# PUBLIC SUBMISSION

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**Docket:** IRS-2009-0008
Request for Information for Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

**Comment On:** IRS-2009-0008-0001
Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

**Document:** IRS-2009-0008-0007
Comment on FR Doc # E9-09629

## Submitter Information

**Name:** David R. Riemer
**Address:**
Wauwatosa, WI,
**Organization:** Community Advocates Public Policy Institute
**Government Agency Type:** Federal
**Government Agency:** CMS

## General Comment

Please see the attached letter dated May 19, 2009, from David R. Riemer, Director of Policy and Planning for Community Advocates Public Policy Institute, Wauwatosa, Wisconsin, to Adam Shaw, Centers for Medicare and Medicaid Services, Department of Health and Human Services, in which Mr. Riemer requests that the proposed federal rules state that Medicaid managed care organizations are subject to compliance with the addiction and mental health parity provisions of Subpart 2 of Part A of Section 2705 of the Public Health Service Act, as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Division C, Title V, Subtitle B, Sections 511-512 of the Emergency Economic Stabilization Act, H.R. 1424, P.L. 110-343), cited as 42 U.S.C.S. Section 300gg-5.

## Attachments

IRS-2009-0008-0007.1 Comment on FR Doc # E9-09629

COMMUNITY ADVOCATES
Public Policy Institute

May 19, 2009

Direct Dial: 414.475.6253, ext. 301
Email: driemermil@yahoo.com

Mr. Adam Shaw
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Dear Mr. Shaw:

My name is David Riemer and I am Director of Policy and Planning at the Public Policy Institute of Community Advocates, an organization in Milwaukee that provides basic needs advocacy and services to low-income and at-risk individuals. As head of the Community Advocates Public Policy Institute, I lead an effort to create and implement sound public policy that will dramatically reduce poverty and its effects in both Milwaukee and Wisconsin. Chief among these poverty effects are negative health outcomes -- including lower life expectancy, higher rates of chronic illness, and untreated mental illness and addiction -- and the imposition of barriers to accessing medical care.

Of fundamental importance to the Institute, then, is the formation of a rational health care delivery system that improves access and benefit coverage for the poor and near-poor through Medicaid managed care programs that provide health insurance coverage for their enrollees by Medicaid managed care organizations. We believe federal law requires such coverage to include parity for addiction and mental health services. Yet, the applicability of parity coverage to such organizations is not generally known.

In order to eliminate and avoid any doubt or confusion regarding this issue, the regulations to be developed should clearly state that Medicaid managed care organizations are subject to compliance with the parity provisions of Subpart 2 of Part A of Section 2705 of the Public Health Service Act as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Division C, Title V, Subtitle B, Secs. 511-512 of the Emergency Economic Stabilization Act, H.R. 1424, P.L. 110-343) (the MHPAEA).

We have conducted an extensive legal analysis regarding the applicability of the MHPAEA to Medicaid managed care organizations. This research has resulted in our conclusion that federal law compels compliance with the parity provisions of the MHPAEA by Medicaid managed care organizations. We would briefly like to share the key results of the analysis with you.

As noted in the Request for Information, the Mental Health Parity Act of 1996 (MHPA) was the first federal mental health parity law which was enacted on September 26, 1996, as P.L. 104-204, Title VII, Section 703(a), 110 Stat. 2947. According to the Congressional Research Service Report for Congress dated November 19, 2008, the MHPA requires partial parity "by mandating that annual and lifetime dollar limits on coverage for mental health treatment under group health plans offering mental health coverage be no less than for physical illnesses." This law amended the Public Health Service Act (PHSA), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 (IRC). The MHPA's amendments to the PHSA are the provisions of the Act that, in conjunction with Section 1932(b)8 of Title XIX of the Social Security Act, require Medicaid managed care organizations to provide this limited parity coverage for mental health benefits.[1] The MHPA added to Title XXVII, Part A, Subpart 2, Section 2705 of the PHSA, which is codified as 42 U.S.C.S. Section 300gg-5 (Parity in the application of certain limits to mental health benefits).

On October 3, 2008, President George W. Bush signed into law P.L. 110-343, H.R. 1424, the Emergency Economic Stabilization Act which included the MHPAEA. The MHPAEA further expands and amends Section 2705 of the PHSA (42 U.S.C.S. Section 300gg-5) to "…require group health plans for employers larger than 50 employees that provide both medical and surgical benefits and mental health or substance use disorder benefits to ensure that: (1) the financial requirements, such as deductibles and copayments, applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan; (2) there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; (3) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered under the plan; and (4) there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits." (2008 Bill Tracking Report, H.R. 1424; 110 Bill Tracking H.R. 1424, LexisNexis, 04/01/09)

[1] The MHPA's other provisions relating to Section 712 of ERISA apply only to employers, requiring employers of a certain size to include mental health parity in the annual and lifetime dollar limits of employer-sponsored health care plans. The MHPA's changes to Section 9812 of the IRC apply to a slightly broader definition of group health plans than ERISA, and impose excise taxes on such plans which fail to meet the parity requirements.

In addition, the MHPAEA modifies the PHSA definition of "mental health benefits" and adds a definition for "substance use disorder benefits". Mental health benefits are defined to mean "benefits with respect to services for mental health conditions, as defined under the terms of the plan, and in accordance with applicable Federal and State law". Substance use disorder benefits will mean "benefits with respect to services for substance use disorders, as defined under the terms of the plan, and in accordance with applicable Federal and State law."

The PHSA's original parity requirements for annual and lifetime dollar limits, created by the MHPA, will remain the same once the MHPAEA takes effect. All of the amendments to the PHSA resulting from the MHPAEA should become effective either one year after the Act's October 3, 2008, enactment or no later than January 1, 2010.

Like the original MHPA itself, the MHPAEA amends the same three distinct federal laws: the PHSA, ERISA and the IRC. Again, only the amendments to the PHSA are relevant to an analysis about the applicability of the MHPAEA's parity requirements to Medicaid managed care organizations. The PHSA–amending provisions of the MHPAEA are found in Division C, Title V, Subtitle B, Sec. 512(b) of the Emergency Economic Stabilization Act, H.R. 1424, P.L. 110-343.[2]

Section 1932(b) 8 of Title XIX of the Social Security Act (cited as 42 U.S.C.S. Section 1396u-2(b)(8)) applies the full parity provisions of the PHSA (Title XXVII, Part A, Subpart 2, Section 2705 of the Public Health Service Act, i.e., 42 U.S.C.S. Sec. 300gg-4 et seq., and specifically Sec. 300gg-5 (Parity in the application of certain limits to mental health benefits)) -- including the expanded parity amendments to the PHSA added by the MHPAEA -- to Medicaid managed care organizations. The text of the Social Security Act statute that requires the application of the full parity provisions of the PHSA -- including the new provisions added by the MHPAEA -- to Medicaid managed care organizations is as follows:

> "Title 42 – The Public Health and Welfare, Chapter 7 – Social Security, Subchapter XIX – Grants to States for Medical Assistance Programs, Section 1396u-2, Provisions relating to managed care, (b) Beneficiary protections, (8) Compliance with certain maternity and mental health requirements (cited as 42 U.S.C.S. Section 1396u-2(b)(8)[3]):
>
> (b) Beneficiary Protections.
> …

[2] Attachment A shows the PHSA before its amendment by the MHPAEA (Column 1), indicates how the PHSA was altered by the MHPAEA (Column 2) with strike-throughs showing deletions and underlining showing additions, and finally provides a "clean" version of the PHSA after its amendment by the MHPAEA (Column 3).

[3] This amendment to the Social Security Act was added on August 5, 1997 as P.L. 105-33.

> (8) Compliance with certain maternity and mental health requirements. Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage." (LexisNexis)

In other words, all Medicaid managed care organizations that provide any addiction or mental health benefit -- whether (1) the Medicaid agencies with which they contract. require them to provide such a benefit, or (2) they unilaterally choose to provide such a benefit -- are required by the Social Security Act to provide the addiction or mental health benefit in a manner that complies with the parity provisions of Section 2705 of the PHSA. The interaction between the Social Security Act and the PHSA does not technically compel a Medicaid agency to deliver parity, but, rather, compels Medicaid managed care organizations to include parity in their benefit packages if they are contractually obligated or otherwise elect to provide an addiction or mental health service in the first place. Either way, however, the practical effect is the same. If a Medicaid agency includes an addiction or mental health benefit in its overall health benefit package and delivers that benefit package through a Medicaid managed care organization, the addiction or mental health benefit must be provided on a parity basis because the Medicaid managed care organization under Section 1932(b)(8) of Title XIX of the Social Security Act -- and its link to Section 2705 of the PHSA -- has no legal option to do otherwise.

We have participated in numerous discussions with federal congressional and agency staff, as well as with national and local health care advocacy organizations, regarding this issue of applicability of coverage. We have been advised by the Congressional Research Service (CRS) as well as by staff at the Center for Medicare and Medicaid Services (CMS) that the parity provisions of the PHSA -- which now incorporate the new and expanded parity language from the MHPAEA-- are fully applicable to Medicaid managed care organizations. In fact, a State Medicaid Director Letter dated January 20, 1998, signed by Sally Richardson, Director, and posted on the CMS Medicaid website at www.cms.hhs.gov, unequivocally states that Medicaid managed care organizations must comply with the requirements of the MHPA (See Attachment B). By extension, the provisions of the MHPAEA are similarly applicable to Medicaid managed care organizations as this Act further amends and expands the parity provisions of the MHPA.

The Congressional Budget Office (CBO) has also concluded that the parity provisions of the MHPAEA apply to Medicaid managed care organizations. The CBO fiscal estimates for the MHPAEA prepared for Congress in 2007 all state: "The bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program…".[4] (Emphasis added). Our own legal research has confirmed this conclusion.

[4] CBO prepared Congressional Budget Office Cost Estimates for H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007 and for S. 558, the Mental Health Parity Act of 2007, (the provisions of which were substantially the same as those of the Wellstone-Domenici Act) for the U.S.

Unfortunately, the applicability of the PHSA parity provisions to Medicaid managed care organizations in accordance with federal law is barely understood. Our discussions with the health care advocacy organizations, businesses, and, most significantly, the State of Wisconsin have revealed that there remains great uncertainty surrounding the question of whether the parity provisions of the PHSA apply to Medicaid managed care organizations.

Federal law requires that Medicaid managed care organizations comply with the parity provisions of Section 2705 of the PHSA – as further amended by the MHPAEA. To ensure that there is no further question concerning the applicability of the MHPAEA to Medicaid managed care organizations, the federal rules should state that the provisions of Section 2705 of the PHSA cited as 42 U.S.C.S. Section 300gg-5 apply to Medicaid managed care organizations in accordance with the authority found in Section 1932(b)8 of Title XIX of the Social Security Act cited as 42 U.S.C.S. Section 1396u-2(b)(8).

Thank you for the opportunity to comment on this most important of rulemaking processes.

Very truly yours,

David R Riemer

David R. Riemer
Director of Policy and Planning

DJK/ser
Attachment

House Committee on Education and Labor (dated October 15, 2007), the U.S. House Committee on Ways and Means (dated October 15, 2007), the U.S. House Committee on Energy and Commerce (dated November 21, 2007) and the U.S. Senate Committee on Health, Education, Labor and Pensions (dated March 20, 2007).

ATTACHMENT A

# THE PUBLIC HEALTH SERVICE ACT PARITY REQUIREMENTS: APPLICABLE TO MEDICAID MANAGED CARE ORGANIZATIONS

## 42 U.S.C.S. SECTION 1396u-2(b)(8). COMPLIANCE WITH CERTAIN MATERNITY AND MENTAL HEALTH REQUIREMENTS.

## 42 U.S.C.S. SECTION 300gg-5. PARITY IN THE APPLICATION OF CERTAIN LIMITS TO MENTAL HEALTH BENEFITS.

COMMUNITY ADVOCATES
Public Policy
Institute

# The Public Health Service Act Parity Requirements: Applicable to Medicaid Managed Care Plans

## I. The addiction and mental health benefits parity provisions of the Public Health Service Act (42 U.S.C.S. Section 300gg-5)[1] apply to Medicaid managed care organizations under the authority of 42 U.S.C.S. Section 1396u-2(b)(8)[2].

Title 42 – The Public Health and Welfare, Chapter 7 – Social Security, Subchapter XIX – Grants to States for Medical Assistance Programs, Sec. 1396u-2 – Provisions relating to managed care, (b)- Beneficiary protections, (8) – Compliance with certain maternity and mental health requirements.

Cite as: 42 U.S.C.S. Sec. 1396u-2(b)(8)

(b) Beneficiary Protections.

…..

(8) Compliance with certain maternity and mental health requirements.-- Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.

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[1] Title XXVII, Part A, Subpart 2, Sec. 2705 of the Public Health Service Act, cited as 42 U.S.C.S. Section 300gg-5 (Parity in the application of certain limits to mental health benefits); as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Division C, Title V, Subtitle B, Secs. 511-512 of the Emergency Economic Stabilization Act, H.R. 1424, P.L. 110-343 enacted October 3, 2008 (the Wellstone-Domenici Act)). The amendments added by the Wellstone-Domenici Act take effect one year after the date of the Act's enactment or no later than January 1, 2010.

[2] Section 1932(b)(8) of Title XIX of the Social Security Act, enacted on August 5, 1997, cited as 42 U.S.C.S. Section 1396u-2(b)(8).

**Revised May 1, 2009**

## II. The Public Health Service Act: A Comparison of Current Law, Amended Law and Final Law

| Current Law Prior to Application of the Wellstone-Domenici Act[3] | Amended Law After the Wellstone-Domenici Act Takes Effect[4] | Final Text of Amended Law After the Wellstone-Domenici Act Takes Effect |
|---|---|---|
| | [NOTE: Deleted language shown with ~~strike-throughs~~. New language shown with underlining] | |
| 42 U.S.C.S. Sec. 300gg-5. Parity in the application of certain limits to mental health benefits | 42 U.S.C.S Sec. 300gg-5. Parity in the application of certain limits to ~~mental health benefits~~ mental health and substance use disorder benefits. | 42 U.S.C.S Sec. 300gg-5. Parity in the application of certain limits to mental health and substance use disorder benefits. |
| (a) In general.<br>(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) In general.<br>(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~~ mental health or substance use disorder benefits-- | (a) In general.<br>(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 or substance use disorder 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. | (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~~ mental health or substance use disorder 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 or substance use disorder benefits. |
| (B) Lifetime limit. If the plan or cover- | (B) Lifetime limit. If the plan or cover- | (B) Lifetime limit. If the plan or cover- |

[3] Title XXVII, Part A, Subpart 2, Section 2705 of the Public Health Service Act, cited as 42 U.S.C.S. Section 300gg-5 (Parity in the application of certain limits to mental health benefits); as added September 26, 1996, P.L. 104-204, Title VII, Section 703(a), 110 Stat. 2947 (MHPA).

[4] The Wellstone-Domenici Act was enacted on October 3, 2008, and will take effect one year after the date of the Act's enactment or no later than January 1, 2010.

age 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

age 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~~ mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and ~~mental health benefits~~ mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on ~~mental health benefits~~ mental health or substance use disorder 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~~ mental health and substance use disorder 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

age 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 and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any aggregate lifetime limit on mental health or substance use disorder 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 and substance use disorder 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

provides both medical and surgical benefits and ~~mental health benefits~~ mental health or substance use disorder 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~~ mental health or substance use disorder 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~~ mental health and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and ~~mental health benefits~~ mental health and substance use disorder benefits; or

(ii) not include any annual limit on ~~mental health benefits~~ mental health or substance use disorder 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~~ mental health and substance use disorder benefits by substituting for the

provides both medical and surgical benefits and mental health or substance use disorder 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 or substance use disorder 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 and substance use disorder benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health and substance use disorder benefits; or

(ii) not include any annual limit on mental health or substance use disorder 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 and substance use disorder benefits by substituting for the applicable annual

that is computed taking into account the weighted average of the annual limits applicable to such categories.

applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

‘(3) Financial requirements and treatment limitations.

(A) In general. 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 or substance use disorder benefits, such plan or coverage shall ensure that--

“ ‘(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

“ ‘(iii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

“ ‘(B) Definitions. In this paragraph:

“ ‘(i) Financial requirement. The term “financial requirement” includes

limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(3) Financial requirements and treatment limitations.

(A) In general. 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 or substance use disorder benefits, such plan or coverage shall ensure that--

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(iii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(B) Definitions. In this paragraph:

(i) Financial requirement. The term “financial requirement” includes

deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

" '(ii) Predominant. A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

" '(iii) Treatment limitation. The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

" '(4) Availability of plan information. The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

" '(5) Out-of-network providers. In the

deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

(ii) Predominant. A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

(iii) Treatment limitation. The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

(4) Availability of plan information. The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

(5) Out-of-network providers. In the

(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).

case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.';

(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~~ mental health or substance use disorder 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).~~

" '(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the

case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.

(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 or substance use disorder 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 or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).

plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).';

(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.

(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 (as defined in section 2791(e)(4), except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

~~(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.~~:

" '(2) Cost exemption.

(A) In general. With respect to a group health plan (or health insurance coverage offered in connection with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable

(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 (as defined in section 2791(e)(4), except that for purposes of this paragraph such term shall include employers with 1 employee in the case of an employer residing in a State that permits small groups to include a single individual).

(2) Cost exemption.

(A) In general. With respect to a group health plan (or health insurance coverage offered in connection with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable

percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

" '(B) Applicable percentage. With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be--

" '(i) 2 percent in the case of the first plan year in which this section is applied; and

" '(ii) 1 percent in the case of each subsequent plan year.

" '(C) Determinations by actuaries. Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

" '(D) 6-month determinations. If a group health plan (or a health insurance issuer offering coverage in connection with a group

percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

(B) Applicable percentage. With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be--

(i) 2 percent in the case of the first plan year in which this section is applied; and

(ii) 1 percent in the case of each subsequent plan year.

(C) Determinations by actuaries. Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

(D) 6-month determinations. If a group health plan (or a health insurance issuer offering coverage in connection with a group

health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

" '(E) Notification.

(i) In general. A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

" '(ii) Requirement. A notification to the Secretary under clause (i) shall include--

" '(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

" '(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

" '(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

" '(iii) Confidentiality. A notification

health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

(E) Notification.

(i) In general. A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

(ii) Requirement. A notification to the Secretary under clause (i) shall include--

(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(iii) Confidentiality. A notification

to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes--

" '(I) a breakdown of States by the size and type of employers submitting such notification; and

" '(II) a summary of the data received under clause (ii).

" '(F) Audits by appropriate agencies. To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification."

(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

to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes--

(I) a breakdown of States by the size and type of employers submitting such notification; and

(II) a summary of the data received under clause (ii).

(F) Audits by appropriate agencies. To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.

(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.

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.~~

" '(4) Mental health benefits. The term "mental health benefits" means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

" '(5) Substance use disorder benefits. The term "substance use disorder benefits" means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.';

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 services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(5) Substance use disorder benefits. The term "substance use disorder benefits" means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

(f) [Deleted]

(f) [Deleted]"

(f) [Deleted]

History (Applicable to Current Law and Amended Law):

(July 1, 1944, ch 373, Title XXVII, Part A, Subpart 2, § 2705, as added Sept. 26, 1996, P.L. 104-204, Title VII, § 703(a), 110 Stat. 2947; Jan. 10, 2002, P.L. 107-116, Title VII, § 701(b), 115 Stat. 2228; Dec. 2, 2002, P.L. 107-313, § 2(b), 116 Stat. 2457; Dec. 19, 2003, P.L. 108-197, § 2(b), 117 Stat. 2898; Oct. 4, 2004, P.L. 108-311, Title III, § 302(c), 118 Stat. 1179; Dec. 30, 2005, P.L. 109-151, § 1(b), 119 Stat. 2886; Dec. 20, 2006, P.L. 109-432, Div A, Title I, § 115(c), 120 Stat. 2941; June 17, 2008, P.L. 110-245, Title IV, § 401(c), 122 Stat. 1650; Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(b), (g)(2), 122 Stat. 3885, 3892.)

History; Ancillary Laws and Directives:

1. Prospective amendment
2. Amendments
3. Other provisions

1. Prospective amendment (See text of Amended Law)

2. Amendments (Applicable to Current Law and Amended Law):

2002. Act Jan. 10, 2002, in subsec. (f), substituted "December 31, 2002" for "September 30, 2001".

Act Dec. 2, 2002, in subsec. (f), substituted "December 31, 2003" for "December 31, 2002".

2003. Act Dec. 19, 2003, in subsec. (f), substituted "December 31, 2004" for "December 31, 2003".

2004. Act Oct. 4, 2004 (effective on enactment, as provided by § 302(d) of such Act, which appears as 26 USCS § 9812 note), in subsec. (f), substituted "after December 31, 2005" for "on or after December 31, 2004".

2005. Act Dec. 30, 2005, in subsec. (f), substituted "December 31, 2006" for "December 31, 2005".

2006. Act Dec. 20, 2006, in subsec. (f), substituted "2007" for "2006".

2008. Act June 17, 2008, in subsec. (f), substituted "services furnished--" and paras. (1) and (2) for "services furnished after December 31, 2007".

Act Oct. 3, 2008 (effective on 1/1/2009, as provided by § 512(e) of such Act, which appears as a note to this section), deleted subsec. (f), which read:

"(f) Sunset. This section shall not apply to benefits for services furnished--

"(1) on or after January 1, 2008, and before the date of the enactment of the Heroes Earnings Assistance and Relief Tax Act of 2008, and

"(2) after December 31, 2008.[.]".

3. Other provisions (Applicable to Current Law and Amended Law)

Applicability of section. Act Sept. 26, 1996, P.L. 104-204, Title VII, § 703(b), 110 Stat.

2950, provides: "The amendments made by this section [adding this section] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998.".

Act Oct. 3, 2008; regulations. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(d), 122 Stat. 3891, provides: "Not later than 1 year after the date of enactment of this Act, the Secretaries of Labor, Health and Human Services, and the Treasury shall issue regulations to carry out the amendments made by subsections (a), (b), and (c) [amending 26 USCS § 9812, 29 USCS § 1185a, and 42 USCS § 300gg-5], respectively.".

Application of Oct. 3, 2008 amendments. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(e), 122 Stat. 3891; Dec. 23, 2008, P.L. 110-460, § 1, 122 Stat. 5123, provides:

"(1) In general. The amendments made by this section [for full classification, consult USCS Tables volumes] shall apply with respect to group health plans for plan years beginning after the date that is 1 year after the date of enactment of this Act, regardless of whether regulations have been issued to carry out such amendments by such effective date, except that the amendments made by subsections (a)(5), (b)(5), and (c)(5) [deleting 26 USCS § 9812(f), 29 USCS § 1185a(f), and 42 USCS § 300gg-5(f)], relating to striking of certain sunset provisions, shall take effect on January 1, 2009.

"(2) Special rule for collective bargaining agreements. 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 the date of the enactment of this Act, the amendments made by this section [for full classification, consult USCS Tables volumes] shall not apply to plan years beginning before the later of--

"(A) 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 the date of the enactment of this Act), or

"(B) January 1, 2010.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.".

Assuring coordination. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(f), 122 Stat. 3892, provides:

"The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury may ensure, through the execution or revision of an interagency memorandum of understanding among such Secretaries, that--

"(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this section (and the amendments made by this section [for full classification, consult USCS Tables volumes]) are administered so

as to have the same effect at all times; and

"(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.".

(Emphasis added. LexisNexis)

ATTACHMENT B

STATE MEDICAID DIRECTOR LETTER DATED JANUARY 20, 1998, SIGNED BY SALLY RICHARDSON, DIRECTOR

January 20, 1998

Dear State Medicaid Director:

This letter is one in a series of letters that provides guidance on the implementation of the Balanced Budget Act of 1997(BBA). The BBA contains numerous provisions relating specifically to managed care. In order to provide guidance as quickly as possible, we are issuing a number of managed care State letters (list of those already issued is attached). This letter is the seventh in this managed care series.

The purpose of this letter is to alert you to Federal requirements affecting limits on mental health benefits and to clarify their applicability to State Medicaid programs. Section 4704(a) of the BBA creates a new section in the Social Security Act (1932(b)(8)) that requires each Medicaid managed care organization to comply with certain requirements added to the Public Health Service Act by the Mental Health Parity Act (MHPA), Public Law 104-204. MHPA provides for parity in the application of certain dollar limits on mental health benefits when limits are placed on medical and surgical benefits.

**Requirements**

MHPA was enacted on September 26, 1996 and provides that a group health plan, or health insurance coverage offered in connection with a group health plan (as those terms are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)), 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 dollar limit on substantially all of the medical and surgical benefits. If the plan does impose an aggregate lifetime limit or annual limit on substantially all medical and surgical benefits, the plan cannot impose a comparable 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 MHPA apply separately to each option. 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.

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. Finally, MHPA requirements do not apply to benefits for substance abuse or chemical dependency.

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.

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.

Many States have passed legislation or adopted regulations to address parity for mental health benefits. 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. In the absence of such laws, the provisions of MHPA apply.

**Interim Rules**

HHS, the Department of Labor, and the Department of the Treasury developed interim rules to implement MHPA. These interim rules were published in the Federal Register on December 22, 1997 at 62 FR 66932. Please see these rules for a detailed discussion of the parity provisions.

**Impact on Medicaid**

If mental health benefits are covered by the Medicaid contract, then all Medicaid managed care organizations with prepaid contracts must comply with the requirements of MHPA and provide for parity in the application of annual and lifetime dollar limits on mental health benefits when limits are placed on medical and surgical benefits. MHPA does not apply to fee-for-service arrangements because the State Medicaid Agency does not meet the definition of a "group health plan" as defined in HIPAA. Section 1932(b)(8) of the Social Security Act, as added by section 4704(a) of the BBA, specifically requires Medicaid managed care organizations to comply with MHPA by treating them, for that purpose, like health insurance issuers offering group health insurance coverage (as those terms are defined in HIPAA). However, the exemptions from the parity provisions in MHPA apply only to group health plans and to insurance products sold to those plans. Therefore, the exemptions are not available to Medicaid managed care plans because they are furnishing services in connection with a State Medicaid program, which is not a group health plan. Thus, the parity requirements of MHPA apply to Medicaid managed care organizations without exemptions.

It is the responsibility of the State Medicaid Agency to ensure that each managed care organization with which it contracts meets the requirements of MHPA with regard to its Medicaid services.

**MHPA is effective for managed care plans beginning on or after January 1, 1998**

If you or your staff have any questions, you may contact Terese Klitenic of the Center for Medicaid and State Operations, Insurance Standards Team. Ms. Klitenic can be reached at (410) 786-5942. We hope you find this information useful as you implement the provisions of MHPA.

Sincerely,

Sally Richardson

Director

Attachment

cc: HCFA Regional Administrators HCFA Associate Regional Administrators for Medicaid & State Operations HIPAA Regional Office Contacts Lee Partridge - American Public Welfare Association Joy Wilson - National Council of State Legislatures Jennifer Baxendell - National Governors Association HCFA Press Office

BBA MANAGED CARE STATE LETTERS

Section Subject Date Issued

4701 SPA Option for Managed Care 12/17/97

4704(a) Specification of Benefits 12/17/97

4707(a) Marketing Restrictions 12/30/97

4704(e) Miscellaneous Managed Care Provisions 12/30/97

4704(h)

4707(a)
4707(c)
4708(b)
4708(c)
4708(d)

4701 Choice, MCE Definition, Repeal of 75/25, and Approval Threshold 1/14/98

4708(a)

4705 External Quality Review 1/20/98