisions may be subject to an excise tax under section 4980D of the Code.
- The MHPA provisions in ERISA generally apply to all group health plans other than governmental plans, church plans, and certain other plans. These provisions also apply to health insurance issuers that offer health insurance coverage in connection with such group health plans. Generally, the Secretary of Labor enforces the MHPA provisions in ERISA, except that no enforcement action may be taken by the Secretary against issuers. However, individuals may generally pursue actions against issuers under ERISA and, in some circumstances, under State law.
- The MHPA provisions in the PHS Act generally apply to health insurance issuers that offer health insurance coverage in connection with group health plans and to certain State and local governmental plans. States, in the first instance, enforce the PHS Act with respect to issuers. Only if a State does not substantially enforce any provisions under its insurance laws will the Department of Health and Human Services enforce the provisions, through the imposition of civil money penalties. Moreover, no enforcement action may be taken by the Secretary of Health and Human Services against any group health plan except certain State and local governmental plans.

The interim rules being issued today by the Secretaries of the Treasury, Labor, and Health and Human Services have been developed on a coordinated basis by the Departments. In addition, these interim rules take into account comments received by the Departments in response to the request for public comments on MHPA published in the Federal Register on June 26, 1997 (62 FR 34604). Except to the extent needed to reflect the statutory differences described above, the interim rules of each Department are substantively identical. However, there are certain non-substantive differences. The interim rules reflect certain stylistic differences in language and structure to conform to conventions used by a particular Department. These differences have been minimized and any differences in wording are not intended to create any substantive difference.

2. Preemption of State Laws

The McCarran-Ferguson Act of 1945 (Pub. L. 79-15) exempts the business of insurance from federal antitrust regulation to the extent that it is regulated by the States and indicates that no federal law should be interpreted as overriding State insurance regulation unless it does so explicitly. Section 514(a) of ERISA preempts State laws relating to employee benefit plans (including group health plans). Section 731 of ERISA and section 2723 of the PHS Act provide that Part 7 of Subtitle B of Title I of ERISA and Part A of Title XXVII of the PHS Act (including the MHPA provisions) do not in any way affect or modify section 514

of ERISA with respect to group health plans.

Section 514(b)(2) of ERISA saves from preemption any State law that regulates insurance. However, section 731(a) of ERISA and section 2723(a) of the PHS Act preempt State insurance laws relating to health insurance issuers in connection with group health insurance coverage to the extent such laws "prevent the application of" Part 7 of Subtitle B of Title I of ERISA or Part A of Title XXVII of the PHS Act, including the MHPA provisions. (There is no corresponding provision in the Code.) In this regard, the conference report to HIPAA states that the conferees generally intended the narrowest preemption of State laws with regard to health insurance issuers (not group health plans) with respect to the provisions of Part 7 of Subtitle B of Title I of ERISA and Part A of Title XXVII of the PHS Act. Consequently, the conference report to HIPAA states that State laws with regard to health insurance issuers that are broader than federal requirements in certain areas would not "prevent the application of" the provisions of Part 7 of Subtitle B of Title I of ERISA or Part A of Title XXVII of the PHS Act. Further, the conference report to MHPA states that the application of these preemption provisions should permit the operation of any State law or provision that requires more favorable treatment of mental health benefits under health insurance coverage than that required under the MHPA provisions.

However, the preemption is broader for the statutory requirements of section 701 of ERISA and section 2701 of the PHS Act that limit the application of preexisting condition exclusions. Under these broader provisions, State laws cannot "differ" from the preexisting condition exclusion requirements of section 701 of ERISA or section 2701 of the PHS Act except as specifically permitted by section 731(b)(2) of ERISA and section 2723(b)(2) of the PHS Act. These provisions permit a State to impose on health insurance issuers certain stricter limitations relating to preexisting condition exclusions.

Thus, generally, a State law that requires more favorable treatment of mental health benefits under health insurance coverage offered by issuers would not be preempted by the provisions of MHPA and the interim rules.

B. Overview of MHPA and the Interim Rules

The MHPA provisions are set forth in section 9812 of the Code, section 712 of ERISA, and section 2705 of the PHS Act. MHPA and the interim rules apply to a group health plan (or health insurance coverage offered by issuers in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits.

The MHPA provisions provide for parity in the application of aggregate lifetime dollar limits, and annual dollar limits, between mental health benefits and medical/surgical benefits. If a group health plan offers two or more benefit packages under the plan, the requirements of MHPA and the interim rules apply separately to each package. The interim rules make clear that the MHPA requirements apply regardless of whether the mental health benefits are administered separately under the plan. In addition, the interim rules make clear that the MHPA requirements in ERISA and the PHS Act apply both to group health plans and to health insurance issuers offering coverage in connection with a group health plan.

MHPA and the interim rules do not require a group health plan (or health insurance coverage offered in connection with a group health plan) to provide mental health benefits. In addition, MHPA and the interim rules do not affect the terms and conditions (including cost sharing, limits on the number of visits or

days of coverage, requirements relating to medical necessity, requirements that patients or providers obtain prior authorization for treatment, and requirements relating to primary care physicians' referrals for treatment) relating to the amount, duration, or scope of mental health benefits under a plan (or coverage) except as specifically provided in regard to parity of aggregate lifetime dollar limits and annual dollar limits.

1. Aggregate Lifetime Limits and Annual Limits

Under MHPA and the interim rules, a group health plan (or health insurance coverage offered in connection with a group health plan) providing both medical/surgical benefits and mental health benefits may comply with the MHPA parity requirements in any of the following general ways:

- The plan (or coverage) may comply by not including any aggregate lifetime dollar limit or annual dollar limit on mental health benefits.
- The plan (or coverage) may comply by imposing a single aggregate lifetime or annual dollar limit on both medical/surgical benefits and mental health benefits in a way that does not distinguish between the two.
- The plan (or coverage) may comply by imposing an aggregate lifetime dollar limit or annual dollar limit on mental health benefits that is not less than the aggregate lifetime dollar limit or annual dollar limit on medical/surgical benefits.
- In the case of a plan (or coverage) under which aggregate lifetime dollar limits or annual dollar limits differ for categories of medical/surgical benefits, the plan (or coverage) may comply by calculating a weighted average aggregate lifetime dollar limit or weighted average annual dollar limit for mental health benefits. The weighted average must be based on a formula in the interim rules that takes into account the limits on different categories of medical/ surgical benefits.

In addition, under MHPA and the interim rules, benefits for treatment of substance abuse or chemical dependency may not be counted in applying an aggregate lifetime or annual dollar limit that applies separately to mental health benefits.

2. Exemptions from the Requirements of MHPA

(a) Small Employer Exemption

The parity requirements under MHPA and the interim rules do not apply to any group health plan (or health insurance coverage offered in connection with a group health plan) for any plan year of a small employer. The term "small employer" is defined as an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

For purposes of the small employer exemption, all persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Code (26 U.S.C. 414) are treated as one employer. In addition, if an employer was not in existence throughout the preceding calendar year, whether the employer is a small employer is determined on the average number of employees the employer reasonably expects to employ on business days during the current calendar year. Finally, any reference to an employer in the small employer exemption includes a reference to a predecessor of the employer.

(b) Increased Cost Exemption

The second exemption from the MHPA requirements applies to group health plans (or health insurance coverage offered in connection with a group health plan) if the application of the MHPA parity requirements described in paragraph (b)(1)(i) results in an increase in the cost under the plan (or coverage) of at least one percent. This exemption is available only if the requirements of paragraph (f) are met. If a plan offers more than one benefit package, the exemption is applied separately to each benefit package. Except as provided in the transition period described in paragraph (h), a plan must implement the parity requirements for the first plan year beginning on or after January 1, 1998, and must continue to comply with the parity requirements until September 30, 2001 (the sunset date in paragraph (i)) unless the plan satisfies the exemption described in paragraph (f). However, the exemption is not effective until 30 days after the notice requirements in paragraph (f)(3) are satisfied.

The interim rules, in paragraph (f)(2), describe the ratio of two terms used to determine if a plan (or coverage) has experienced a cost increase of one percent or more. The first term is the total cost incurred under parity (including both mental health costs and medical/ surgical costs). The second term is the total cost incurred under parity reduced by the costs required solely to comply with parity. Costs required solely to comply with parity include mental health claims that would have been denied absent amendments required to comply with parity, the administrative costs related to those claims, and other administrative costs attributable to complying with the parity requirements. Premium payments are not considered in this calculation.

The ratio is expressed by the following formula: ie/ie-(ce+ae)>=1.0100

IE represents the incurred expenditures during the base period. CE represents the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with the parity requirements of paragraph (b)(1)(i). AE represents administrative costs related to claims in CE and other administrative costs attributable to complying with the parity requirements of paragraph (b)(1)(i).

Examples illustrate how the rule is applied in the case of a self-funded plan, a fully insured plan, and a partially insured plan. Moreover, in the case of a partially insured plan in which the partially insured portion is pooled for rating purposes, the costs of the pool should be allocated proportionally among the pool members by reasonable methods, including proportional enrollment. Additional provisions in paragraph (f) describe the baseline for determining those costs that are attributable solely to compliance with the parity requirements, the base period used to calculate whether a plan may claim the exemption, and how long the exemption applies once it is claimed. The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

Before a group health plan may claim the one-percent increased cost exemption, it must furnish participants and beneficiaries with a notice of the plan's exemption from the parity requirements that includes the information described in paragraph (f)(3)(i). A plan may satisfy this requirement by providing participants and beneficiaries with a summary of material reductions in covered services or benefits, under 29 CFR 2520.104b-3(d), if it includes all the information required by paragraph (f)(3)(i). However, this exemption under

MHPA is not effective until at least 30 days after the notice is sent to the participants and beneficiaries and the appropriate federal agency even if the notice is incorporated into a summary of material reductions in covered services or benefits.

A group health plan that is not subject to Part 7 of Subtitle B of Title I of ERISA, and a plan subject to Part 7 of Subtitle B of Title I of ERISA that chooses not to incorporate the information in paragraph (f)(3)(i) into a summary of material reductions in covered services or benefits (which must be furnished to participants and beneficiaries and the appropriate federal agency), may use the following model to satisfy the notice requirement under paragraph (f)(3) of the interim rules:

BILLING CODE 4830-01-P; 4510-29-P; 4120-01-P

NOTICE OF GROUP HEALTH -PLAN'S EXEMPTION FROM THE MENTAL HEALTH PARITY ACT

* DESCRIPTION OF THE ONE PERCENT INCREASED COST EXEMPTION - This notice is required to be provided to you under the requirements of the Mental Health Parity Act of 19% (MHPA) bemuse the group health plan identified in Line I below is claiming the one percent increased cost exemption from the requirements of MHPA. Under MHPA, a group health plan offering both medical/surgical and mental health benefits generally can so longer set annual or aggregate lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits In addition, a plan that does not impose am annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. However, a group health plan can claim an exemption from these requirements if the plan's costs Increase one percent or more due to the application of MHPA's requirements.

This notice is to inform you that the group health plan identified in Line 1 below Is claiming the exemption from the requirements o(MHPA. The exemption is effective as of the date identified In Line 4 below. Since benefits under your group health plan may change as of the date identified in Line 4 it is important that you contact your administrator or the plan representative identified in Line 5 below to see how your benefits may be affected as a result of your group health plan's election of this exemption from the requirements of MHPA.

Upon submission of this notice by you (or your representative) to the plan administrator or the person identified in Line 5 below, the plan will provide you or your representative, free of charge, a summary Or the information upon which the plan's exemption is based.

1. Name of the group health plan and the plan number (PN):

2. Name. address, and telephone number of plan administrator responsible for providing this notice:

3. For single-employer plans, the narrate, address, telephone number, (if different from Line 2) and employer identification number (EFN) of the employer sponsoring the group health plan:

4. Effective date of the exemption (at least 30 days after the notices are sent):

5. For further information, call:

BILLING CODE 4830-01-C; 4510-29-C; 4120-01-C

To claim the one-percent increased cost exemption, a group health plan that is a church plan (as defined in section 414(e) of the Code) also must furnish to the Department of the Treasury a copy of the notice sent to participants and beneficiaries that satisfies the requirements of paragraph (f)(3)(i). To claim the one percent increased cost exemption, a group health plan subject to Part 7 of Subtitle B of Title I of ERISA also must furnish to the Department of Labor a copy of the notice sent to participants and beneficiaries that satisfies the requirements of paragraph (f)(3)(i). To claim the one percent increased cost exemption, a group health plan that is a nonfederal governmental plan also must furnish to the Department of Health and Human Services a copy of the notice sent to participants and beneficiaries that satisfies the requirements of paragraph (f)(3)(i). In all cases, the exemption is not effective until 30 days after notice has been sent both to participants and beneficiaries and to the appropriate federal agency. Any notice submitted to the Department of Labor or Health and Human Services will be available for public inspection.

The Secretaries have designated the following addresses for delivery of these notices:

For notices to the Department of the Treasury, church plans should mail the notice to: Office of the Assistant Commissioner, Examination, Examination Programs CP:EX:E, 1111 Constitution Avenue, NW., Washington, DC 20224; Attention: MHPA one-percent cost exemption notice.

For notices to the Department of Labor, plans should mail the notice to: Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5638, 200 Constitution Avenue, NW., Washington, DC 20210; Attention: MHPA one-percent cost exemption notice.

For notices to the Department of Health and Human Services, plans should mail the notice to: Health Care Financing Administration, 7500 Security Boulevard, Baltimore, MD 21244-1850; Attention: Insurance Standards: Exemptions.

Finally, to claim the one percent increased cost exemption, a plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information described in paragraph (f)(4). An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) is considered to be a representative. For this purpose, individually identifiable information in the notice may be redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with parity, and the administrative expenses attributable to complying with the parity requirements. In no event should a summary of information include individually identifiable information.

Civil money penalties as described in regulations at 45 CFR 146.184(d) apply to an issuer or nonfederal governmental plan that fails to satisfy the requirements of paragraph (f).

3. MHPA's Effective Date and Sunset Provision

The MHPA provisions are generally effective for group health plans (and health insurance issuers offering health insurance coverage in connection with a group

health plan) for plan years beginning on or after January 1, 1998. MHPA includes a sunset provision under which the MHPA requirements do not apply to benefits for services furnished on or after September 30, 2001.

However, for requirements of this section other than the one-percent increased cost exemption, the interim rules provide a limitation on enforcement actions in paragraph (h)(2). Under that paragraph, no enforcement action can be taken by any of the Secretaries against a group health plan (or issuer) that has sought to comply in good faith with the requirements of section 9812 of the Code, section 712 of ERISA, and section 2705 of the PHS Act with respect to a violation that occurs before the earlier of the first day of the first plan year beginning on or after April 1, 1998, or January 1, 1999. Compliance with the requirements of the interim rules is deemed to be good faith compliance with the requirements of section 9812 of the Code, section 712 of ERISA, and section 2705 of the PHS Act.

With respect to the increased cost exemption, the interim rules provide in paragraph (h)(3) a transition period for compliance with the requirements of paragraph (f). Under paragraph (h)(3), no enforcement action will be taken against a group health plan (or issuer) that is subject to the MHPA requirements prior to April 1, 1998 solely because the plan has claimed the increased cost exemption under section 9812(c)(2) of the Code, section 712(c)(2) of ERISA, or section 2705(c)(2) of the PHS Act based on assumptions inconsistent with the rules under paragraph (f) of the interim rules, provided that the plan is amended to comply with the parity requirements no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii).

A group health plan satisfies this transition period notice requirement only if the plan provides notice to the applicable federal agency and posts such notice at the location(s) where documents must be made available for examination under section 104(b)(2) of ERISA and the regulations thereunder (Sec. 2520.104b-1(b)(3)). The notice must indicate the plan's intent to use the transition period by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. In all cases, the notice must include the date; the name of the plan and the plan number; the name, address, and telephone number of the plan sponsor or plan administrator; the employer identification number (in the case of single-employer plans only); the individual to contact for further information; the signature of the plan administrator; and the date signed. In addition, the notice must be provided at no charge to participants and beneficiaries (or their representatives) within 15 days after receipt of a written or oral request for such notification, but in no event does the notice have to be provided before it has been sent to the applicable federal agency. For this purpose, plans may use the following model:

BILLING CODE 4830-01-P; 4510-29-P; 4210-01-P

NOTICE OF GROUP HEALTH PLAN'S USE OF TRANSITION PERIOD

* IMPORTANT - This notice is required to be provided if a group health plan uses the transition period under the requirements of the Mental Health Parity Act (MHPA). Under MHPA, a group health plan offering both medical surgical and mental health benefits generally can no longer set annual or aggregate lifetime

dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. In addition, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. However, a group health plan can claim an exemption from these requirements if the plan's costs Increase one percent or more due to the application of MHPA's requirements. Under MHPA, a plan that claims the one percent increased cost exemption prior to the issuance of the MHPA interim regulations based on assumptions inconsistent with the MHPA interim regulations may delay compliance with the parity requirements of MHPA until a date no later than March 31, 1"8.

This notice is to inform you that the plan is utilizing the MHPA transition period and that the plan is delaying compliance with the parity requirements of MHPA until a time no later than March 31, 1"8.

1 Name of the group health plan and the plan number (PN):

2. Name, address, and telephone number of plan administrator responsible for providing this notice:

3. For single-employer plans, the name, address, telephone number, (if different from Line 2), and employer identification number (EIN) of the employer sponsoring the group health plan:

4. For further information, call:

5- Signature of plan administrator: Date:

BILLING CODE 4830-01-C; 4510-29-C; 4120-01-C

The Secretaries have designated the following addresses for delivery of the notices: For notices to the Department of the Treasury, plans should mail the notice to: Office of the Assistant Commissioner, Examination, Examination Programs CP:EX:E, 1111 Constitution Avenue, NW., Washington, DC 20224; Attention: MHPA transition period notice.

For notices to the Department of Labor, plans should mail the notice to: Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5638, 200 Constitution Avenue, NW., Washington, DC 20210; Attention: MHPA transition period notice.

For notices to the Department of Health and Human Services, plans should mail the notice to: Health Care Financing Administration, 7500 Security Boulevard, Baltimore, MD 21244-1850; Attention: Insurance Standards: Exemptions.

C. Interim Rules and Request for Comments

Section 9833 of the Code (formerly section 9806), section 734 of ERISA (formerly section 707), and section 2792 of the PHS Act provide, in part, that the Secretaries of the Treasury, Labor, and Health and Human Services may promulgate any interim final rules as they determine are appropriate to carry out the provisions of Chapter 100 of Subtitle K of the Code, Part 7 of Subtitle B of Title I of ERISA, and Part A of Title XXVII of the PHS Act, including the MHPA provisions.

Under Section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) a general notice of proposed rulemaking is not required when an agency, for

good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest.

These rules are being adopted on an interim final basis because the Secretaries have determined that without prompt guidance some members of the regulated community may not know what steps to take to comply with the MHPA requirements, which may result in an adverse impact on participants and beneficiaries with regard to their mental health benefits under group health plans and the protections provided under MHPA. Moreover, MHPA's requirements will affect the regulated community in the immediate future.

MHPA's requirements are effective for all group health plans and for health insurance issuers offering coverage in connection with such plans for plan years beginning on or after January 1, 1998. Plan administrators and sponsors, issuers, and participants and beneficiaries, will need guidance on the new statutory provisions before MHPA's effective date. As noted earlier, these interim rules take into account comments received by the Departments in response to the request for public comments on MHPA published in the Federal Register on June 26, 1997 (62 FR 34604). For the foregoing reasons, the Departments find that the publication of a proposed regulation, for the purpose of notice and public comment thereon, would be impracticable, unnecessary, and contrary to the public interest.

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et. seq.) (RFA) requires an agency to publish a regulatory flexibility analysis describing the impact of a proposed rule which the agency determines would have a significant impact on a substantial number of small entities. The RFA requires that the agency present an initial regulatory flexibility analysis and seek public comment on its analysis when the agency publishes a general notice of proposed rulemaking (NPRM) under section 553 of the Administrative Procedures Act (5 U.S.C. 553 et seq.) (APA). Under the RFA, small entities include small businesses, non-profit organizations and governmental agencies. For our purposes, under the RFA, States and individuals are not considered small entities. However, small employers and small group health plans are considered small entities.

Since these rules are issued as interim final rules, and not as an NPRM, a formal regulatory flexibility analysis has not been prepared. Nonetheless, in the discussion below on the rule's impact on the regulated community, the Departments present an analysis addressing many of the same issues otherwise required by the RFA, including the likely impact of the interim rule on small entities, and a discussion of regulatory alternatives considered in crafting the rule. The Departments invite interested persons to submit comments for consideration in the development of the final rules implementing the MHPA. Consistent with the RFA, the Departments encourage the public to submit comments that accomplish the stated purpose of the MHPA and minimize the impact on small entities. Specifically, we welcome comments addressing the impact of the MHPA's 1 percent cost exemption for plans and issuers that can demonstrate that implementation of the parity rules would raise their expenditures by more than one percent. We also welcome comments addressing the operation of the MHPA provision requiring that plans using differential aggregate lifetime or annual limits for various categories of benefits use a weighted average of such differential limits to calculate the overall aggregate lifetime and annual limits for the plan.

E. Executive Order 12866--Departments of Labor and Health and Human

Services

The Office of Management and Budget has determined this rule to be a major rule, as well as an economically significant regulatory action under Section 3(f) of Executive Order 12866. The following analysis fulfills the requirement under the Executive Order to assess the economic impact of major and economically significant regulatory actions.

Executive Order 12866 requires agencies to assess the costs and benefits of available regulatory alternatives, and when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Section 3(f) of the Executive Order 12866 requires agencies to prepare a regulatory impact analysis for any rule which is deemed a "significant regulatory action" according to specified criteria, including whether the rule may have an annual effect on the economy of $100 million or more or certain other specified effects; or whether the rules raise novel legal or policy issues arising out of the President's priorities.

This analysis was conducted by the Departments of Labor and Health and Human Services. It discusses the economic impact of the MHPA, which this rule implements, with special emphasis on the one percent cost exemption. It quantifies the number of plans and individuals who might be affected by the exemption rule, illustrating the exemption's effect in the context of other statutory MHPA provisions. It separately considers the impact of regulatory discretion exercised by the Departments in connection with this rule.

a. Overall Impact of the MHPA

In general, the MHPA may have both direct and indirect effects on group health plans, plan sponsors, and plan participants. Direct effects may include broader coverage of mental health treatments and associated increases in mental health benefit payments. Indirect effects may include the steps employers who sponsor plans may take to reduce or offset their expenditures attributable to compliance with the MHPA, such as amending, curtailing or dropping mental health benefits or other components of compensation, as well as participants' responses to any expenditure increases that are passed to them.

Direct Effects

The most direct effect of the MHPA is broader health insurance coverage for mental health treatment. In many health plans, mental health coverage is more restrictive than medical/surgical coverage due to lower annual and/or lifetime dollar limits, more restrictive limits on visits and stays, and other plan provisions. For example, a recent survey of employee benefit plans by Hay/Huggins illustrates the differences in plan terms and lower dollar limits of mental health services and medical/surgical services. The survey reported that indemnity plans typically impose a lifetime limit of $50,000 for mental health benefits. On the other hand, medical/surgical benefits of a typical indemnity plan provide a lifetime limit of $1,000,000.

Requiring fuller coverage of mental health treatment will increase mental health benefit payments and associated plan expenditures. Some of this increase will be paid by plan sponsors, and some will be paid by participants in the form of increased premiums and/or reductions in other compensation. Aside from any increased administrative costs involved, these plan expenditure increases generally represent one side of transfer payments rather than erosion in overall

social welfare. In other words, additional plan expenditures arising from the MHPA are balanced by additional benefits paid for mental health services. One result will be that some money that would have been spent on other goods or services will be spent instead on mental health services.

The direct effects of the MHPA will in turn cause other effects due to subsequent responses by affected employers (in their capacity as plans sponsors) and participants.

Indirect Effects of the MHPA

There are numerous ways in which plan sponsors affected by the MHPA might react. Some might take no action other than to remove or increase dollar limits on mental health benefits. Others might make other changes to their mental health benefits in order to reduce or offset expenditure increases from compliance with MHPA. The statute explicitly preserves plan sponsors' right to provide no mental health benefits, or to set the "terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits," except with respect to annual or lifetime dollar limits. Some plan design options would be associated with lower plan expenditure increases from compliance with the MHPA. The statute also provides an "increased cost exemption" under which the statute "shall not apply" if its application "results in an increase in the cost . . . of at least 1 percent" (ERISA Section 712(c)(2)). Plan sponsors' responses to the MHPA may lessen their expenditures associated with compliance; that is, their responses may reduce the amount of transfers arising from the MHPA.

For example, many mental health plans currently have non-dollar limits. According to the U.S. Bureau of Labor Statistics, among full-time participants at private establishments with 100 or more employees in 1993, 55 percent were subject to separate day limits for inpatient mental health treatment, and 43 percent were subject to separate visit limits for outpatient mental health treatment (U.S. Bureau of Labor Statistics, Employee Benefits in Medium and Large Private Establishments, 1993). Plans that impose non-dollar limits on mental health benefits may face smaller expenditures increases from the MHPA.

Many plans currently subject mental health benefits to separate cost sharing provisions. Among full-time participants in medium and large private establishments in 1993, 15 percent were subject to separate coinsurance rates and 4 percent were subject to separate copayment rates for inpatient mental health care, while 53 percent and 18 percent were respectively subject to separate coinsurance and copayment rates for outpatient mental health care. Cost sharing generally affects plan expenditures in two ways. First, by shifting some payments for services to participants, cost sharing directly reduces the expenditures borne by plans. Second, by increasing the price of services faced by participants, cost sharing reduces the quantity of services that participants demand. Because of both of these mechanisms, plans that have more cost sharing for mental health benefits will not be impacted as much by the MHPA as plans that have parity in cost sharing.

Many plans use HMO-style management techniques to control mental health benefit expenditures. Plans that have HMO-style mental health "carve-outs" but no mental health limits are likely to pay less for mental health benefits than fee-for-service plans with low dollar limits that are impermissible under the MHPA. For example, a FFS plan with utilization review and an annual mental health limit of $10,000 averages $6.51 per member per month, while an

unlimited "carve out" plan pays $6.12, according to a Price Waterhouse LLP actuarial model developed for the Departments based on the same data as above.

There are a number of reasons why the permissible plan designs outlined here should have little negative effect on existing mental health coverage. First, the modest expenditure increases necessitated by the MHPA would be unlikely to prompt many major design changes. As noted below, approximately 10 percent of affected plans will face increased expenditures under the MHPA of at least one percent, according to the Price Waterhouse, LLP analysis conducted for the Departments. Only 4 percent of affected plans are expected to be faced with increases from the MHPA of 1.5 percent or more, according to the same analysis. Second, the largest expenditure increases and therefore the most aggressive responses will be associated with plans that have the tightest dollar caps today—that is, with plans that would have provided the most restrictive coverage anyway.

Other effects resulting from the MHPA may include plan sponsors dropping mental health coverage altogether, or dropping or curtailing other health benefits or components of compensation. Such curtailments could include shifting some of the cost of benefits to employees, for example in the form of increased participant premium contributions for health benefits. Participants, in turn, might respond to premium increases by dropping their health benefits or electing less expensive plans. As with plan sponsor amendments to mental health benefits, such responses by plan sponsors and participants are expected to be modest and/or rare, given the generally small direct effects of the MHPA on plan expenditures.

b. Review of Quantitative Estimates

The Congressional Budget Office (CBO) estimated that the MHPA's direct effect would be to increase health plan expenditures by 0.4 percent on aggregate. (See Congressional Budget Office, "CBOs Estimates of the Mental Health Parity Amendments to the VA/HUD Appropriation Bill, as Passed in the Senate," September 10, 1996.) This assumes that plan sponsors make no changes to their plans other than to raise or eliminate dollar limits on mental health benefits consistent with the MHPA's parity requirements. However, some plan sponsors may make other changes to their plans in order to reduce or offset the impact of the MHPA on their expenditures. For example, some plan sponsors might amend, curtail, or drop mental health benefits or health benefits in general. Taking into account the likely incidence of such plan sponsor responses to the MHPA, CBO estimated that the true aggregate increase in health plan expenditures attributable to the MHPA would only be 0.16 percent.

Combining these figures with those from an earlier CBO analysis, the Departments calculate that, in dollar terms, the total annual direct impact of the MHPA would be to increase aggregate health plan expenditures by $1.16 billion, not accounting for plan sponsor responses to reduce that impact. Accounting for those responses, the actual increase in annual aggregate health plan expenditures would be $464 million. It should be noted that these figures do not account for the MHPA's increased cost exemption, its exemption of firms with 50 or fewer employees, the incidence of managed care plans whose added cost under the MHPA would be smaller than those of managed fee for service plans, or for plans that are separately subject to state requirements equal or greater than the MHPA's. The Departments' estimates, reported below, incorporate these adjustments.

CBO also reports the Joint Committee on Taxation's estimate that the MHPA

will reduce federal revenues by $560 million over six years. CBO explains that most of the 0.16 percent increase in plan expenditures would be shifted back to employees as lower pay, thus eroding the income and payroll tax bases. On an annual basis, the MHPA would increase expenditures for federal annuitants' health benefits by $30 million, CBO reports. Finally, the MHPA's impact on nonfederal governmental entities would amount to $50 million, while its impact on the private sector would probably exceed $100 million, according to CBO.

The CBO estimates were based on a typical fee-for-service indemnity plan with customary management techniques to control expenditures, and not on plans with other types of delivery systems, such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), or Point-of-Service (POS) plans. In fact, plans using different delivery systems will face different expenditure increases under the MHPA. For example, HMOs, which typically contract with health care providers at discounted rates and tightly manage utilization, will face smaller increases under the MHPA.

Coopers & Lybrand (C&L) also estimated the impact of the MHPA (Ronald E. Bachman, "An Actuarial Analysis of S. 2031, The Mental Health Parity Act of 1996," prepared for the American Psychological Association. Coopers & Lybrand LLP, September 1996). C&L estimated that the MHPA would increase plan expenditures by 0.12 percent per plan on average before taking into account any responses by plan sponsors. Taking plans sponsors' responses into account and using the same response assumption as CBO, C&L estimated that plan expenditures would increase by less than 0.05 percent. In dollar terms, these increases would amount to $348 million and $139 million respectively.

Unlike CBO, C&L considered four different delivery systems: fee-for-service with standard utilization review on typical medical services, fee-for-service with specialized mental health utilization review, PPO and POS plans with specialized mental health utilization review, and HMO and carve-out mental health plans. Under each delivery system, C&L also considered a variety of annual dollar limits ranging from $10,000 to unlimited amounts, rather than assuming that all plans in the delivery system provided the same level of benefits.

The Departments performed additional quantitative analysis, generally analogous to CBO's, in the course of assessing the impact of the regulatory discretion reflected in this rule. The additional analysis suggests that the direct impact of the MHPA, not accounting for plan sponsors' responses, would be to increase annual aggregate health plans expenditures by 0.29 percent or $653 million. Under CBO's assumption regarding plan sponsor responses to reduce the added expenditure, actual added expenditures would amount to $261 million. The Departments did not attempt to independently quantify such responses. However, the Departments estimate that if all plans eligible for the one percent cost exemption exercise it, the increase in plan expenditures would be reduced from 0.29 percent to 0.14 percent or $310 million. The Departments' analysis is detailed below.

c. Exercise of Regulatory Discretion

One Percent Cost Exemption

The main area in which the agencies exercised regulatory discretion is in connection with the one percent cost increase exemption. Alternative regulatory interpretations can impact the outcome of the number of plans, firms, policyholders, and covered lives that would be exempted from the MHPA.

The Departments considered options concerning the interpretation of the one-percent cost exemption and how it should be implemented. In general, they considered (1) whether the eligibility for the exemption should be determined retrospectively or prospectively, and what, if any, rules should be established with respect to how eligibility should be determined, (2) whether eligibility should be contingent on affirmative approval from an enforcement agency or simply subject to possible review by such an agency, and (3) whether plan sponsors electing exemptions should be required to notify participants and/or enforcement agencies of this action and/or to disclose to these parties evidence documenting eligibility for the exemption. They also considered the administrability of each option, seeking to balance the costs and benefits to plans and participants, as well as the benefits and burdens of the regulatory scheme on the federal government.

Retro/prospective Determination

The options considered ranged from a purely retrospective interpretation to a purely prospective one, and included intermediate interpretations that blend these two approaches.

Under a purely retrospective interpretation, the one percent increased cost exemption would be based on actually incurred expenditures increases, measured retrospectively after implementation of the statute. In other words, all plans must comply and provide parity of annual and/or lifetime dollar limits of mental health and medical services for the first year beginning with the start of a plan year on or after January 1, 1998. If during the first year, a plan experiences increases in expenditures equal to one percent or more as a result of complying with the statute, that plan would then be eligible to exercise an exemption from the MHPA for subsequent plan years.

The calculation for determining the percent increase would be based on the ratio of the increase in plan expenditures to the total plan expenditures, that is, both medical and mental health expenditures. For self-insured plans, the numerator would be the actual value of mental health claims paid in excess of the previous plan limits. For example, if the annual mental health limit were $10,000 and the medical/surgical were $1,000,000, then the sum of all mental health claims paid in excess of $10,000 would be included in the numerator of the ratio used for that plan in calculations related to the one percent exemption. The denominator for self-insured plans would be the total value of medical and mental health claims excluding mental health claims in excess of $10,000. If the result is an increase of one or more percent, the plan would be exempt from complying with the statute in any other year until the statute sunsets in 2001. Because there is a lag between the time that claims are incurred and the time they are reported, complete data needed for the calculation might not be available until three or six months after the end of the first plan year under the MHPA. With respect to fully insured plans, the calculation would be slightly different. To the extent that different plans' experiences are pooled for purposes of setting premiums, their eligibility for the exemption would depend on their pooled experience under MHPA, rather than on each plan's individual experience.

The purely retrospective interpretation would minimize the availability of the exemption, and therefore might result in both the greatest incidence of parity in lifetime and annual dollar limits and the greatest incidence of other plan actions to reduce or offset the increase in expenditures arising from the MHPA. It would also assure that all plan elections to exercise the one percent increased cost exemption are based on actual experience under the MHPA's parity requirements and not on projections or estimates of such experience.

Under a purely prospective interpretation, a plan would be eligible for the exemption prospectively if its expected additional expenditures from the MHPA act equaled or exceeded one percent of its expected total expenditures absent the MHPA. A self-insured plan would project these figures, relying on available data and actuarial projection methods. A fully insured plan would compare legitimate premium quotes with and without the exemption to determine if the difference equals or exceeds one percent. The purely prospective interpretation would maximize the availability of the exemption, and therefore might result in both the least incidence of parity in lifetime and annual dollar limits and the least incidence of other plan actions to reduce or offset expenditure increases arising from the MHPA.

Other interpretations were also considered, some closer to a purely retrospective interpretation and others closer to a purely prospective one. For example, one interpretation might allow plans to prospectively determine their eligibility and exercise the exemption, but only based upon a narrowly constrained analysis of their own prior experience, taking into account only the potential added expenditure from the MHPA associated with participants whose past mental health claims reached or nearly reached MHPA-prohibited dollar limits. Interpretations closer to the purely retrospective view would lessen the availability of the exemption, and therefore might result in both greater incidence of parity in lifetime and annual dollar limits and lesser incidence of other plan actions to reduce or offset expenditure increases arising from the MHPA; those closer to the purely prospective view would do the opposite.

The approach adopted under this rule, referenced above, can be characterized as modified retrospective approach, based on a relatively brief base period. It is intended to assure the accurate measurement of increased costs while minimizing the burden on plan sponsors who wish to exercise the exemption as soon as accurate measurements can be made. It also assures that all plan elections to exercise the one percent increased cost exemption are based on actual experience under the MHPA's parity requirements and not on projections or estimates of such experience. The rule eases compliance burdens by providing a transition period under which certain plans whose plan years begin during the first quarter of 1998 can exercise the exemption until April 1, 1998.

Exemption Authority

This rule provides that plans may determine their own eligibility for the exemption and, if eligible, exercise the exemption, without affirmative approval from any enforcement agency.

Notification and Disclosure

The Departments also exercised discretion in requiring notice and disclosure in connection with the one percent increased cost exemption. The rule requires plans exercising the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions to notify the federal government, and to post a copy of this notice at the workplace. It further requires plans otherwise exercising the exemption to notify participants and the federal government, and to disclose on request to these parties summary documentation of the plans' eligibility for the exemption.

Notifications and disclosures will be of benefit to participants. They will help assure plans' compliance with the MHPA, and will promote participants' understanding of their and their plans' status under the MHPA. Moreover, by

promoting participants' understanding, notifications and disclosures will inform participants' choices among plans and their feedback to plan sponsors, thereby fostering more vigorous competition among plan sponsors and issuers to provide benefits attractive to participants at competitive prices. The cost of these notifications and disclosures is outlined below.

Weighted Average Limits

The Departments also exercised discretion in developing rules that specify when plans may impose separate dollar limits on mental health benefits equal to the weighted average of limits imposed on other benefit categories, and in how this weighted average may be calculated. In general, the rules provide that such mental health limits 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 total 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.

Alternative rules might have permitted more, fewer, or different plans to impose such limits on mental health benefits, and/or resulted in calculated averages that were higher or lower. For example, if unlimited categories were treated as having infinite limits, then the weighted average of category limits would equal infinity and the option of imposing a weighted average limit on mental health benefits effectively would be foreclosed. In contrast, if limits applicable to benefit categories narrower in scope than mental health benefits could be averaged to arrive at the permissible mental health limit, plans might be able to impose very low limits on very narrow benefit categories, with little effect on coverage of these categories but with the result of a lower permissible mental health benefit limit.

d. Impact of Regulatory Discretion

Because the Departments exercised regulatory discretion in connection with the one percent cost exemption, it is necessary to quantify the number of plans eligible for the exemption. Thisrequires both estimates of the affected universe and estimates of the distribution of impacts within that universe. CBO reported universe estimates but did not estimate the distribution of impacts. C&L provided a distribution but not universe estimates. Thus, neither source provides the necessary basis for estimating the reach of the one percent cost exemption. To address this gap, the Departments, assisted by Price Waterhouse LLP, combined the CBO and C&L analyses with other data to produce relevant national estimates, as follows.

First, the Departments estimated the relevant universe at 3.0 million plans sponsored by 2.8 million employers covering 145 million individuals. To derive these estimates, we tallied the number of group health plan policyholders and dependents by firm size from the Census Bureau's March 1996 Current Population Survey. Census enterprise data provided average firm sizes in each size category, allowing us to estimate the number of employers covering these individuals. KPMG Peat Marwick's 1997 survey provided the average number of plans per firm in each size group, supporting estimates of the number of plans. Data from the Bureau of Labor Statistics' Employee Benefits Survey and the Health and Retirement Study provided a proportionate breakdown of plans and individuals in each firm size group across plan types (HMO, PPO, and fee for

service). Likewise, data from KPMG and Foster Higgins surveys were used to divide insured from self-insured plans.

Second, the Departments narrowed the focus to plans affected by the MHPA. Approximately 296,000 plans, sponsored by 136,000 employers and covering 113 million individuals, would be directly affected by the MHPA. This excludes firms with fewer than 50 employees (which are exempt under ERISA Section 712 (c)(1)), plans already covered by state mandates to provide parity in annual and lifetime dollar limits (based on C&L and Hay Huggins reports of the incidence of differential limits—roughly 29,000 plans were excluded here), and insured plans in 13 states that, independent of the MHPA, as of January 1, 1998 will require parity equivalent to or surpassing that required by the MHPA. (Those 13 states are: Indiana, Maryland, Minnesota, Montana, Arkansas, Colorado, Connecticut, Maine, Missouri, New Hampshire, North Carolina, Rhode Island, and Texas.) Some of the plans identified here as affected may not be affected. The MHPA permits self-insured nonfederal governmental plans to opt out of compliance. This includes roughly 22,000 plans covering about 18 million individuals. It also exempts plans whose costs increase by one percent or more, as enumerated below.

Third, the Departments estimated the overall impact of the MHPA as follows: affected plans' potential increases in mental health expenditures under the MHPA equal $653 million, or 0.29 percent of affected plans' $226 billion in total expenditures. (The 0.29 percent figure is benchmarked to CBO's estimate that the average cost increase for indemnity plans would be 0.4 percent, but it is adjusted to reflect C&L's assessment of the relative magnitude of cost increases for different plan types. The $226 billion figure is benchmarked to CBO's $290 billion universe, but reduced proportionately to reflect the Department's estimate of the proportion of the total universe that is affected by the MHPA.) Under CBO's assumption regarding plan sponsor actions to reduce the added expenditure, actual added expenditures would amount to $261 million. Expenditures could be smaller still as a result of self-insured nonfederal governmental plans' right to opt out of compliance and the MHPA's one percent increased cost exemption, which are not accounted for in the foregoing estimates. Recall also that these expenditures represent transfer payments and not social costs.

One Percent Cost Exemption

The effect of this rule will be to prohibit all covered plans from imposing annual or lifetime dollar limits on mental health benefits that are lower than limits imposed on medical and surgical benefits during at least seven months of the first plan year beginning on or after January 1, 1998. Specifically, after six months, the rule permits plans to exercise an exemption as soon as they document a cost increase of one percent or more and provide 30 days notice to participants and the federal government.

Exactly when a given plan will become eligible to elect the one percent increased cost exemption will depend on the timing of its increased costs and its documentation of those costs. In many cases, plans' increased costs under the MHPA will not equal or exceed one percent until more than the initial six months have elapsed. For example, added costs from the MHPA's provision restricting the use of annual dollar limits on mental health benefits would likely be concentrated late in the plans year, when some participants would otherwise have reached these limits. In addition, plans that utilize this rule' transition period may not be affected by the MHPA's provisions until after the first three months of the plan year have elapsed. Therefore, these may be less likely to incur

added costs of one percent or more until later in the plan year, or until a subsequent plan year (in which they would be affected by the MHPA beginning on the first day of the plan year).

Whether eligible plans wishing to reduce the direct impact of the MHPA will opt to pursue the exemption or opt for alternative responses will depend on each plan's particular circumstances and priorities.

The Departments estimated the number of affected plans with potential increases of at least one percent. Roughly 30,000 plans, or about 10 percent of a plans affected by MHPA, potentially would be eligible for the one-percent increased cost exemption. That is, all else being equal, complying with the MHPA would increase 30,000 plans' expenditures by at least one percent. These plans cover about 5 million policyholders and 11 million individuals. This is the universe potentially affected by the provisions of this rule that address the one percent increased cost exemption.

In assessing the impact of this rule, the Departments considered the economic consequences of its provisions implementing the one percent cost exemption. Several factors are likely to affect the magnitude of those consequences.

First, under any interpretation, only 10 percent of MHPA-affected plans (or 30,000 plans) could become eligible for the exemption, and only some of those would elect to exercise it. The estimated 30,000 plans that would become eligible for the one-percent cost exemption represents the upper limit of the number of plans that would actually exercise the exemption. Many of the potentially eligible plans are likely to forego the exemption in favor of other permitted actions. A survey of 300 large firms conducted by William M. Mercer, Inc., found that fewer than 2 percent intended to pursue the one percent increased cost exemption. Extrapolated to the Departments' estimated plan universe, this suggests that 6,000 plans, or 22 percent of the 30,000 that are potentially eligible, would pursue the exemption.

Second, expenditure increases from the MHPA will generally be modest, even for plans potentially eligible for the one percent cost exemption. Their potential expenditure increase would be $332 million on a base of $23 billion in total expenditures, or 1.47 percent overall.

Third, as noted above, plans can be designed in ways that lessen these expenditure increases.

Fourth, the 2,215 self-insured nonfederal governmental plans that might become eligible for the one percent cost exemption are separately permitted to opt out of the MHPA entirely, thereby exercising an alternative exemption with equivalent effect. These plans cover 1.8 million individuals, or 16 percent of individuals in potentially eligible plans.

Fifth, the estimates presented in this analysis are conservative; actual expenditures arising from compliance with the MHPA are likely to be less than reported here. In particular, the estimates may understate the reach and cost-effectiveness of managed mental health programs that will exist during the years that the MHPA is in effect (See Roland Sturm, "How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?" JAMA, Nov. 12, 1997--Vol. 278 No. 18).

Sixth, because plan expenditure increases under the MHPA (aside from increases in administrative expenses) are transfers, the availability and use of the

exemption does not change aggregate social welfare. However, the availability and use of the exemption does affect the size and incidence of transfers across affected parties.

Finally, this rule preserves the availability of most of this savings under the one percent exemption—certain eligible plans are permitted to exercise the exemption after seven months, thereby operating under the exemption for up to 38 of the 45 months during which the MHPA is in effect.

This rule also requires certain notices and disclosures by plans exercising the one percent increased cost exemption. The Departments undertook to estimate the paperwork burdens associated with these provisions, as well as the burden associated with determining whether a plan is eligible for the exemption. These estimates are summarized below.

The estimates reported immediately below are for all plans affected by the notice and disclosure provisions of this rule. The Paperwork Reduction Act (PRA) analysis that follows is presented separately for affected private-sector plans and for plans sponsored by nonfederal governmental employers, which are under the jurisdictions of the Departments of Labor and of Health and Human Services, respectively.

With respect to the notice to participants and beneficiaries and to the federal government by plans exercising the one percent cost exemption, the maximum possible number of such notices is approximately 5.0 million (reflecting all plans potentially eligible to elect the exemption), while a more likely figure is 1.1 million (reflecting the Mercer survey cited above). Assuming each notice requires 2 minutes of labor at $11 per hour, plus $0.50 for postage and materials, total costs would amount to up to $4.3 million or more probably $931,000. (These assumptions reflect plans' ability to satisfy this notice requirement through the provisions of a separately required summary of material modifications, as well as availability of a model notice to the government, which together essentially eliminate separate preparation burdens under this requirement and help minimize ongoing burdens.)

With respect to requirement for group health plans to notify the federal government of use of the transition period, and to post these notices in the workplace, only those plans whose plan years begin during the first three months on 1998 and who are potentially eligible for the one percent cost exemption are potentially affected by this provision. These notices would be filed and posted within 30 days or less of the beginning of the plan year, so all would be filed in 1998. Based on annual reports filed with the Department of Labor, the Departments estimate that 60 percent of all eligible plans, accounting for 72 percent of participants in such plans, begin their plan years during these months. This amounts to 18,000 plans, representing the maximum number of notices that would be filed. Extrapolating from the Mercer survey cited above, about 4,000 of these plans might intend to pursue the exemption, representing a more probable number of notices to be filed. Applying the same per unit cost assumptions as above to the filing and posting of these notices, the cost of these notices would be no more than $8,000 and more likely $2,000. These assumptions reflect the availability of a model notice, the use of which eliminates preparation costs and helps minimize ongoing burdens.

With respect to the requirement for plans to disclose on request summary information documenting the plan's eligibility for the one percent increased cost exemption, the number of such disclosures will depend on the volume of requests. One might expect requests to arise most commonly when participants

are at or near plans' dollar limits. Hay Huggins estimates for the Congressional Research Service (See Roland Sturm, "How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?" JAMA, Nov. 12, 1997--Vol. 278 No. 18) suggest that 0.73 percent of participants on average incur mental health claims of more than $10,000--a typical annual limit—in a given year. The Departments adjusted this figure to reflect the estimated relationship between increased expenditures under the MHPA for plans eligible for the one percent increased cost exemption and increased expenditures under the MHPA for all affected plans, concluding that 3.74 percent of participants in plans eligible for the one percent increased cost exemption incur claims of more than $10,000 in a given year. Assuming that this proportion of participants in plans electing the exemption request disclosures, the maximum number of such disclosure requests would be 186,000, while a more probable figure would be 40,000. Given the same per unit cost assumptions as above, the associated costs would be $161,000 and $35,000, respectively.

Finally, with respect to plan determinations of eligibility for the one percent increased cost exemption, the Departments expect that plans wishing to exercise the one percent increased cost exemption or their service providers will revise their automated claim record systems to facilitate calculation of the plans' increased costs attributable to the MHPA. The number of plans performing such functions in-house that might wish to exercise the exemption is estimated to be no more than 5,346 and more probably 1,142. The number of service providers (including health insurance issuers and third party administrators) that will perform this function for plans that wish to exercise the exemption is estimated to be 1,770 (including 400 third party administrators, 650 health insurers, 645 HMOs, and 75 Blue Cross Blue Shield organizations). Assuming a start up cost of $5,000 per affected entity, the total start-up cost associated with determining plans' eligibility to exercise the exemption amounts to $14.6 million to $35.6 million, to be amortized over 10 years beginning in 1998.

The estimates of the numbers and costs of notices, disclosures and calculations reported above, and below in connection with the Paperwork Reduction Act, may be high with respect to nonfederal governmental plans. An estimated 2,215 self-insured nonfederal governmental plans might become eligible for the one percent cost exemption. These plans are separately permitted to opt out of the MHPA entirely, thereby exercising an alternative exemption with equivalent effect, and without becoming subject to the calculation, notice, and disclosure requirements. These plans cover 1.8million individuals, or 16 percent of individuals in potentially eligible plans.

Weighted Average

The economic impact of the Departments' exercise of discretion in the weighted average rule is also expected to be modest.

First, separate limits for benefit categories other than mental health are not very common. For example, among full-time employees at establishments with 100 or more employees participating in non-HMO group health plans in 1993, only a fraction were subject to separate limits for many major benefit categories. For example, just 14 percent were subject to separate limits for inpatient surgery, just 13 percent were subject to such limits for outpatient surgery, and only about one in four were subject to separate limits for both inpatient and office physician visits (U.S. Bureau of Labor Statistics, Employee Benefits in Medium and Large Private Establishments, 1993). "Separate limits" in this context include not only dollar limits, but also non-dollar limits, such as inpatient day or outpatient visit limits, as well as differential coinsurance rates, copayments, or deductibles.

Therefore, the proportion with separate dollar limits that would permit imposition of a weighted average limit on mental health benefits would be even smaller. In addition, such separate limits are even less common in HMOs.

Second, discretion exercised in the weighted average rule affects plans' ability to impose weighted average limits on mental health benefits only at the margin. In other words, compared with the approach set forth in the rule, alternative approaches would have increased or decreased the proportion of plans that are able to impose weighted average limits and the dollar level of calculated averages by only a small amount.

Third, not all plans that are permitted to impose weighted average limits on mental health benefits will elect to do so.

Fourth, some plans that under the rule are not permitted to impose weighted average limits on mental health benefits, under an alternative approach, might have been permitted to impose only a relatively high limit. As such, their expenditure increases from the MHPA might have been nearly the same with a weighted average limit on mental health benefits as with no separate limit on such benefits. Consider a plan with a $500,000 annual cap on all inpatient care and a $250,000 annual cap on all outpatient care, and a $25,000 annual cap on mental health benefits. Under the interim rules, such a plan could not impose a weighted average limit on mental health benefits. Any separate limit on mental health care would have to be at least $750,000, or at least $500,000 for inpatient care and at least $250,000 for outpatient care. Had the plan been permitted to impose a weighted average cap, however, it still would have been required to increase its mental health cap from $25,000 to some amount between $250,000 and $500,000, depending on the weights.

Finally, as with the one percent cost exemption and with the MHPA generally, the impact of regulatory discretion in the weighted average rule will be reduced because self-insured nonfederal governmental plans can opt out, the MHPA's added expenditure is modest, plans can be designed in ways that lessen the MHPA's added expenditure, and the estimates presented here are conservative.

F. Unfunded Mandates Reform Act of 1995

The Unfunded Mandates Reform Act of 1995 (P.L. 104-4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of $100 million by state, local and tribal governments or the private sector. These rules are not subject to the Unfunded Mandates Reform Act because they are interim final rules. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, the regulation has been designed to be the least burdensome alternative for state, local and tribal governments, and the private sector, while achieving the objectives of the MHPA.

G. Small Business Regulatory Enforcement and Fairness Act of 1995

The Administrator of the Office of Information and Regulatory Affairs of the Office of Management and Budget has determined that this is a major rule for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. Section 801 et. seq.) (SBREFA).

The Secretaries have determined that the effective date of these interim final rules is January 1, 1998. Pursuant to Section 808(2) of SBREFA, the Secretaries find, for good cause, that notice and public procedure thereon are impracticable,

unnecessary and contrary to the public interest.

These rules are adopted on an interim final basis because the Secretaries have determined that without prompt guidance some members of the regulated community may have difficulty complying with the MHPA requirements, which may result in an adverse impact on participants and beneficiaries with regard to their mental health benefits under group health plans and the protections provided under MHPA. Moreover, MHPA's requirements will affect the regulated community in the immediate future.

MHPA's requirements are effective for all group health plans, and for health insurance issuers offering coverage in connection with such plans for plan years beginning on or after January 1, 1998. Plan administrators and sponsors, issuers and participants and beneficiaries will need guidance on the new statutory provisions before MHPA's effective date. As noted earlier, these interim rules take into account comments received by the Departments, in response to the request for public comments on MHPA published in the Federal Register on June 26, 1997. 62 FR 34604. For the foregoing reasons, the Departments find that notice and public comment would be impracticable, unnecessary and contrary to the public interest.

H. Paperwork Reduction Act—The Department of Labor and the Department of the Treasury

The Department of Labor and the Department of the Treasury have submitted this emergency processing public information collection request (ICR), consisting of three distinct ICRs to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35). The Departments have asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.These regulations contain three distinct ICRs. The first ICR is a notice to participants and beneficiaries and to the federal government of the plan's election of the exemption from the MHPA's provisions due to an increase in cost under the plan of at least one percent attributable to compliance with these provisions. A plan may satisfy this requirement by providing participants and beneficiaries with a notice of material reductions in covered service or benefits, under the Department of Labor's regulations at 29 CFR section 2520.104b-3(d), that includes the information in paragraph (f)(3)(i) of this interim final rule regarding issuing a notice to participants and beneficiaries of the plan's exemption from these parity requirements. Before the one percent increased cost exemption is effective, the plan must also notify the federal government. For this purpose, the group health plan may either send Department of Labor a copy of the summary of material reductions in covered services or benefits sent to participants and beneficiaries, containing the plan number and the plan sponsor's employer identification number, or the plan (or coverage) may use the Departments' model notice in this interim final rule which has been developed for this purpose.

The second ICR is a summary of the information used to calculate the plan's increased costs under the MHPA for purposes of electing the one percent increased cost exemption, which the plan must make available to participants and beneficiaries, on request at no charge.

The third ICR is a notice of a group health plan's use of the transition period. The rule requires plans exercising the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions to notify the federal government, and to post a copy of this notice at the

workplace.

1. Notice to Participants and Beneficiaries and the Federal Government of Electing One Percent Increased Cost Exemption

i. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed collection of information, Notice to Participants and Beneficiaries and the Federal Government of Electing One Percent Increased Cost Exemption. A copy of the proposed ICR can be obtained by contacting the employee listed below in the contact section of the notice.

Information collection: affected parties are not required to comply with the ICRs in these rules until the Department of Labor publishes in the Federal Register the control numbers assigned to these ICRs by OMB. The publication of the control numbers notifies the public that OMB has approved these ICRs under the Paperwork Reduction Act of 1995. The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

Dates: Written comments must be submitted to the office listed in the addressee section below on or before February 20, 1998. The Department of Labor is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Addressee: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N-5647, Washington, D.C. 20210. Telephone: 202-219-4782 (this is not a toll-free number). Fax: 202-219-4745.

ii. Department of the Treasury

The collection of information is in 54.9812-1T. This information is required by the interim final rules so that participants will be informed about their rights

under MHPA, and so that participants and beneficiaries, and the federal government, will receive notice of a plan's election of the one percent increased cost exemption. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required to obtain the benefit of the exemption.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received on or before February 20, 1998. In light of the request for OMB clearance by the effective date of the MHPA, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How to enhance the quality, utility, and clarity of the information to be collected;

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

I. Background

MHPA generally requires that group health plans provide parity in the application of dollar limits to mental health and medical/surgical benefits. The statute exempts plans from this requirement if its application results in an increase in the cost under the plan or coverage of at least one percent. This regulation requires a plan electing this exemption to notify participants and beneficiaries and the federal government of the plan's election of the exemption. This ICR covers this notification requirement.

II. Current Actions

Under 29 CFR 2590.712(f)(3) (i) and (ii), and 26 CFR 54.9812-1T a group health plan electing the one percent exemption is obligated to provide a written notice of that election to participants and beneficiaries and to the federal government of the plan's election of the exemption. A plan may satisfy this requirement by providing participants and beneficiaries with a notice of material reductions in covered service or benefits, under the Department of Labor's regulations at 29 CFR section 2520.104b-3(d), that includes the information in paragraph (f)(3)(i) of this interim final rule regarding issuing a notice to participants and

beneficiaries of the plan's exemption from these parity requirements. To satisfy the requirement to notify the federal government, a group health plan may either send the Department a copy of the summary of material reductions in covered services or benefits sent to participants and beneficiaries, containing the plan number and the plan sponsor's employer identification number, or the plan may use the Department's model notice in this interim final rule which has been developed for this purpose. Based on past experience, the staff believes that most of the materials required to be issued under this notice procedure will be prepared by contract service providers such as insurance companies and third-party administrators.

Type of Review: New.Agencies: U.S. Department of Labor, Pension and Welfare Benefits Administration; U.S. Department of the Treasury, Internal Revenue Service.

Title: Notice to Participants and Beneficiaries and the Federal Government of Electing One Percent Increased Cost Exemption.

OMB Number: XXXXXXX

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions; Group health plans.

Frequency: On occasion.

Burden:

Year	Total respondents (range)	Total responses (range)	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1998.....	.....	.....	.....	.....	.....
1999.....	5,612 to 25,446	813,505 to 3.8MM.	2.....	6,324 to 29,605.	$705,037 to $3.3MM
2000.....	.....	.....	.....	.....	.....
Totals.....	5,612 to 25,446	813,505 to 3.8MM.	2.....	6,324 to 29,605.	$705,037 to $3.3MM

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the ICRs; they will also become a matter of public record.

2. Calculation and Disclosure of Documentation of Eligibility for Exemption

i. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the

Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed collection of information, Disclosure of Documentation of Eligibility for Exemption. A copy of the proposed ICR can be obtained by contacting the employee listed below in the contact section of the notice.

Information collection: Affected parties are not required to comply with the ICRs in these rules until the Department of Labor publishes in the Federal Register the control numbers assigned to these ICRs by OMB. The publication of the control numbers notifies the public that OMB has approved these ICRs under the Paperwork Reduction Act of 1995. The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

Dates: Written comments must be submitted to the office listed in the addressee section below on or before February 20, 1998. The Department of Labor is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Addressee: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N-5647, Washington, D.C. 20210. Telephone:

202-219-4782 (this is not a toll-free number). Fax: 202-219-4745.

ii. Department of the Treasury

The collection of information is in Section 54.9812-1T. This information is required by the interim final rules so that participants will be informed about their rights under MHPA, and so that participants and beneficiaries may receive a summary of the information upon which the plan based its election of the one percent increased cost exemption. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required to obtain the benefit of the exemption.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received on or before February 20, 1998. In light of the request for OMB clearance by the effective date of the MHPA, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How to enhance the quality, utility, and clarity of the information to be collected;

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and

Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

I. Background

MHPA generally requires that group health plans provide parity in the application of dollar limits to mental health and medical/surgical benefits. The statute exempts plans from this requirement if its application results in an increase in the cost under the plan or coverage of at least one percent. This regulation requires plans wishing to elect this exemption to calculate their increased costs according to certain rules. It further requires plans electing this exemption to disclose to participants and beneficiaries (or their representatives), on request, and at no charge, a summary of the information upon which the exemption was based. This ICR covers this disclosure requirement.

II. Current Actions:

Under 29 CFR 2590.712(f)(2) and 26 CFR 54.9812-1T, a group health plan wishing to elect the one percent exemption must calculate their increased costs according to certain rules. Under 29 CFR 2590.712(f)(4) and 26 CFR 54.9812-1T, a group health plan electing the one percent exemption is obligated to disclose to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based.

Type of Review: New.

Agencies: U.S. Department of Labor, Pension and Welfare Benefits

Administration; U.S. Department of the Treasury, Internal Revenue Service.

Title: Calculation and Disclosure of Documentation of Eligibility for Exemption.

OMB Number: XXXXXXX.

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions; Group Health Plans.

Frequency: On occasion.

Calculation burden: It is expected that plans wishing to exercise the one percent increased cost exemption or their service providers will revise their automated claim record systems to facilitate calculation of the plans' increased costs attributable to the MHPA. The number of plans performing such functions in-house that might wish to exercise the exemption is estimated to be no more than 4,489 and probably 958. The number of service providers (including health insurance issuers and third party administrators) that will perform this function for plans using service providers that wish to exercise the exemption is estimated to be 1,770. Assuming a cost of $5,000 per affected entity, the total cost associated with determining plans' eligibility to exercise the exemption amounts to $12.5 million to $30.1 million, to be amortized over 10 years beginning in 1998.

Disclosure burden: In addition to the calculation burden, plans wishing to elect the one percent increased cost exemption will incur a burden in connection with disclosure requests from participants, as detailed below.

Year	Total respondents (range)	Total responses (range)	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1998.....	.....	.....	.....	.....	.....
1999.....	5,612 to 25,446	30,188 to 140,412.	2.....	235 to 1,101.	$26,163 to $121,690
2000.....	5,612 to 25,446	30,188 to 140,412.	.....	235 to 1,101.	$26,163 to $121,690
Totals.....	5,612 to 25,446	60,377 to 280.824.	2.....	470 to 2,201.	$52,326 to $243,381

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the ICRs; they will also become a matter of public record.

3. Notice of Group Health Plan's Use of Transition Period, and Posting Thereof

i. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is

minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed collection of information, Notice of Group Health Plan's Use of Transition Period. A copy of the proposed ICR can be obtained by contacting the employee listed below in the contact section of the notice.

Information collection: affected parties are not required to comply with the ICRs in these rules until the Department of Labor publishes in the Federal Register the control numbers assigned to these ICRs by OMB. The publication of the control numbers notifies the public that OMB has approved these ICRs under the Paperwork Reduction Act of 1995. The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

Dates: Written comments must be submitted to the office listed in the addressee section below on or before February 20, 1998. The Department of Labor is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Addressee: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N-5647, Washington, D.C. 20210. Telephone:

202-219-4782 (this is not a toll-free number). Fax: 202-219-4745.

ii. Department of the Treasury

The collection of information is in Section 54.9812-1T. This information is required by the interim final rules so that participants will be informed about their rights under MHPA, and so that plans electing the one percent increased cost exemption during all or part of the first quarter of 1998 under the rules' transition provisions will notify the federal government and post the notice in the workplace. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required to obtain the benefit of the exemption.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Comments on the collection of information should be sent to the Office of

Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received on or before February 20, 1998. In light of the request for OMB clearance by the effective date of the MHPA, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How to enhance the quality, utility, and clarity of the information to be collected;

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

I. Background

MHPA generally requires that group health plans provide parity in the application of dollar limits to mental health and medical/surgical benefits. The statute exempts plans from this requirement if its application results in an increase in the cost under the plan or coverage of at least one percent. This regulation requires a notice of group health plan's use of transition period, under which plans electing the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions must notify the federal government and to post a copy of the notice in the workplace. This ICR covers this notification requirement.

II. Current Actions

Under 29 CFR 2590.712(h)(3)(ii) and 26 CFR 54.9812-1T, group health plans electing the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions must notify the federal government. Based on past experience, the staff believes that most of the materials required to be issued under this notice procedure will be prepared by contract service providers such as insurance companies and third-party administrators.

Type of Review: New.

Agencies: U.S. Department of Labor, Pension and Welfare Benefits

Administration; U.S. Department of the Treasury, Internal Revenue Service.

Title: Notice of Group Health Plan's Use of Transition Period.

OMB Number:

Affected Public: Individuals or households; Business or other for-profit;

Not-for-profit institutions; Group Health Plans.

Frequency: On occasion.

Burden:

Year	Total respondents (range)	Total responses (range)	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1998.....	3,348 to 15,193	3,348 to 15,193	2.....	19 to 89.....	$1,514 to $6,910
1999.....	.....	.....	.....	.....	.....
2000.....	.....	.....	.....	.....	.....
Totals.....	3,348 to 15,193	3,348 to 15,193	2.....	19 to 89.....	$1,514 to $6,910

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the ICRs; they will also become a matter of public record.

I. Paperwork Reduction Act—Department of Health and Human Services

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the Federal Register and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements discussed below.

Section 146.136 of this document contains three distinct information collection requirements, as summarized below:

Type of Information Request: New collection.

Title of Information Collection: Mental Health Parity Act of 1996;

Information Collection Requirements Contained in 45 CFR 146.136; HCFA-2891-IFC.

Form Number: HCFA-R-223 (OMB approval #: 0938-XXXX).

Use: The information collection requirements contained in this interim final rule will help ensure that sponsors and administrators of group health plans notify the required individuals/entities of a plan's exemption from the MHPA parity requirements and make the data used to calculate the exemption available to affected individuals and entities.

Frequency: On occasion.

Affected Public: States, businesses or other for profit, not-for-profit institutions, Federal Government, individuals or households.

Notification Requirements: Nonfederal governmental plans, not exempt from the parity requirements by reason of an opt out under regulations at 45 CFR 146.180, must furnish participants and beneficiaries with a notice of the plan's exemption from the parity requirements based on increased costs. A plan may satisfy this requirement by providing participants and beneficiaries with a notice of material reductions in covered services or benefits, under 29 CFR 2520.104b-3(d), that includes the information in paragraph (f)(3)(i). Even though a plan generally is not required to furnish a material reduction in covered services or benefits for 60 days, in no case will the exemption be effective until 30 days after the notice is sent to participants and beneficiaries. For this purpose, a plan that does not furnish the summary of material reductions in covered services or benefits may satisfy its notice requirements by using the model exemption notice described above in this preamble.

In addition, the nonfederal governmental plan (or issuer providing coverage to such a plan) must also furnish to the Department of Health and Human Services a notice similar to the notice sent to participants and beneficiaries before the exemption is effective. For this purpose, the plan may either send the Department the summary of material reductions in covered services or benefits sent to participants and beneficiaries, or the plan (or issuer) may use the model described above. In all cases, the exemption is not effective until 30 days after notice has been sent.

Burden:

Year	Total respondents (range)	Total responses (range)	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1998.....	.....	.....	.....	.....	.....
1999.....	890 to 4,092...	261,000 to 1.2 MM.	2.....	2,133 to 9,975	$226,000 to $1.1 MM
2000.....	.....	.....	.....	.....	.....
Totals.....	890 to 4,092...	261,000 to 1.2 MM.	2.....	2,133 to 9,975	$226,000 to $1.1 MM

Availability of documentation: Nonfederal governmental plans that take the exemption, or issuers that provide coverage for such plans, must make available to participants and beneficiaries, on request and at no charge, a summary of the

data used to calculate the exemption of this section. The summary of data must include the incurred expenditures (including identification of the portion of the total representing claims and the portion of the total representing administrative expenses), the base period, the claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with parity, and the administrative expenses attributable to complying with the parity requirements.

Burden:

Year	Total respondents (range)	Total responses (range)	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1998.....	.....	.....	.....	.....	.....
1999.....	890 to 4,092...	9,700 to 45,300	2.....	79 to 372.....	$8,400 to $39,300
2000.....	890 to 4,092...	9,700 to 45,300	2.....	79 to 372.....	$8,400 to $39,300
Totals.....	890 to 4,092...	19,400 to 90,600.	2.....	158 to 744....	$16,800 to $78,600

Plans that take the exemption will incur start up costs for preparing to issue the information they must disclose. We estimate the start up costs for nonfederal governmental plans that take this exemption to range from $2.1 million to $5.5 million.

Notice of Use of Transition Period: With respect to the increased cost exemption, the interim rules provide in paragraph (g)(3) a transition period for compliance with the requirements of paragraph (f). Under paragraph (g)(3), no enforcement action shall be taken against a nonfederal governmental plan that is subject to the MHPA requirements prior to April 1, 1998 solely because the plan claims the increased cost exemption under section 2705(c)(2) of the PHS Act based on assumptions inconsistent with the rules under paragraph (f), provided that the plan is amended to comply with the parity requirements no later than March 31, 1998 and the plan complies with certain notice requirements. A nonfederal governmental plan satisfies the notice requirements only if such plan provides notice to the Department of Health and Human Services of the plan's intent to use the transition period by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event can the notice be provided later than March 31, 1998. Such notice shall include the name of the plan; the name, address, and telephone number of the plan sponsor or plan administrator; the employer identification number; and the plan number. In addition, such notice must be provided at no charge to participants within 30 days after receipt of a written request for such notification.

Burden:

Year	Total respondents (range)	Total responses (range)	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1998.....	531 to 2,441...	531 to 2,441...	2.....	4 to 17.....	$250 to $1,151
1999.....	.....	.....	.....	.....	.....
2000.....	.....	.....	.....	.....	.....
Totals.....	531 to 2,441...	531 to 2,441...	2.....	4 to 17.....	$250 to $1,151

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in Sec. 146.136. These requirements are not effective until they have been approved by OMB.

If you comment on any of these information collection and recordkeeping requirements, please mail copies directly to the following: Health Care Financing Administration, Office of Information Services, information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2-26-17, 7500 Security Boulevard, Baltimore, MD 21244-1850. ATTN: John Burke HCFA-2891-IFC.

We have submitted a copy of this rule to OMB for its review of these information collections. A notice will be published in the Federal Register when approval is obtained. Interested persons are invited to send comments regarding this burden or any other aspect of these collections of information. If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following addresses:

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20530, Attn: Allison Herron Eydt, HCFA Desk Officer. DATED:

Gerald B. Lindrew, Deputy Director, Pension and Welfare Benefits

Administration, Office of Policy and Research

Statutory Authority

The Department of the Treasury temporary rule is adopted pursuant to the authority contained in sections 7805 and 9833 of the Code (26 U.S.C. 7805, 9833), as amended by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and the Taxpayer Relief Act of 1997 (Pub. L. 105-34, 111 Stat.

788).

The Department of Labor interim final rule is adopted pursuant to the authority contained in sections 107, 209, 505, 701-703, 711, 712, and 731-734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171-1173, 1181, 1182, and 1191-1194), as amended by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and MHPA (Pub. L. 104-204, 110 Stat. 2944), and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

The Department of Health and Human Services interim final rule is adopted

pursuant to the authority contained in sections 2701, 2702, 2705, 2711, 2712, 2713, 2721, 2722, 2723, and 2792 of the PHS Act (42 U.S.C. 300gg, 300gg-1, 300gg-5, 300gg-11, 300gg-12, 300gg-13, 300gg-21, 300gg-22, 300gg-23, and 300gg-92), as established by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and MHPA (Pub. L. 104-204, 110 Stat. 2944).

List of Subjects

26 CFR Part 54

Excise taxes, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Employee benefit plans, Employee Retirement Income Security Act, Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 146

Health care, Health insurance, Reporting and recordkeeping requirements, State regulation of health insurance.

Adoption of Amendments to the Regulations

Internal Revenue Service

26 CFR Chapter I

Accordingly, 26 CFR Part 54 is amended as follows:

PART 54--PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by revising the entries for sections 54.9801-1T through 54.9801-6T and 54.9802-1T, by removing the entries for sections 54.9804-1T, and 54.9806-1T, and by adding entries for sections 54.9812-1T, 54.9831-1T, and 54.9833-1T to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Section 54.9801-1T also issued under 26 U.S.C. 9833.

Section 54.9801-2T also issued under 26 U.S.C. 9833.

Section 54.9801-3T also issued under 26 U.S.C. 9833.

Section 54.9801-4T also issued under 26 U.S.C. 9833.

Section 54.9801-5T also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9833.

Section 54.9801-6T also issued under 26 U.S.C. 9833.

Section 54.9802-1T also issued under 26 U.S.C. 9833.

Section 54.9812-1T also issued under 26 U.S.C. 9833.

Section 54.9831-1T also issued under 26 U.S.C. 9833.

Section 54.9833-1T also issued under 26 U.S.C. 9833.

Par. 2. In Sec. 54.9801-1T, paragraph (a) is revised to read as follows:

Sec. 54.9801-1T Basis and scope (temporary).

(a) Statutory basis. Sections 54.9801-1T through 54.9801-6T,

54.9802-1T, 54.9812-1T, 54.9831-1T and 54.9833-1T (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

* * * * *

Par. 3. Section 54.9801-2T is amended by:

1. Revising the introductory text.

2. Revising the definition of excepted benefits.

3. Revising the definition of health insurance coverage.

The revisions read as follows:

Sec. 54.9801-2T Definitions (temporary).

Unless otherwise provided, the definitions in this section govern in applying the provisions of Secs. 54.9801-1T through 54.9801-6T, 54.9802-1T, 54.9812-1T, 54.9831-1T, and 54.9833-1T.

* * * * *

Excepted benefits means the benefits described as excepted in Sec. 54.9831-1T(b).

* * * * *

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. However, benefits described in Sec. 54.9831-1T(b)(2) are not treated as benefits consisting of medical care.

* * * * *

Par. 4. In Sec. 54.9801-4T, paragraph (a)(2) is revised to read as follows:

Sec. 54.9801-4T Rules relating to creditable coverage (temporary).

(a) * * *

(2) Excluded coverage. Creditable coverage does not include coverage consisting solely of coverage of excepted benefits (described in Sec. 54.9831-1T).

* * * * *

Par. 5. In Sec. 54.9801-5T, the first sentence of paragraph (a)(3)(vi) is revised to read as follows:

Sec. 54.9801-5T Certification and disclosure of previous coverage (temporary).

(a) * * *

(3) * * *

(vi) Excepted benefits; categories of benefits. No certificate is

required to be furnished with respect to excepted benefits described in

Sec. 54.9831-1T. * * *

* * * * *

Sec. 54.9804-1T [Redesignated as Sec. 54.9831-1T]

Par. 6. Section 54.9804-1T is redesignated as Sec. 54.9831-1T and amended by revising paragraph (b)(1) to read as follows:

Sec. 54.9831-1T Special rules relating to group health plans (temporary).

* * * * *

(b) Excepted benefits--(1) In general. The requirements of

Secs. 54.9801-1T through 54.9801-6T, 54.9802-1T, and 54.9812-1T do not apply to any group health plan in relation to its provision of the benefits described in paragraph (b) (2), (3), (4), or (5) of this section (or any combination of these benefits).

* * * * *

Sec. 54.9806-1T [Redesignated as Sec. 54.9833-1T]

Par. 7. Section 54.9806-1T is redesignated as Sec. 54.9833-1T and amended by:

1. Revising paragraph (a)(1).

2. Revising the first sentence of paragraph (a)(2).

The revisions read as follows:

Sec. 54.9833-1T Effective dates (temporary).

(a) General effective dates--(1) Non-collectively-bargained plans.

Except as otherwise provided in this section, Chapter 100 of Subtitle K and Secs. 54.9801-1T through 54.9806-1T, 54.9802-1T, and 54.9831-1T apply with respect to group health plans for plan years beginning after June 30, 1997.

(2) Collectively bargained plans. Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Chapter 100 of Subtitle K and Secs. 54.9801-1T through 54.9801-6T, 54.9802-1T, and 54.9831-1T do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996).* * *

* * * * *

Par. 8. Section 54.9812-1T is added to read as follows:

Sec. 54.9812-1T Parity in the application of certain limits to mental health benefits (temporary).

(a) Definitions. For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) Requirements regarding limits on benefits--(1) In general--(i) General parity requirement. A group health plan that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b) (2), (3), or (6) of this section.

(ii) Exception. The rule in paragraph (b)(1)(i) of this section does not apply if a plan satisfies the requirements of paragraph (e) or (f) of this section.

(2) Plan with no limit or limits on less than one-third of all medical/surgical benefits. If a plan does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) Plan with a limit on at least two-thirds of all medical/ surgical benefits. If a plan includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical

benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) Examples. The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a $10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a $500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a $250,000 annual limit on medical/surgical benefits and a $250,000 annual limit on mental health benefits.

(ii) In this Example 1, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 2. (i) Prior to the effective date of the mental health parity provisions, a group health plan had a $100,000 annual limit on medical/surgical inpatient benefits, a $50,000 annual limit on medical/surgical outpatient benefits, and a $100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a $150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a $100,000 annual limit on mental health inpatient benefits and a $50,000 annual limit on mental health outpatient benefits.

(ii) In this Example 2, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/ surgical and mental health benefits.

Example 3. (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this Example 3, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and

mental health benefits.

Example 4. (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/ surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this Example 4, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this Example 4 would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this Example 4 would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) Determining one-third and two-thirds of all medical/surgical benefits. For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) Plan not described in paragraph (b)(2) or (3) of this section—(i) In general. A group health plan that is not described in paragraph (b)(2) or (3) of this section, must either—

(A) Impose no aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) Impose an aggregate lifetime or annual limit on mental health benefits that is no less than an average limit for medical/surgical benefits calculated in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) Weighting. For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) Example. The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a $100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that $1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this Example, the plan is not described in paragraph

(b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is $640,000 (40% x $100,000 + 60% x $1,000,000 = $640,000).

(c) Rule in the case of separate benefit packages. If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) Applicability--(1) Group health plans. The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) Health insurance issuers. See 29 CFR 2590.712(d)(2) and 45 CFR 146.136(d)(2), which provide that health insurance issuers offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan are subject to rules similar to those applicable to group health plans under this section.

(3) Scope. This section does not—

(i) Require a group health plan to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan except as specifically provided in paragraph (b) of this section.

(e) Small employer exemption--(1) In general. The requirements of this section do not apply to a group health plan for a plan year of a small employer. For purposes of this paragraph (e), the term small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 9831(a) and Sec. 54.9831-1T(a), which provide that this section (and certain other sections) does not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) Rules in determining employer size. For purposes of paragraph (e)(1) of this section—(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) Increased cost exemption--(1) In general. A group health plan is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements

of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) Calculation of the one-percent increase--(i) Ratio. A group health plan satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan results in an increase in the cost under the plan of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by—

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) Formula. The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

(A) IE means the incurred expenditures during the base period.

(B) CE means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section(c) AE means administrative costs related to claims in CE and other administrative costs attributable to complying with the requirements of this section.

(iii) Incurred expenditures. Incurred expenditures means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) Base period. Base period means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) Rating pools. For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator based on the incurred expenditures of the plan.

(vi) Examples. The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that $1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that $100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are $1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are $40,000 and that administrative expenses attributable to complying with the requirements of this section are $10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are $1,050,000 ($1,100,000--

($40,000 + $10,000) = $1,050,000).

(ii) In this Example 1, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ($1,100,000/$1,050,000 = 1.04762).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this Example 2, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be $2,000,000 and the administrative expenses for the base period for the self-funded portion to be $200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are $1,000,000 and the administrative expenses for the base period are $100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are $0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are $1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are $25,000 and the administrative costs attributable to complying with the requirements of this section are $1,000. Thus, the total incurred expenditures for the plan for the base period are $3,300,000 ($2,000,000 + $200,000 + $1,000,000 + $100,000 =

$3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are $3,273,000 ($3,300,000-($0 + $1,000 + $25,000 + $1,000) = $3,273,000).

(ii) In this Example 3, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ($3,300,000/$3,273,000 = 1.00825).

(3) Notice of exemption--(i) Participants and beneficiaries--(A) In general. A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;

(2) The name and telephone number of the individual to contact for further information;

(3) The plan name and plan number (PN);

(4) The plan administrator's name, address, and telephone number;

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN);

(6) The effective date of the exemption;

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and

(8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) Use of summary of material reductions in covered services or benefits. A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(c) of this section) with a summary of material reductions in covered services or benefits required under 29 CFR 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) Delivery. The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(b)(1)) (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) Example. The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this Example, the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) Federal agencies. A group health plan that is a church plan (as defined in section 414(e)) claiming the exemption of this paragraph (f) for any benefit package must provide notice in accordance with the requirement of this paragraph (f)(3)(ii). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies. For any other group health plan, see 29 CFR 2590.712(f)(3)(ii)(B).

(4) Availability of documentation. The plan must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any individually identifiable information.

(g) Special rules for group health insurance coverage--(1) Sale of nonparity policies. See 29 CFR 2590.712(g)(1) and 45 CFR 146.136(g)(1) for rules limiting the right of an issuer to sell a policy without parity (as described in 29 CFR 2590.712(b) and 45 CFR 146.136(b)) to a plan that meets the requirements of 29 CFR 2590.712 (e) or (f) and 45 CFR 146.136 (e) or (f)).

(2) Duration of exemption. After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) Effective dates--(1) In general. The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) Limitation on actions. (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of section 9812, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after

April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 9812.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 9812 in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this Example 1, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a $1,000,000 annual limit on medical/surgical benefits and a $100,000 annual limit on mental health benefits.

(ii) In this Example 2, the plan has not sought to comply with the requirements of section 9812 in good faith, and this paragraph (h)(2) does not apply.

(3) Transition period for increased cost exemption--(i) In general. No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 9812(c)(2) based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) Notice of plan's use of transition period. (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts the notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of the Employee Retirement Income Security Act of 1974, and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan (as defined in section 414(e)), the applicable federal agency is the Department of the Treasury. For a group health plan that is not a church plan, see 29 CFR 2590.712(h)(3)(ii). The notice must include—

(1) The name of the plan and the plan number (PN);

(2) The name, address, and telephone number of the plan administrator;

(3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(4) The name and telephone number of the individual to contact for

further information; and

(5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) Sunset. This section does not apply to benefits for services furnished on or after September 30, 2001.

Dated: December 16, 1997.

Michael P. Dolan,

Deputy Commissioner of Internal Revenue.

Approved: December 16, 1997.

Donald C. Lubick,

Acting Assistant Secretary of the Treasury.

Pension and Welfare Benefits Administration

29 CFR Chapter XXV

29 CFR Part 2590 is amended as follows:

PART 2590--RULES AND REGULATIONS FOR HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

1. The authority citation for Part 2590 is revised to read as follows:

Authority: Secs. 107, 209, 505, 701-703, 711, 712, and 731-734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171-1173, 1181, 1182, and 1191-1194), as amended by Pub. L. 104-191, 110 Stat. 1936 and Pub. L. 104-204, 110 Stat. 2944; and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

Subpart B—Other Requirements

2. Section 2590.712 is revised to read as follows:

Sec. 2590.712 Parity in the application of certain limits to mental health benefits.

(a) Definitions. For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan or group health insurance coverage, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan or group health insurance coverage, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) Requirements regarding limits on benefits--(1)--general--(i) General parity requirement. A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), (3), or (6) of this section.

(ii) Exception. The rule in paragraph (b)(1)(i) of this section does not apply if a plan, or coverage, satisfies the requirements of paragraph (e) or (f) of this section.

(2) Plan with no limit or limits on less than one-third of all medical/surgical benefits. If a plan (or group health insurance coverage) does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) Plan with a limit on at least two-thirds of all medical/ surgical benefits. If a plan (or group health insurance coverage) includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) Examples. The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a $10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a

$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and(c) Replacing the plan's previous annual limit on mental health benefits with a $250,000 annual limit on medical/surgical benefits and a $250,000 annual limit on mental health benefits.

(ii) In this Example 1, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 2. (i) Prior to the effective date of the mental health parity provisions, a group health plan had a $100,000 annual limit on medical/surgical inpatient benefits, a $50,000 annual limit on medical/surgical outpatient benefits, and a $100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health

benefits with a $150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a $100,000 annual limit on mental health inpatient benefits and a $50,000 annual limit on mental health outpatient benefits.

(ii) In this Example 2, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/ surgical and mental health benefits.

Example 3. (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this Example 3, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 4. (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of

chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/ surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this Example 4, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this Example 4 would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this Example 4 would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) Determining one-third and two-thirds of all medical/surgical benefits. For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/ surgical benefits.

(6) Plan not described in paragraph (b)(2) or (3) of this section—(i) In general. A group health plan (or group health insurance coverage) that is not described in paragraph (b)(2) or (3) of this section, must either—

(A) Impose no aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) Impose an aggregate lifetime or annual limit on mental health benefits that is no less than an average limit calculated for medical/ surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) Weighting. For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in

paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) Example. The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a $100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that $1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this Example, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is $640,000 (40% x $100,000 + 60% x $1,000,000 = $640,000).

(c) Rule in the case of separate benefit packages. If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) Applicability--(1) Group health plans. The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) Health insurance issuers. The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) Scope. This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in paragraph (b) of this section.

(e) Small employer exemption--(1) In general. The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 732(a) of the Act and Sec. 2590.732(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) Rules in determining employer size. For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) Increased cost exemption--(1) In general. A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) Calculation of the one-percent increase--(i) Ratio. A group health plan (or group health insurance coverage) satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by, (B) The incurred expenditures during the base period, reduced by—

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) Formula. The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

(A) IE means the incurred expenditures during the base period.

(B) CE means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section

(C) AE means administrative costs related to claims in CE and other administrative costs attributable to complying with the requirements of this section.

(iii) Incurred expenditures. Incurred expenditures means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) Base period. Base period means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) Rating pools. For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) Examples. The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that $1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that $100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are $1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section

are $40,000 and that administrative expenses attributable to complying with the requirements of this section are $10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are $1,050,000 ($1,100,000 - ($40,000 + $10,000) = $1,050,000).

(ii) In this Example 1, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ($1,100,000/$1,050,000 = 1.04762).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this Example 2, none of the plans satisfy the

requirements of this paragraph

(f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be $2,000,000 and the administrative expenses for the base period for the self-funded portion to be $200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are $1,000,000 and the administrative expenses for the base period are $100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are $0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are $1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are $25,000 and the administrative costs attributable to complying with the requirements of this section are $1,000. Thus, the total incurred expenditures for the plan for the base period are $3,300,000 ($2,000,000 + $200,000 + $1,000,000 + $100,000 = $3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are $3,273,000 ($3,300,000-($0 + $1,000 + $25,000 + $1,000) = $3,273,000).

(ii) In this Example 3, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ($3,300,000/$3,273,000 = 1.00825).

(3) Notice of exemption--(i) Participants and beneficiaries--(A) In general. A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;

(2) The name and telephone number of the individual to contact for further information;

(3) The plan name and plan number (PN);

(4) The plan administrator's name, address, and telephone number;

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN);

(6) The effective date of the exemption;

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and

(8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) Use of summary of material reductions in covered services or benefits. A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(c) of this section) with a summary of material reductions in covered services or benefits required under Sec. 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) Delivery. The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) Example. The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this Example, the plan has sent the notice in a manner that complies with

this paragraph (f)(3)(i).

(ii) Federal agencies--(A) Church plans. A church plan (as defined in section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) Group health plans subject to Part 7 of Subtitle B of Title I of ERISA. A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(c) Nonfederal governmental plans. A group health plan that is a nonfederal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) Availability of documentation. The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any individually identifiable information.

(g) Special rules for group health insurance coverage--(1) Sale of nonparity policies. An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraphs (e) or (f) of this section.

(2) Duration of exemption. After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) Effective dates--(1) In general. The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) Limitation on actions. (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of

section 712 of the Act, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 712 of Part 7 of Subtitle B of Title I of ERISA.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 712 of Part 7 of Subtitle B of Title I of ERISA in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this Example 1, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a $1,000,000 annual limit on medical/surgical benefits and a $100,000 annual limit on mental health benefits.

(ii) In this Example 2, the plan has not sought to comply with the requirements of section 712 of the Act in good faith and this paragraph (h)(2) does not apply.

(3) Transition period for increased cost exemption-- (i) In general. No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 712(c)(2) of Part 7 of Subtitle B of Title I of ERISA based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) Notice of plan's use of transition period. (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts such notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include—

(1) The name of the plan and the plan number (PN);

(2) The name, address, and telephone number of the plan administrator;

(3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(4) The name and telephone number of the individual to contact for further information; and

(5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) Sunset. This section does not apply to benefits for services furnished on or after September 30, 2001.

Signed at Washington, DC, this 16th day of December, 1997.

Olena Berg,

Assistant Secretary, Pension Welfare Benefits Administration, U.S.

Department of Labor.

Health Care Financing Administration

45 CFR Subtitle A, Subchapter B

45 CFR Part 146 is amended as follows:

PART 146--REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

1. The authority citation for Part 146 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92).

2. A new Subpart C is added to Part 146 to read as follows:

Subpart C—Requirements Related to Benefits

Sec. 146.136 Parity in the application of certain limits to mental health benefits.

(a) Definitions. For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or group health insurance coverage offered in connection with such plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or group health insurance coverage offered in connection with such plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan or group health insurance coverage, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan or group health insurance coverage, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) Requirements regarding limits on benefits--(1) In general--(i) General parity requirement. A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), paragraph (b)(3), or paragraph (b)(6) of this section.

(ii) Exception. The rule in paragraph (b)(1)(i) of this section does not apply if a plan, or coverage, satisfies the requirements of paragraph (e) or paragraph (f) of this section.

(2) Plan with no limit or limits on less than one-third of all medical/surgical benefits. If a plan (or group health insurance coverage) does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) Plan with a limit on at least two-thirds of all medical/ surgical benefits. If a plan (or group health insurance coverage) includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) Examples. The rules of paragraphs (b) (2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a $10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a

$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a $250,000 annual limit on medical/surgical benefits and a $250,000 annual limit on mental health benefits.

(ii) In this Example 1, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 2. (i) Prior to the effective date of the mental health parity provisions, a group health plan had a $100,000 annual limit on medical/surgical inpatient benefits, a $50,000 annual limit on medical/surgical outpatient benefits, and a $100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a $150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a $100,000 annual limit on mental health inpatient benefits and a $50,000 annual limit on mental health outpatient benefits.

(ii) In this Example 2, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/ surgical and mental health benefits.

Example 3. (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this Example 3, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 4. (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/ surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this Example 4, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this Example 4 would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this Example 4 would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) Determining one-third and two-thirds of all medical/surgical benefits. For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/ surgical benefits.

(6) Plan not described in paragraph (b)(2) or paragraph (b)(3) of this section--(i) In general. A group health plan (or group health insurance coverage) that is not described in paragraph (b)(2) or paragraph (b)(3) of this section, must either impose—

(A) No aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) An aggregate lifetime or annual limit on mental health benefits that is no less than an average limit for medical/surgical benefits calculated in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment, or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) Weighting. For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) Examples. The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a $100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that $1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this Example, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is $640,000 (40% " $100,000 + 60% " $1,000,000 = $640,000).

(c) Rule in the case of separate benefit packages. If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) Applicability--(1) Group health plans. The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) Health insurance issuers. The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) Scope. This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in

paragraph (b) of this section.

(e) Small employer exemption--(1) In general. The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See regulations at Sec. 146.145(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) Rules in determining employer size. For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) Increased cost exemption--(1) In general. A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) Calculation of the one-percent increase--(i) Ratio. A group health plan (or group health insurance coverage) satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by—

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section, and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) Formula. The ratio of paragraph (f)(2)(i) is expressed mathematically as follows:

(A) IE means the incurred expenditures during the base period.

(B) CE means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section.

(C) AE means administrative costs related to claims in CE and other administrative costs attributable to complying with the requirements of this section.

(iii) Incurred expenditures. Incurred expenditures means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) Base period. Base period means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) Rating pools. For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) Examples. The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that $1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that $100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are $1,100,000. The plan also determines that

the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are $40,000 and that administrative expenses attributable to complying with the requirements of this section are $10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are $1,050,000 ($1,100,000--

($40,000 + $10,000) = $1,050,000).

(ii) In this Example 1, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ($1,100,000/$1,050,000 = 1.04762).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled-basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this Example 2, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially-insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be $2,000,000 and the administrative expenses for the base period for the self-funded portion to be $200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are $1,000,000 and the administrative expenses for the base period are $100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are $0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are $1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are $25,000 and the administrative costs attributable to complying with the requirements of this section are $1,000. Thus, the total incurred expenditures for the plan for the base period are $3,300,000 ($2,000,000 + $200,000 + $1,000,000 + $100,000 = $3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are $3,273,000 ($3,300,000 - ($0 + $1,000 + $25,000 + $1,000) = $3,273,000).

(ii) In this Example 3, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ($3,300,000/$3,273,000 = 1.00825).

(3) Notice of exemption--(i) Participants and beneficiaries--(A) In general. A group health plan must notify participants and beneficiaries of the plan's decision to claim the one percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption.

(2) The name and telephone number of the individual to contact for further information.

(3) The plan name and plan number (PN).

(4) The plan administrator's name, address, and telephone number.

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN).

(6) The effective date of such exemption.

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's election of the exemption.

(8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) Use of summary of material reductions in covered services or benefits. A plan may satisfy the requirements of paragraph (f)(3)(i)(A) by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(c)) with a summary of material reductions in covered services or benefits consistent with Department of Labor regulations at 29 CFR 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) Delivery. The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (29 U.S.C. 1024(b)(1)) (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) Example. The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this Example, the plan has sent the notice in a manner that complies with

this paragraph (f)(3)(i).

(ii) Federal agencies--(A) Church plans. A church plan (as defined in section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) Group health plans subject to Part 7 of Subtitle B of Title I of ERISA. A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(C) Non-Federal governmental plans. A group health plan that is a non-Federal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) Availability of documentation. The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements for the exemption. In no event should the summary of information include any individually identifiable information.

(g) Special rules for group health insurance coverage--(1) Sale of nonparity policies. An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraph (e) or paragraph (f) of this section.

(2) Duration of exemption. After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) Effective dates--(1) In general. The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) Limitation on actions. (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of

section 2705 of the PHS Act, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after

April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 2705 of the PHS Act.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 2705 of the PHS Act in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this Example 1, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a $1,000,000 annual limit on medical/surgical benefits and a $100,000 annual limit on mental health benefits.

(ii) In this Example 2, the plan has not sought to comply with the requirements of section 2705 of the PHS Act in good faith and this paragraph (h)(2) does not apply.

(3) Transition period for increased cost exemption--(i) In general. No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 2705(c)(2) of the PHS Act based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) Notice of plan's use of transition period. (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts the notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury.

For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include—

(1) The name of the plan and the plan number (PN);

(2) The name, address, and telephone number of the plan administrator;

(3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(4) The name and telephone number of the individual to contact for further information; and

(5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) Sunset. This section does not apply to benefits for services furnished on or after September 30, 2001.

Dated: December 16, 1997.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: December 16, 1997.

Donna E. Shalala,

Secretary, Department of Health and Human Services.

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