STATE OF CONNECTICUT

INSURANCE DEPARTMENT

BULLETIN HC-87
AUGUST 1, 2011

TO: ALL INSURANCE COMPANIES, FRATERNAL BENEFIT SOCIETIES, HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS AND HEALTH CARE CENTERS THAT DELIVER OR ISSUE LARGE GROUP HEALTH INSURANCE POLICIES IN CONNECTICUT

SUBJECT: ALLOWABLE OFFICE VISIT COPAYMENTS FOR MENTAL HEALTH SERVICES TO COMPLY WITH MENTAL HEALTH PARITY

Purpose

The purpose of this bulletin is to clarify what copayments are allowed for mental health office visits to comply with state and federal mental health parity laws. Based on initial guidance from the Department of Health and Human Services (HHS), the Insurance Department disapproved policies sold in the large group market on or after July 1, 2010 that differentiated office visit copayments for primary care physicians and specialists if the mental health provider office visit copayment was subject to the specialist copayment. In Connecticut, the large employer group market is defined as groups of 51 or more employees. HHS has recently provided further guidance that mental health providers may be subject to the specialist copayment in certain circumstances. This bulletin also sets forth additional filing requirements for carriers seeking to subject mental health providers to the specialist copayment in the large group market.

History

Connecticut General Statutes Sections §38a-488a and §38a-514 require specified types of health insurance policies to provide coverage for the diagnosis and treatment of mental and nervous conditions and prohibit such individual and group policies from establishing any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis and treatment for mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical conditions. The Interim Final Rules under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (45 CFR Part 146) provides tests for determining "substantially all" and "predominant" medical/surgical benefits for reviewing the financial requirements and quantitative treatment limitations. Since Connecticut law is more stringent in its requirements, and MHPAEA does not pre-empt state law where state law provides stronger protections, policy forms must conform to state requirements. The one exception where federal law

may provide greater protection is with regard to office visit copayments if there is a differential in copayment for primary care physicians and specialists. This provision of federal law is applicable only to employer groups of 51 or more employees.

Under state law, the Insurance Department allows differentials in copayments for primary care physicians and specialists and allows the mental and nervous providers to be viewed as specialists. However, beginning on July 1, 2010, the Insurance Department no longer approved such filings for large group policies that are subject to federal law. In the preamble to the Interim Final Rules under MHPAEA, there is language that implied mental health providers could not be subject to a specialist copayment that differed from the copayment for a primary care physician. The Insurance Department asked for clarification on this issue and whether the substantially all and predominant tests would rule. The initial guidance from HHS was that the mental health office visit copayment could be no higher than the copayment for a primary care physician under any circumstance. As such, carriers were required to modify their large group policy form filings to conform to the federal standard. HHS recently modified its initial guidance to allow the mental health office visit copayment to be at the specialist copayment if the substantially all and predominant tests were both met. HHS indicated that the Insurance Department should require the carriers to provide documentation that the tests have been met.

Required Filings

Any insurance carrier that wishes to offer plans that differentiate primary care physician and specialist copayments for office visits and treat mental health providers as specialists in the large group market must file a demonstration that each such plan meets the substantially all and predominant tests set forth in the Interim Final Rules under MHPAEA. Such demonstration must accompany any form filing with this option. If carriers have previously approved forms, a demonstration should be filed with the Insurance Department before issuing any new contracts with this provision. After the initial approval, such demonstration must be made annually. The demonstration for each plan offered must be in the following format and accompanied by a certification signed by a member of the American Academy of Actuaries.

For each plan, the carrier must provide data in the attached format. The plan description should be brief, but clearly identify the plan. The chart should be populated with the copayment amounts for all available options. The actual calculation of the two tests should be detailed.

Questions

Please contact the Insurance Department Life and Health Division at cid.lh@ct.gov with any questions.

Thomas B. Leonardi
Insurance Commissioner

Attachment

Plan Description:

Copayment amount	$	$	$	$	$	Total
Projected payments						
Percent of total plan costs						
Percent subject to copayment						

Provide the calculation demonstrating that the substantially all standard is met:

Provide the calculation demonstrating the determination of the predominant rate/amount: