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

Comment On: CMS-2009-0040-0048

Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Document: CMS-2009-0040-DRAFT-0104

WI

Submitter Information

Name: Debra Kraft

Address:

Milwaukee, WI, 53203

Organization: Community Advocates Public Policy Institute

General Comment

Please see the attached letter dated May 3, 2010 from Debra J. Kraft, Deputy Director and Counsel for Community Advocates Public Policy Institute, Milwaukee, Wisconsin, to Adam Shaw, Centers for Medicare and Medicaid Services, Department of Health and Human Services, in which Ms. Kraft makes the following requests and recommendations:

1. CMS should provide a specific formal response to the question of the applicability of the MHPAEA to Medicaid managed care organizations (MCOs) providing services under Medicaid waiver programs.
 2. The Final Rules should explicitly state that Medicaid MCOs, including waiver programs, are subject to the provisions of the MHPAEA.
 4. CMS should provide clear direction, including a contact person, regarding the process and timetable that Medicaid will follow in promulgating regulations that implement the MHPAEA by Medicaid MCOs.
 5. The Final Rules should adopt a standard of care that include treatment by non-physician providers and treatment programs.
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Attachments

CMS-2009-0040-DRAFT-0104.1: WI



COMMUNITY ADVOCATES
Public Policy Institute

May 03, 2010

Direct Dial: 414.270.2944

Email: dkraft@communityadvocates.net

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

RE: Comment to Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Final Rule

Dear Mr. Shaw:

As you know from our previous discussions, Community Advocates Public Policy Institute had requested a formal response from the Centers for Medicare and Medicaid Services (CMS) to the question of whether the provisions of 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) apply to Medicaid managed care organizations, including those entities that provide services under Medicaid managed care waiver programs such as the State of Wisconsin BadgerCare Plus Core Plan.¹

We have become aware for a multiple of reasons that it is the position of CMS that the MHPAEA does apply to Medicaid managed care organizations. First, Clarke Cagey, Acting Director for the Center for Medicaid and State Operations, Family and Children's Health Programs Group wrote in his November 24, 2009, response to our initial inquiry that:

“MHPAEA applies to group health plans as cited in the Public Health Services Act (cited as 42 U.S.C.S. Section 300gg-5 ‘Parity in application of certain limits to mental health benefits’ in Medicaid this application would apply to managed care entities. The answer to your inquiry about the MHPAEA provisions being applicable to Medicaid managed care organizations is yes, under Medicaid, this application would apply to managed care entities.”²

¹ Letter from David R. Riemer to Charlene Frizzera, Acting Administrator, Centers for Medicare and Medicaid Services dated April 24, 2009, attached hereto as Exhibit 1.

² Letter from Clarke Cagey, Acting Director, Center for Medicaid and State Operations, Family and Children's Health Programs Group, to David R. Riemer, dated November 24, 2009, attached hereto as Exhibit 2.

Mr. Adam Shaw
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However, Mr. Cagey did not specifically address the question of applicability of the MHPAEA to the Medicaid managed care organizations that are providing benefits in accordance with waiver programs. We are left to speculate if the lack of this direct reference may have resulted because CMS does not view a distinction between the programs. **In order to eliminate any confusion over this issue, we request that CMS provide a specific formal response to our waiver program inquiry.**

Second, the CMS website for the Mental Health Parity and Addiction Equity Act now states that the “Medicaid Managed Care plans, however, are subject to the MHPAEA statute”.³ Finally, you have verbally affirmed this position both to me personally and in an early February conference call regarding the Interim Final Rules for the MHPAEA. Despite these acknowledgements of this critical conclusion, the applicability of the MHPAEA to Medicaid managed care organizations has still not been formally recognized in the Interim Final Rules.

If you recall, David R. Riemer, Director for the Public Policy Institute, made the following request in his May 19, 2009, public comment addressed to you for the Request for Information Regarding the MHPAEA:

“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 ... MHPAEA.”⁴

We are writing to again ask that the Final Rules under the MHPAEA explicitly state, with direct references to the applicable federal citations, that Medicaid managed care organizations, including waiver programs such as the BadgerCare Plus Core Plan, are subject to the provisions of the MHPAEA.⁵

We have been informed that the Interim Final Rules do not apply to Medicaid managed care organizations. If it is CMS’s conclusion that our requested clarification of applicability as noted herein is more appropriately included in formal regulations to be issued by Medicaid, then we would ask that such specific statement be included in the Medicaid final rules. Unfortunately, Medicaid has not provided any information regarding whether or how Medicaid managed care organizations will implement the MHPAEA. **Accordingly, we request that CMS provide clear direction, including a contact person, regarding the process and**

³ See: http://www.cms.hhs.gov/HealthInsReformfor_Consume/04_TheMentalHealthParityAct.asp

⁴ Letter from David R. Riemer to Adam Shaw, Centers for Medicare and Medicaid Services, dated May 19, 2009, attached hereto as Exhibit 3.

⁵ Section 1932(b)(8) of Title XIX of the Social Security Act (42 U.S.C.S. Section 1396u-2(b)(8)) applies the full parity provisions of the Public Health Service Act (PHSA) (Title XXVII, Part A, Subpart 2, Section 2705 of the PHSA, cited as 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.

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timetable that Medicaid will follow in promulgating regulations for the implementation of the MHPAEA by Medicaid managed care organizations.

Last Friday, April 30, Wisconsin Governor Jim Doyle signed the Wisconsin Parity Act into law (Senate Substitute Amendment 1 to SB362).⁶ This historic legislation, which will become effective at the end of this year, requires that commercial group health plans for large and small employers, as well as for self-insured non-federal governmental entities, provide mental health and substance use disorder insurance benefit coverage at parity levels with physical condition coverage. The law also provides for individual plans that choose to offer mental health or substance use disorder insurance benefit coverage to do so at parity levels. In many respects, the Wisconsin Parity Act closely parallels the provisions of the MHPAEA. In one key area, that of standard of care, this legislation went even farther than the federal law. The Wisconsin Legislature and Governor Doyle expanded the scope of the standard of care for which parity coverage will be provided to include referrals to non-physician providers and treatment programs for the treatment of mental health conditions and substance use disorders.

The scope of treatment for accident victims, asthma patients, diabetes patients or cancer patients not only includes treatment by their physicians but also incorporates treatment by non-physician providers such as physical therapists or rehabilitation therapists and from programs. These services are considered covered benefits under the patient's health insurance plan. We believe that mental health and substance use disorder parity must also mean that the patient has to be able to obtain – and the group health insurance plans have to pay for – treatment from treatment programs and non-physician providers, including but not limited to social workers, clinical psychologists, therapists, peer specialists and professional counselors, among others, with or without physician referral. **We therefore recommend that the Final Rules adopt this standard to include treatment by non-physician providers and treatment programs.**

We appreciate the opportunity to comment on this most important rule-making process.

Very truly yours,



Debra J. Kraft
Deputy Director and Counsel

DJK/ser
Attachment

⁶ See: www.parityforwisconsin.org for a full text of the Wisconsin Parity Act.



COMMUNITY ADVOCATES
Public Policy Institute

Exhibit 1

**Letter from David R. Riemer,
Community Advocates Public Policy Institute,
to Charlene Frizzera,
Centers for Medicare & Medicaid Services,
Dated April 24, 2009**



COMMUNITY ADVOCATES
PUBLIC POLICY INSTITUTE

April 24, 2009

Direct Dial: 414.475.6253, ext. 301

Email: DRiemerMil@yahoo.com

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Confirmation of the Applicability of the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicaid Managed Care Organizations

Dear Ms. Frizzera:

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. The Institute works to create and implement sound public policy that will dramatically reduce poverty and its effects in Milwaukee and Wisconsin. Chief among these 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. We believe such coverage must include parity for mental health and addiction services.

As you are aware, the State of Wisconsin offers health care services to eligible individuals through the ForwardHealth Medicaid program called BadgerCare Plus. BadgerCare Plus offers three benefit plans --- Standard, Benchmark and Core. The Standard Plan covers children and their parents or caretakers at income levels up to 200% of the Federal Poverty Level (FPL), young adults who are leaving foster care when they turn 18 regardless of income, parents with incomes up to 200% of the FPL who have children in foster care, and certain farm families and self-employed families (the "Standard Plan"). The Benchmark Plan offers coverage for children

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under 19 whose family's income exceeds 200% of the FPL, pregnant women with income greater than 200% but less than 300% of the FPL, and self-employed parents and caretaker relatives of children under age 19 whose income is greater than 200% of the FPL (the "Benchmark Plan"). Finally, the Core Plan provides health care for adults from ages 19-64 who do not have children, or do not have dependent children under 19 living with them, and who have incomes up to 200% of the FPL (the "Core Plan"). Most BadgerCare Plus enrollees in all three plans (Standard, Benchmark and Core) receive health insurance coverage through Medicaid managed care organizations. In late December of last year, CMS granted waiver authority to Wisconsin with respect to the Core Plan for a section 1115 Medicaid demonstration project. A copy of the CMS waiver is attached as Attachment A.

As you know, on October 3, 2008, President George W. Bush signed into law H.R. 1424, the Emergency Economic Stabilization Act, P.L. 110-343, that included 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 H.R. 1424 of the Emergency Economic Stabilization Act, P.L. 110-343) (the "Wellstone-Domenici Act"). A copy of the entire Wellstone Domenici Act is attached as Attachment B. Senator Herb Kohl's staff has advised us that the Congressional Research Service (CRS) believes that the parity provisions of the Wellstone-Domenici Act apply to Medicaid managed care organizations.

We have been told that the statutory authority for CRS's conclusion is Sec. 1932(b) 8 of title XIX of the Social Security Act (cited as 42 U.S.C.S. Sec. 1396u-2(b)(8)). CRS indicates that this law requires Medicaid managed care organizations to comply with subpart 2 of part A of title XXVII of the Public Health Service Act (cited as 42 U.S.C.S. Sec. 300gg-4 et seq., specifically 300gg-5 "Parity in the application of certain limits to mental health benefits"), including the application by no later than January 1, 2010, of the Wellstone-Domenici Act's expanded mental health and addiction treatment parity requirements. The text of the federal statutes cited above, i.e., 42 U.S.C.S. Sec. 300gg-5 (both before and after its amendment by the Wellstone-Domenici Act) and 42 U.S.C.S. Sec. 1396u-2(b)(8), are included as Attachment C.

At the suggestion of Senator Kohl's office, we are writing to request your written confirmation of CRS's conclusion, which we share. In particular, we would appreciate your written response to the following two questions:

1. Do the provisions of the Wellstone-Domenici Act apply to Medicaid managed care organizations? If so, upon what basis, including a statutory analysis that references U.S.C.S. citations?

Ms. Charlene Frizzera
Acting Administrator
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2. If the answer to Question 1 is yes, is there any reason why this requirement would not apply to Medicaid managed care **waiver** programs, in particular the Wisconsin BadgerCarePlus Core Plan? Again, if yes, upon what basis, including a statutory analysis that references U.S.C.S. citations.

Your timely response to these questions is critical to providing improved mental health and addiction treatment coverage on a parity basis to the Medicaid population in Wisconsin. If we can provide you with any additional information, please let me know. We greatly appreciate your assistance. Thank you.

Very truly yours,

A handwritten signature in black ink that reads "David R. Riemer". The signature is written in a cursive, slightly slanted style.

David R. Riemer
Director of Policy and Planning

DRR: djc

cc: Senator Herb Kohl

ATTACHMENT A

CENTERS FOR MEDICARE & MEDICAID SERVICES WAIVER AUTHORITY
FOR
WISCONSIN BADGERCARE PLUS
HEALTH INSURANCE FOR CHILDLESS ADULTS
SECTION 1115 DEMONSTRATION



Administrator
Washington, DC 20201

DEC 31 2008

Mr. Jason A. Helgerson
Administrator
Division of Health Care Financing
Department of Health and Family Services
1 West Wilson Street
P.O. Box 309
Madison, WI 53701-0309

Dear Mr. Helgerson:

We are pleased to inform you that Wisconsin's section 1115 Medicaid demonstration project, entitled BadgerCare Plus Health Insurance for Childless Adults (Project No. 11-W-00242/5) has been approved for a 5-year period, January 1, 2009, through December 31, 2013, in accordance with section 1115(a) of the Social Security Act (the Act).

Our approval of the BadgerCare Plus Health Insurance for Childless Adults section 1115(a) demonstration project is limited to the extent of the waivers and expenditure authorities in the accompanying list, and is conditioned upon compliance with the enclosed Special Terms and Conditions (STCs). The STCs set forth in detail the nature, character, and the extent of Federal involvement in the demonstration. The STCs are effective January 1, 2009, unless otherwise specified. All the requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the enclosed expenditure authority list, shall apply to the demonstration.

Written notification to our office of your acceptance of this award must be received within 30 days after your receipt of this letter. Your project officer is Ms. Wanda Pigatt-Canty. She is available to answer any questions concerning this demonstration project. Ms. Pigatt-Canty's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mailstop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-6177
Facsimile: (410) 786-5882
E-mail: wanda.pigatt-canty@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Pigatt-Canty and to Ms. Verlon Johnson, Associate Regional Administrator in our Chicago Regional Office.

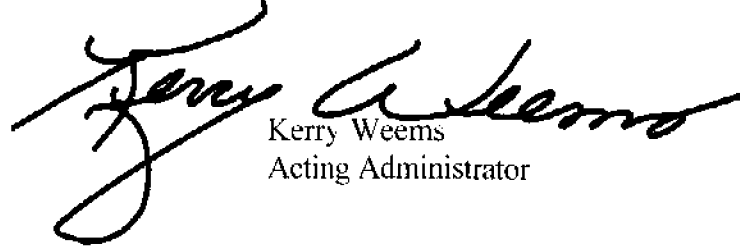
Ms. Johnson's contact information is as follows:

Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601-5519

If you have questions regarding this correspondence, please contact Ms. Dianne Heffron, Acting Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

A handwritten signature in black ink, appearing to read "Kerry Weems". The signature is fluid and cursive, with a large initial "K" and "W".

Kerry Weems
Acting Administrator

Enclosure

cc: James Jones – Wisconsin, Department of Health and Family Services
Verlon Johnson - CMS , Region V
Charles Friedlich-CMS, Region V

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY**

NUMBER: 11-W-00242/5

TITLE: Wisconsin BadgerCare Plus Health Insurance for Childless Adults
Section 1115 Demonstration

AWARDEE: Wisconsin Department of Health Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning January 1, 2009, through December 31, 2013.

The following waiver shall enable Wisconsin to operate its Childless Adults Section 1115 Demonstration.

- 1. Disproportionate Share Hospital (DSH) Payments** Section 1902(a)(13)(A),
insofar as it incorporates
1923(c)

To the extent necessary to allow Wisconsin reduce the amount of payments to disproportionate share hospitals beneath the levels specified in the approved State plan, to the extent necessary to fund expenditures under this demonstration.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00242/5

TITLE: Wisconsin BadgerCare Plus Health Insurance for Childless Adults Section 1115 Demonstration

AWARDEE: Wisconsin Department of Health Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this Demonstration, shall be regarded as expenditures under the State's title XIX plan.

The following expenditure authority shall enable the State to operate its section 1115 Medicaid Childless Adults Demonstration.

1. **Childless Adult Demonstration Population.** Expenditures for health care-related costs for childless, non-pregnant, adults ages 19 through 64 years who have family incomes that do not exceed 200 percent of the Federal poverty level (FPL), who are not otherwise eligible under the Medicaid State plan, and who do not have other health insurance coverage.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration Population beginning January 1, 2009, through December 31, 2013.

Title XIX Requirements Not Applicable to the Demonstration Population:

1. **Reasonable Promptness** **Section 1902(a)(3) and 1902(a)(8)**
To the extent necessary to enable the State to cap enrollment for the Demonstration-Eligible Population, and to delay provision of medical assistance until 15 days after the date when the individual is determined eligible for coverage, or the date of enrollment into the Health Maintenance Organization (HMO), whichever is sooner.
2. **Application Procedures** **Section 1902(a)(4) as implemented
by 42 CFR Part 435, Subpart J**

To the extent necessary to permit the State to limit the application methods to online and telephonic methods, using electronic or audio signatures to comply with applicable signature requirements.
3. **Amount, Duration, and Scope** **Section 1902(a)(10)(B)**
To the extent necessary to enable the State to offer a different benefit package to the Demonstration-Eligible Population that varies in amount, duration, and scope from the benefits offered under the State Plan.

4. **Freedom of Choice** **Section 1902(a)(23)**
To the extent necessary to enable the State to restrict freedom-of-choice of provider for the Demonstration-Eligible Population.
5. **Retroactive Eligibility** **Section 1902(a)(34)**
To the extent necessary to enable the State to not provide coverage for the Demonstration-Eligible Population for any time prior to the date of enrollment into an HMO, or within 15 days after the date in which the individual is determined eligible for coverage, whichever is sooner.
6. **Eligibility Standards** **Section 1902(a)(17)**
To the extent necessary to enable the State to apply different eligibility methodologies and standards to the Demonstration-Eligible Population than are applied under the State plan.
7. **Cost Sharing** **Section 1902(a)(14)**
To the extent necessary to enable the State to impose an annual non-refundable application fee and cost sharing that are above the limits that would apply under the State plan.
8. **Methods of Administration: Transportation** **Section 1902(a)(4), insofar as it incorporates 42 CFR 431.53**
To the extent necessary to enable the State to not assure transportation to and from providers for the Demonstration-Eligible Population.
9. **Early and Periodic Screening, Diagnostic, and Treatment Services** **Section 1902(a)(43)**
To the extent necessary to enable the State to not provide coverage of early and periodic screening, diagnostic and treatment services to 19- and 20-year-old individuals in the Demonstration-Eligible Population.
10. **Income and Eligibility Verification** **Section 1902(a)(46)**
To the extent necessary to enable the State to forgo use of the Internal Revenue Services data exchange for income verification for the Demonstration-Eligible Population.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00242/5

TITLE: Wisconsin BadgerCare Plus Health Insurance for Childless Adults
Section 1115 Demonstration

AWARDEE: Wisconsin Department of Health Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Wisconsin's BadgerCare Plus Health Insurance for Childless Adults section 1115(a) Medicaid Demonstration extension (hereinafter referred to as "Demonstration"). The parties to this agreement are the Wisconsin Department of Health Services ("State") and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective January 1, 2009, unless otherwise specified. This Demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Enrollment; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of Deliverables for the Demonstration Period.

II. PROGRAM DESCRIPTION

The BadgerCare Plus expansion to low-income childless adults is the second step in a comprehensive strategy to ensure access to affordable health insurance for virtually all Wisconsin residents. Wisconsin is building on the success of the current BadgerCare Plus and is well positioned to lead the Nation both in terms of health insurance access as well as overall health care reform.

The demonstration population consists of the most chronically uninsured population: adults without dependent children, between the ages of 19 and 64 and with incomes that do not exceed 200 percent of the Federal Poverty Level (FPL). The program includes new and innovative features including, 1) centralized eligibility and enrollment functions, 2) requirement for participants to complete a health needs assessment that will be used to match enrollees with health maintenance organizations (HMOs) and providers that meet the individual's specific health care needs, 3) the tiering of health plans based on quality of care indicators, and

4) enhanced online and telephone application tools that will empower childless adults to choose from a variety of health insurance options.

Wisconsin will form a new Clinical Advisory Committee on Health and Emerging Technology (CACHET) that will advise the State on how best to structure the health insurance benefit so as to meet the needs of the population as well as control costs. The CACHET will consist of health care professionals from across Wisconsin and across health care disciplines. The CACHET will also create criteria for tiering HMOs based on quality and cost-effectiveness.

The key program goals include:

- Expanding BadgerCare Plus to childless adults and together with Medicaid, the State Children's Health Insurance Program (SCHIP), Medicare, and employer-sponsored insurance, Wisconsin will be able to provide access to insurance to 98 percent of residents in the most cost-effective manner;
- Effectiveness in meeting the health care needs of the uninsured childless adults population through flexible benefit package using evidence-based medicine and advice from the medical community via the CACHET;
- Encouraging quality health care outcomes from private health plans utilized by the BadgerCare Plus for Childless Adults population through the use of a new health plan selection tool and the tiering of the health plans (and differing enrollment fee amount) based upon quality measures;
- Reduction in emergency room usage and uncompensated care by encouraging use of preventative primary care for this population; and
- Improved health outcomes for this population in the areas of prevention and successful management of chronic diseases such as diabetes and asthma.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

- a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.
- b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. State Plan Amendments. The State will not be required to submit title XIX State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. Changes Subject to the Amendment Process. Changes related to eligibility (such as the expansion of eligibility beyond 200 percent of the FPL, and/or changes to non-financial eligibility criteria) enrollment, benefit, cost sharing changes not described in Attachment A – Core Benefit Plan, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. Amendment Process. Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

- a) An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;
- b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a

summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

- d) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.
8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

- a) **Demonstration Summary and Objectives:** The State must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.
- b) **Special Terms and Conditions (STCs):** The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time. Consistent with Federal law, CMS reserves the right to deny approval for a requested extension based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein.
- c) **Quality:** The State must provide summaries of External Quality Review Organization reports, managed care organization, and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.
- d) **Compliance with the Budget Neutrality Cap:** The State must provide financial data (as set forth in the current STCs) demonstrating that the State has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

- e) **Interim Evaluation Report:** The State must provide an evaluation report reflecting the hypotheses being tested and any results available.
9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10 a phase-out plan shall not be shorter than 6 months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.
10. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.
11. **CMS Right to Terminate or Suspend for Cause.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.
13. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to submit a request for reconsideration of the determination, containing all information the State deems necessary for that reconsideration. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
14. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education,

outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6 as proposed by the State.
16. **FFP.** No Federal matching funds will be available for expenditures incurred for this Demonstration prior to the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY DETERMINATION, ENROLLMENT AND DISENROLLMENT

17. **Eligibility.** Childless adults eligible for this coverage under this demonstration are defined as individuals between the ages of 19 and 64 years with income that does not exceed 200 percent of the FPL. They are individuals who are not pregnant, disabled, or qualified for any other Medicaid, Medicare, or SCHIP program. Childless adults may have children, but either the minor children are not currently living with them or those children living with them are 19 years of age or older.

An applicant must meet the following eligibility requirements in order to enroll in for coverage under this demonstration:

- a) Must be at least 19 but no more than 64 years of age;
- b) Must not have any children under age 19 under his/her care;
- c) Must not be pregnant;
- d) Must not be eligible for the Medicaid and/or SCHIP benefits under the State Plan, other than eligible under the Family Planning Demonstration Project or eligible for benefits limited to coverage for treatment of Tuberculosis;
- e) Must not be eligible for Medicare under any part;
- f) Must have monthly income that does not exceed 200 percent of the FPL, based upon the average prospective gross income without any deductions or disregards, with verification required;
- g) Must not be covered by health insurance currently, and must not have had health insurance in the previous 12 months; "Health Insurance coverage" is defined according to 45 CFR 146.145 and 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. Health insurance

coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

- h) Must not have had access to employer subsidized insurance in the previous 12 months, cannot have access to employer subsidized insurance during the month of application, or cannot have a potential offer to enroll in employer subsidized insurance in any of the 3 months following the month of application.
- i) Must provide verification, including documentation, of U.S. citizenship and social security number (or proof of application for an SSN) in accordance with Section 1903(x) of the Act;
- j) Must be a Wisconsin resident;
- k) Must complete a Health Needs Assessment at application and annual renewal;
- l) Must obtain a comprehensive physical exam within the first certification period (generally within 1 year after enrollment) or have good cause for not obtaining the required exam, with admissible good cause reasons including (at a minimum) those listed in items (i) through (v) below:
 - i. The HMO or health care provider certifies that they were unable to schedule a physical exam appointment within the required time frame;
 - ii. The individual is a migrant worker;
 - iii. The individual completed a physical exam within a specified time period prior to enrollment in the demonstration;
 - iv. The enrollee was unable to complete the physical exam due to a lack of transportation; or
 - v. Other good cause reasons as determined by the State.
- m) Must pay a non-refundable, annual application fee. The fee must be waived for homeless individuals, and for the General Assistance Medical Program (GAMP) and General Assistance (GA) medical conversion in December 2008. The State must use the Federal Department of Housing and Urban Development (HUD) definition of homelessness.

18. Effective Date of Coverage -- No Retroactive Eligibility. Enrollees who qualify as for coverage under this demonstration will not receive retroactive coverage. The beginning effective date of coverage under the demonstration (for at least the Core Benefit Package) must be no later than 15 days after the individual is determined to be eligible for coverage, or the date of enrollment into the HMO, whichever is sooner.

19. **Continuous Eligibility.** Enrollees who are eligible for coverage under this demonstration remain eligible during the 12-month certification period, regardless of income changes, unless they:
- a) Become eligible for Medicare, Medicaid, or SCHIP coverage;
 - b) No longer reside in the State of Wisconsin;
 - c) Become incarcerated or are institutionalized in an Institution for Mental Disease (IMD);
 - d) Obtain other health insurance coverage;
 - e) Attain age 65; or
 - f) Are no longer living.
20. **Good Cause Exemptions to the 12-Month Waiting Period.** The State must allow individuals to enroll for coverage under this demonstration who otherwise are eligible but who do not meet the 12-month waiting period requirements in subparagraphs 17(g) and 17(h), if they qualify for a good cause exemption as discussed below.
- a) Good cause reasons recognize that there are circumstances beyond the applicant's control that affect their ability to access health insurance. Applicants must be exempt from the 12-month waiting period if:
 - b) They experienced a life-changing event, such as the death or change of marital status of the policy holder;
 - c) Their eligibility or enrollment in health insurance during the prior 12 months consisted only of enrollment in GAMP, Health Insurance Risk Sharing Pool, Medicaid, BadgerCare Plus, or other public health care programs for the uninsured (or a combination of these);
 - d) Expiration of a Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance continuation period occurred during the 12-month period;
 - e) Health insurance was lost during the 12-month period for employment-related reasons, including involuntary termination of employment (or voluntary termination due to incapacitation or health condition of immediate family member), and employer's discontinuation of health plan coverage for all employees; or
 - f) Coverage was denied because of pre-existing conditions; or

- g) For other case-specific good cause reasons as determined by the State that are consistent with good cause reasons a) through f), with notification to CMS in the quarterly demonstration progress report.

21. Application Processing and Enrollment Procedures. The State may require applicants for this demonstration to adhere to the following application and enrollment procedures:

- a) *Electronic or Telephonic Applications*- Applicants for the Childless Adults Population may be required to submit applications *either online or by telephone* using the toll free hotline through the Enrollment Services Center. The State must implement safe guards to ensure that only those persons who qualify are allowed to participate in the childless adults' demonstration. The State must verify the full legal name, date of birth, and social security number of all applicants; retain audio recordings of the summary of information provided in the application process; ensure that applicants receive a full explanation of program rights and responsibilities; and obtain an applicant/member attestation to the accuracy of the information provided. The State will ensure that audio-recordings are stored electronically and retrievable on a case-by-case basis as needed. To the extent that the State maintains those audio-recordings, the State may allow applicants to provide an audio signature over the phone.
- b) *Screening of Eligibility for Medicaid and/or SCHIP* -All applicants must receive a pre-screening in order to determine possible eligibility for either the Medicaid or SCHIP programs before eligibility determination for the childless adults' demonstration.

In addition, all applicants will receive a pre-screening to determine potential eligibility for the Demonstration. If an applicant appears to meet all eligibility requirements for the Demonstration, the non-refundable application fee will be collected. If an applicant does not appear to meet all eligibility requirements for the Demonstration, s/he will be notified of that fact and discouraged from paying the application processing fee.

- c) *Non-Refundable Application Fee*- Applicants who appear to be eligible for the Core Plan (based on the prescreening process described above) will be required to pay a non-refundable application fee at the initial enrollment and at recertification for the program. The application fee must be waived for homeless individuals, and for individuals participating in the GAMP and GA medical programs whose coverage will change to demonstration coverage in January 2009. The State will use the Federal HUD definition of homelessness.
- d) *Mandatory Health Needs Questionnaire* – All applicants will be required to complete a health needs assessment questionnaire as a condition of enrollment under the childless adults' demonstration.

- e) *Selection of HMO or HealthCare Provider* - All applicants must be assisted by the Enrollment Services Center in selecting an HMO (in the service areas where HMOs are available). Individual residing in service areas with no HMOs must be provided assistance in locating a primary care physician, and be given the means to access the State's Medicaid qualified providers on a fee-for-service basis. Tribal members are exempt from mandatory enrollment into HMOs, but may choose to participate in HMOs on a voluntary basis. Migrant workers are not allowed to enroll in an HMO.

22. Redetermination of Eligibility. Redetermination of eligibility for the Childless Adults Population must occur at least once every 12 months, which may be done through the Enrollment Services Center. An enrollee may request a redetermination of eligibility for the demonstration due to a change in family size (e.g., death, divorce, birth, marriage, adoption) at any time, and the State must perform such redeterminations upon request. Each redetermination must include a reassessment of the individual's eligibility for Medicaid and the BadgerCare Plus programs to ensure that enrollees are not eligible for coverage under the Medicaid state plan prior to re-enrollment into the childless adults' demonstration.

23. Imposing Enrollment Cap and Lifting Enrollment Cap. Upon initial implementation of the demonstration the State will facilitate immediate enrollment of the GAMP population and must open the program to additional enrollment within 180 days of implementation. The State may impose an enrollment cap upon the Childless Adults Population in order to remain under the budget neutrality limit/ceiling for expenditures under the demonstration. The State will be required to provide written notice to CMS at least 90 days prior to instituting any enrollment cap or opening enrollment that at a minimum must include the following:

- a) Data on current enrollment levels in the program;
- b) An analysis of the current budget neutrality agreement; and
- c) The projected timeframe for the enrollment cap to be in effect or enrollment to remain open for the demonstration.

24. Disenrollment. Enrollees in the Childless Adults Population may be disenrolled if they:

- a) Become eligible for Medicare, Medicaid, or SCHIP coverage;
- b) No longer reside in the State of Wisconsin;
- c) Become incarcerated or are institutionalized in an IMD;
- d) Obtain health insurance coverage;
- e) Attain age 65; or

- f) Are no longer living.

V. **BENEFITS AND COST SHARING**

25. **Core Benefit Plan.** Upon implementation, the Childless Adults Population participants will receive a basic benefit package which is referred to as the Core Benefit Plan. The Core Benefit Plan consists of the following benefits. *Attachment A provides a full list of the covered and proposed covered benefits with applicable cost sharing for the childless adults.*
- a) Physician services including primary and preventive care, specialists for surgical and medical services, and chronic disease management;
 - b) Diagnostic services including laboratory and radiology;
 - c) Inpatient hospital stays and outpatient hospital visits (excluding inpatient psychiatric stays in either an IMD or the psychiatric ward of an acute care hospital);
 - d) Emergency outpatient services including emergency dental and ambulance transportation service;
 - e) Generic drugs; selected over-the-counter drugs, limited brand name drugs and brand name drugs through a Medicaid pharmacy benefit plan (brand name mental health drugs for individuals converting from the GAMP and GA medical programs in December 2008 must be covered, irrespective of any limits otherwise imposed, for as long as such individuals are enrolled in the BadgerCare Plus for Childless Adults waiver program);
 - f) Physical, occupational, and speech therapy, limited to 20 visits annually per discipline;
 - g) Durable medical equipment limited to \$2,500; and
 - h) Disposable medical supplies, including diabetic pens, syringes and disposable medical supplies that is required with use of durable medical equipment (no limit).
26. **Modifications to Services in the Core Benefit Plan.** After implementation of the demonstration the State may add and/or expand the following services, as recommended by the CACHET and described in Attachment A to the Core Benefit Plan: chiropractic, additional dental, hearing, home care, hospice, additional mental health and substance abuse, podiatry, and vision. The State will be required to provide written notification to CMS related to changes in the initial Core Benefit Plan as described in Attachment A, using the process described below in subparagraphs (a) and (b). Any service changes that are inconsistent with the definition in Attachment A must be submitted to CMS as an amendment to the demonstration as described in paragraph 7.

- a) **Addition and/or Expansion of Services**- In the event the State wants to include chiropractic, additional dental, hearing, home care, hospice, additional mental health and substance abuse, podiatry, and vision services under the Core Benefit Plan the State must provide written notification to CMS at least **60 days** before implementation which must include the following:
- i. The name, description of the service (including any service limitations on the number of visits), rationale for the change and effective date;
 - ii. The cost sharing to be required for accessing the service. The cost sharing amount should not exceed the limits described in subparagraph 27 b; and
 - iii. A revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact on budget neutrality of implementing the services for the remainder of the demonstration.
 - iv. CMS will review the notification documentation and provide a written confirmation to the State within 30 days of receiving the notification. The State cannot implement the changes without written confirmation from CMS that the modification is consistent with paragraph 26. If CMS notifies the State that the requested change is not consistent with paragraph 26, the State must submit the changes as a formal amendment as described in paragraph 7.
- b) **Reduction and/or Elimination of Services** - In the event the State wants to reduce and/or eliminate any of the proposed expanded services (chiropractic, additional dental, hearing, home care, hospice, additional mental health and substance abuse, podiatry, and vision services) that were previously added under paragraph 26(a) by the State. The State must provide written notification to CMS at least **60 days** before implementation which must include the following:
- i. The name, description of the service being reduced and/or eliminated, rationale for the change and effective date; and
 - ii. A revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact on budget neutrality of reducing and/or eliminating the services for the remainder of the demonstration.
 - iii. CMS will review the notification documentation and provide a written confirmation to the State within 30 days of receiving the notification. The State cannot implement the changes without written confirmation from CMS that the modification is consistent with paragraph 26. If CMS notifies the State that the requested change is not consistent with paragraph 26, the State must submit the changes as a formal amendment as described in paragraph 7.

c) In addition, the State must include a description of the current Core Benefit Plan services in each quarterly and annual demonstration progress reports as requested in paragraphs 34 and 35.

27. **Cost Sharing.** Upon implementation, the childless adults' population participants are required to pay the following :

a) **Application Fee:** All applicants are required to pay a **non-refundable application fee** prior to the initial enrollment and at each re-certification period for the demonstration. The amount of the application fee is based upon the applicant's selection of the HMO as follows:

APPLICATION FEE		
Demonstration Eligibles	Tier I HMO	Tier II HMO
Childless adults with an income that does not exceed 200 % of the FPL	\$60	\$75

b) **Co-Payments for Services-** All enrollees may be required to pay co-payments when accessing non-institutional, outpatient hospital, inpatients hospital, emergency room and pharmacy. These co-payments are collected by health care providers at point-of-service, who may be allowed to deny service if the required co-payment is not paid. The amount of the maximum co-payments is based upon the enrollees' income level as summarized in the chart below.

Co-Payments for Services

Federal Poverty Level	Non-Institutional Services	Pharmacy	Outpatient Hospital	Emergency Room Services	Inpatient Hospital
Up to 100 % of the FPL	\$0.50 up to \$3 per service	\$5	\$3 per visit	No co-payment	\$3 per day up to \$75 per stay
Above 100 % but does not exceed 200% of the FPL	\$0.50 up to \$15 per service	\$5-\$15	Up to \$15	\$60	\$3 per day up to \$100 per stay

Total cost sharing for non-institutional , hospital services (both inpatient and outpatient), pharmacy and emergency room services is limited annually up to \$300 for incomes up to 100% of the FPL and limited annually up to \$500 for incomes above 100% but not exceeding 200% of the FPL

VI. DELIVERY SYSTEMS

28. **Prepaid Health Maintenance Organizations (HMO).** The State will utilize the current HMO provider network that provides health care services to the existing Medicaid and Badgercare Plus programs in most of the State to serve persons eligible under this

demonstration. Demonstration enrollees may be required to join an HMO as a condition of eligibility, as long as there is at least one HMO available in their county of residence and the county has been granted a rural exception under Medicaid state plan authority. The State can mandate enrollment into the single HMO in the counties that have been granted the rural exception. If the county has not been granted a rural exception then the State must offer the option of either HMO enrollment or Medicaid fee-for-service. Demonstration eligibles who are not enrolled in HMOs must be provided a Medicaid card or other means to access the Medicaid qualified providers on a fee-for-service basis.

29. **Pay for Performance/Tiering of Health Plans.** The State may develop quality indicators in order to assign each HMO to a two-tiered rating system based on criteria related to quality and cost. The enrollees may be offered a reduced application fee based upon the selection of a high quality ranked Tier I HMO versus Tier II HMO. The State must provide a detailed description of the methodology for rating the HMOs, and the names of the Tier I and Tier II HMOs, in each Annual Report (see paragraph 35). This provision does not authorize Wisconsin to utilize the two-tiered rating system in the Medicaid or BadgerCare programs.

VII. GENERAL REPORTING REQUIREMENTS

30. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in Section VII.
31. **Reporting Requirements Related to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section VIII.
32. **Monthly Enrollment Report.** The State must report demonstration enrollment figures to CMS within 15 days of the end of each month.
33. **Monthly Calls.** CMS will schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any Demonstration amendments the State is considering submitting. CMS shall provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.
34. **Quarterly Progress Reports.** The State must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:
 - a) An updated budget neutrality monitoring spreadsheet;

- b) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;
- c) Action plans for addressing any policy, administrative, or budget issues identified;
- d) Quarterly enrollment reports for Demonstration eligibles and other statistical reports listed in Attachment B;
- e) Quarterly update on the status of the CACHET. The State will provide at a minimum an update on the status of the development /implementation, structure and operational and administrative function of the CACHET. The State will also include any recommendations for changes to benefit design, quality of care (pay for performance/tiering of health plans) health delivery system, emerging medical technologies and procedures, and utilization controls for the demonstration; and
- f) Quarterly update on the covered services and cost sharing for the Core Benefit Plan. The State needs to confirm actual covered services and co-payments required as described in Attachment A- Core Benefit Plan for the demonstration in each quarterly progress report.

35. Annual Report. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives (if relevant), CACHET updates, benefit and cost sharing changes to the Core Benefit Plan, policy and administrative difficulties in the operation of the Demonstration, systems and reporting issues, and information related to the rating of HMOs required in paragraph 30. The State must submit the draft annual report no later than 120 days after the close of the Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

VIII. GENERAL FINANCIAL REQUIREMENTS

- 36. Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided through this Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX.
- 37. Reporting Expenditures Subject to the Budget Neutrality Agreement.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

- a) In order to track expenditures under this Demonstration, the State must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM). All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number (11-W-00242/5) assigned by CMS (including the project number extension, which indicates the Demonstration Year (DY) in which services were rendered or for which capitation payments were made).
- b) To simplify monitoring of both demonstration expenditures and remaining disproportionate share hospital (DSH) payments, DYs will be aligned with the Federal fiscal years (FFYs). DY 1 is defined as the period from January 1, 2009 (the implementation of the demonstration) through September 30, 2009. DYs 2 through 5 will coincide with FFYs 2010, 2011, 2012, and 2013, respectively. Finally, DY 6 will begin October 1, 2013 and will end December 31, 2013, which is the day in which all demonstration authorities will expire. Finally, all DSH expenditures for FFY 2014 will be subject to budget neutrality and reported as demonstration expenditures for DY 6, even if they occur after December 31, 2013. (This is consistent with the definition of the budget neutrality limit for DY 6, as explained below.)

The chart describes the correlation between FFY and DY:

Federal Fiscal Years (FFY)		Demonstration Years (DY)	
2009	10/01/08-09/30/09	DY 1	01/01/09-09/30/09
2010	10/01/09-09/30/10	DY 2	10/01/09-09/30/10
2011	10/01/10-09/30/11	DY 3	10/01/10-09/30/11
2012	10/01/11-09/30/12	DY 4	10/01/11-09/30/12
2013	10/01/12-09/30/13	DY 5	10/01/12-09/30/13
2014	10/01/13-09/30/14	DY 6	10/01/13-12/31/13

- c) Each quarter, the State must submit separate Forms CMS-64.9 Waiver and/or 64.9P Waiver reporting Childless Adults Population expenditures, using waiver name "BC Adults."
- d) **DSH Expenditures.** To facilitate monitoring of budget neutrality and compliance with the DSH allotment, the rules below will govern reporting of DSH expenditures for the demonstration. All DSH expenditures are subject to the DSH allotments defined in section 1923(f) of the Act.
 - i. Wisconsin must report DSH expenditures that are subject to the Federal fiscal year (FFY) 2009 DSH allotment on Forms CMS-64.9 Base (or CMS-64.9P Base for Line 8 adjustments), until such expenditures equal one-quarter of the DSH

allotment for that year. These initial DSH expenditures for FFY 2009 are not demonstration expenditures and are not subject to the budget neutrality limit.

- ii. FFY 2009 DSH expenditures in excess of the amount reported under subparagraph (i) are considered demonstration expenditures, and must be reported on Forms CMS-64.9 Waiver (or CMS-64.9P Waiver for Line 8 adjustments) for DY 1.
 - iii. Line 10B adjustments for FFY 2009 must be reported first on Forms CMS-64.9P Waiver, unless net DSH expenditures reported under the demonstration are or have been reduced to \$0, in which case they must be reported on Forms CMS-64.9P Base. Subparagraphs (i) through (iii) ensure that DSH spending is used first to exhaust the one-quarter of the FFY 2009 DSH allotment that is outside of the demonstration, and only after that is reported as a demonstration expense.
 - iv. All DSH expenditures for FFYs 2010 through 2014 are demonstration expenditures subject to budget neutrality, and must be reported on Forms CMS-64.9 Waiver and CMS-64.9P Waiver for the DY corresponding to the FFY.
 - v. All DSH expenditures reported on Forms CMS-64.9 Waiver or CMS-64.9P Waiver must be reported using waiver name "BC DSH."
 - vi. No later than January 31, 2009, and thereafter no later than August 31 of every year (including August 31, 2009), the State must submit to CMS a statement that describes how the State plans to determine final DSH payment amounts to specific hospitals for the following demonstration year (or, with respect to the January 31, 2009 statement, DY 1), including a listing of the priorities for the use of available funds, and a description of any deviation from the DSH payment methodologies in the Medicaid State Plan, if applicable. The statement must include a projection of the total amounts that the State expects to spend on childless adults' coverage and DSH payments to hospitals, respectively, in the coming FFY. In addition to the submission of this statement to CMS, the State must also publish this statement in an official publication of record or post the description on their public Web site, and include a copy in the Annual Report mentioned in paragraph 35 (along with details on how the statement was published). If the State plans to follow its Medicaid State Plan with respect to all DSH payments to hospitals without exception, the description may contain a statement to that effect. Claimed demonstration expenditures for each DY are allowable only the extent they are consistent with the applicable statement for that year. In addition, claimed demonstration expenditures will be reduced by the amount of any DSH payments that are inconsistent with the applicable statement.
 - vii. All DSH expenditures are subject to the auditing and reporting requirements under section 1923(j) of the Act.
- e) For monitoring purposes, cost settlements associated with expenditures subject to the

budget neutrality expenditure limit may be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements not so associated, the adjustments must be reported on lines 9 or 10C, as instructed in the State Medicaid Manual.

- f) Enrollment fees and other applicable cost sharing contributions from enrollees that are collected by the State under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64 Narrative, with subtotals by DY.
- g) **Pharmacy Rebates.** Using Core-Plan specific medical status codes, the State has the capacity to use its MMIS system to stratify manufacturer's rebate revenue that should be assigned to net demonstration expenditures. The State will generate a demonstration-specific rebate report to support the methodology used to assign rebates to the demonstration. The State will report rebate revenue on the Form CMS-64.9. This revenue will be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid. Budget neutrality will reflect the net cost of prescriptions.
- h) **Federally Qualified Health Center Settlement Expenses.** Using Core-Plan specific medical status codes, the State will assign FQHC settlement expenses to claims covered under the Demonstration. The State will be able to generate reports using MMIS data to show the assignment of these settlement payments to demonstration expenditures.

38. **Administrative Costs.** Administrative costs will not be included in the budget neutrality expenditure limit, but The State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All such administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using waiver name "**Childless Adults.**"

39. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which The State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

40. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the Demonstration. The State must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable

Demonstration expenditures (total computable and Federal share) subject to the budget neutrality agreement must be separately reported by quarter for each FFY on the form CMS-37.12 for both the medical assistance program and administrative costs. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

41. **Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section IX:

- a) Administrative costs, including those associated with the administration of the Demonstration;
- b) Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act for childless adults, with dates of service during the operation of the Demonstration; and
- c) All expenditures made using the State's DSH allotment that are not expenditures for the demonstration population.

42. **Sources of Non-Federal Share.** The State certifies that the matching non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a) CMS may review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
- c) Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses

of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

43. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

IX. MONITORING BUDGET NEUTRALITY

44. **Limit on Federal Title XIX funding.** The State will be subject to a limit on the amount of Federal title XIX funding that the State may receive for expenditures subject to the budget neutrality agreement during the demonstration approval period. The State may use a portion of its annual DSH allotment on expenditures to serve the Childless Adults Population. The remainder of its annual DSH allotment (or residual) shall be spent in accordance with Federal statute and the State’s Medicaid State plan, as modified by waiver authority.
45. **Risk.** The State shall be at risk for both the number of enrollees in the Demonstration as well as the per capita cost for demonstration eligibles under this budget neutrality agreement.
46. **Budget Neutrality Expenditure Limit.** The following table gives the budget neutrality limit for each Demonstration year (DY). The limits are expressed in terms of FFP (i.e., Federal share). Should implementation of the demonstration be delayed beyond January 1, 2009, the State and CMS will mutually determine revised language for this paragraph that is appropriate for a later implementation date, subject to approval as a demonstration amendment. In addition, in DY 6 the childless adults’ expenditures must not exceed one-quarter of the DSH allotment for FFY 2014 unless the demonstration is extended which represents the first quarter of FFY 2014.

DY	Budget Neutrality Limit
DY 1	3/4 of the FFY 2009 DSH allotment
DYs 2, 3, 4, 5 and 6	Corresponding FFY DSH allotment

47. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality on an *annual* basis. If The State exceeds the annual budget neutrality expenditure limit in any given DY, The State must submit a corrective action plan to CMS for approval and will repay (without deferral or disallowance) the Federal share of the amount by which the budget neutrality agreement has been exceeded.
48. **Impermissible DSH, Taxes or Donations.** The CMS reserves the right to adjust the budget neutrality expenditure limit in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS

reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to the budget neutrality agreement will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

X. EVALUATION OF THE DEMONSTRATION

- 49. Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after the effective date of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must also provide for an assessment of the accuracy of the eligibility determinations performed by the Enrollment Services Center centralized processing center. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.
- 50. Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.
- 51. Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.
- 52. Final Evaluation Report.** The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS' comments.
- 53. Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, The State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XI. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date	Deliverable
Per paragraph 49	Submit Draft Evaluation Design
Per paragraph 8	Submit Demonstration Extension Application
Per paragraph 50	Submit Interim Evaluation Report
Quarterly	Deliverable
Per paragraph 34	Quarterly Progress Reports
Per paragraph 34	Quarterly Enrollment Reports
Per paragraph 34	Quarterly Expenditure Reports
Annual	Deliverable
Per paragraph 35	Draft Annual Report

ATTACHMENT A

Summary Chart of the Core Plan -Benefits and Cost Sharing for Childless Adults

(This list represents the covered and potential covered services and cost sharing for the demonstration; any changes that are not identified on this list and STC # 27 b will require an amendment to the demonstration)

Core Plan for Childless Adults		
Service Type	Description of Coverage	Co-Payment
Chiropractic Services	No coverage at implementation, but potential for full coverage	If coverage is added, a co-payment up to \$15, not to exceed \$3 for members under 100% FPL
Dental Services	At present time, coverage is limited to emergency services only but the benefit could be expanded to include limited coverage of preventive, diagnostic, simple restorative, periodontics, and extractions up to \$750 per year	If coverage is expanded beyond emergency services, a \$200 deductible may be applied to all services except for preventive and diagnostic. Cost sharing may be equal to 50% of allowable fee on all services.
Disposable Medical Supplies (DMS)	Coverage of syringes, diabetic pens and DMS that is required with the use of a DME item.	\$0.50 co-payment per priced unit
Drugs	Generic-only formulary drug benefit with a few generic OTC drugs and potential for limited brand name drugs. <i>Upon implementation, certain brand name drugs are covered only for individuals previously covered under General Assistance Medical Programs.</i> Members will be automatically enrolled in the Badger Rx Gold plan. This is a separate program administered by Navitus, which provides for a discount on the cost of drugs.	\$5 co-payment for generic drugs; a co-payment up to \$15 for potential limited brand name drugs, not to exceed \$5 for members under 100% FPL
Durable Medical Equipment (DME)	Full coverage up to \$2,500 per enrollment year.	\$0.50 to \$5 co-payment per item Rental items are not subject to co-payment but count toward the \$2,500 annual limit.
Health screenings for Children	No coverage	
Hearing Services	No coverage at implementation, but	If limited coverage is

	potential for limited coverage provided by an audiologist.	included in the benefit, a co-payment up to \$15 per visit, not to exceed \$3 for members under 100% FPL
Home Care Services (Home Health ,Private Duty Nursing and Personal Care	No coverage at implementation, but potential for full coverage of home health services, up to 60 visits per enrollment year.	If coverage is included, a co-payment up to \$15 per visit, not to exceed \$3 for members under 100% FPL
Hospice Services	No coverage at implementation, but potential for full coverage, up to 360 days per lifetime.	If coverage is included, co-payment up to \$2 per day
Inpatient Hospital Services	Full coverage (not including inpatient psychiatric stays in either an IMD or the psychiatric ward of an acute care hospital)	\$3 co-payment per day up to \$75 per stay for members under 100% FPL and \$100 co-payment per stay for members between 100% and 200% FPL
Mental Health and Substance Abuse	At implementation, coverage is limited to mental health therapy services provided by a psychiatrist only but coverage may be expanded to include outpatient mental health, outpatient substance abuse (including narcotic treatment), mental health day treatment, substance abuse treatment and inpatient hospital stays for mental health and substance abuse.	\$.50 to \$15 co-payment per service, not to exceed \$3 for members under 100% FPL
Nursing Home Services	No coverage	
Outpatient Hospital-Emergency Room	Full coverage	No co-payment up to \$60 co-payment per visit, not to exceed \$3 for members under 100% FPL
Outpatient Hospital Services	Full coverage	\$3- \$15 co-payment per visit, not to exceed \$3 for members under 100% FPL
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)	Full coverage, limited to 20 visits per therapy discipline per enrollment year	\$.50 to \$15 co-payment per visit., not to exceed \$3 for members under 100% FPL

Physician Services (including Nurse Practitioner)	Full coverage, including laboratory and radiology	\$.50 to \$15 co-payment per visit, not to exceed \$3 for members under 100% FPL. No co-payment for emergency services, preventive care, anesthesia or clozapine management
Podiatry Services	No coverage at implementation, but potential for full coverage	If coverage is included, co-payment up to \$15 per visit, not to exceed \$3 for members under 100% FPL
Prenatal/Maternity Services	No coverage	
Reproductive Health Services	Family planning services provided by family planning clinics will be covered separately under the Family Planning Waiver program.	
Routine Vision	No coverage at implementation, but potential for coverage of one eye exam every two years, with refraction	If coverage is included, co-payment up to \$15 per visit, not to exceed \$3 for members under 100% FPL
Smoking Cessation Services	Coverage includes prescription generic and OTC tobacco cessation products.	Refer to the drug benefit for information on co-payments
Transportation	Coverage limited to emergency transportation by ambulance only	\$0-\$50 co-payment per trip, no co-payment for members under 100% FPL

**ATTACHMENT B
QUARTERLY REPORT FORMAT AND CONTENT**

Under Section VII, paragraph 34, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – Wisconsin – BadgerCare Plus Health Insurance for Childless Adults
Section 1115 Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 1 (01/01/09 – 09/30/09)

Federal Fiscal Quarter: 2/2009 (01/01/09 – 03/31/09)

Introduction

Information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, The State should indicate that by “0”.

Enrollment Count

Note: Enrollment counts should be person counts, not member months.

Demonstration Populations (as hard coded in the CMS 64)	Current Enrollees (to date)	Disenrolled in Current Quarter
Childless Adults		

Member Month Reporting

Enter the member months for the quarter.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Childless adults				

Outreach/Innovative Activities:

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:

Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues:

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the State's actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

Consumer Issues:

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:

Identify any quality assurance/monitoring activity in current quarter.

Clinical Advisory Committee on Health and Emerging Technology (CACHET):

Provide at a minimum an update on the status of the development /implementation, structure and operational and administrative function of the CACHET. Include any recommendations for changes to benefit design, quality of care (pay for performance/tiering of health plans) health delivery system, emerging medical technologies and procedures and utilization controls for the demonstration.

Status of Benefits and Cost Sharing under the Core Benefit Plan:

Provide confirmation of the actual covered services and co-payments required as described in Attachment A- Core Benefit Plan for the demonstration in current quarter.

Demonstration Evaluation:

Discuss progress of evaluation design and planning.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS:

ATTACHMENT B

PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (DIVISION C, TITLE V, SUBTITLE B, SECS. 511-512 OF H.R. 1424 OF THE EMERGENCY ECONOMIC STABILIZATION ACT, P.L. 110-343)

Certified by Superintendent of Documents, U.S. Government Printing Office, Certificate Issued by GeoTrust CA for Adobe

PUBLIC LAW 110–343—OCT. 3, 2008 122 STAT. 3765

Public Law 110–343

110th Congress

An Act

To provide authority for the Federal Government to purchase and insure certain types of troubled assets for the purposes of providing stability to and preventing disruption in the economy and financial system and protecting taxpayers, to amend the Internal Revenue Code of 1986 to provide incentives for energy production and conservation, to extend certain expiring provisions, to provide individual income tax relief, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

....

DIVISION C—TAX EXTENDERS AND ALTERNATIVE MINIMUM TAX RELIEF

SEC. 1. SHORT TITLE; AMENDMENT OF 1986 CODE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This division may be cited as the ‘‘Tax Extenders and Alternative Minimum Tax Relief Act of 2008’’.

(b) AMENDMENT OF 1986 CODE.—Except as otherwise expressly provided, whenever in this division an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

(c) TABLE OF CONTENTS.—The table of contents of this division is as follows:

Sec. 1. Short title; amendment of 1986 Code; table of contents.

.....

TITLE V – ADDITIONAL TAX RELIEF AND OTHER TAX PROVISIONS

...

Subtitle B—Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Sec. 511. Short title.

Sec. 512. Mental health parity.

Subtitle B—Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

SEC. 511. SHORT TITLE.

This subtitle may be cited as the “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008”.

SEC. 512. MENTAL HEALTH PARITY.

(a) AMENDMENTS TO ERISA.—Section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a) is amended—

(1) in subsection (a), by adding at the end the following:

“(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

“(ii) 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 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.”;

(2) in subsection (b), by amending paragraph (2) to read as follows:

“(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).”;

(3) in subsection (c)—

(A) in paragraph (1)(B)—

(i) by inserting “(or 1 in the case of an employer residing in a State that permits small groups to include a single individual)” after “at least 2” the first place that such appears; and

(ii) by striking “and who employs at least 2 employees on the first day of the plan year”; and
(B) by striking paragraph (2) and inserting the following:

“(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 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.”;

(4) in subsection (e), by striking paragraph (4) and inserting

the following:

“(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.”;

(5) by striking subsection (f);

(6) by inserting after subsection (e) the following:

“(f) SECRETARY REPORT.—The Secretary shall, by January 1, 2012, and every two years thereafter, submit to the appropriate committees of Congress a report on compliance of group health plans (and health insurance coverage offered in connection with such plans) with the requirements of this section. Such report shall include the results of any surveys or audits on compliance of group health plans (and health insurance coverage offered in connection with such plans) with such requirements and an analysis of the reasons for any failures to comply.

“(g) NOTICE AND ASSISTANCE.—The Secretary, in cooperation with the Secretaries of Health and Human Services and Treasury, as appropriate, shall publish and widely disseminate guidance and information for group health plans, participants and beneficiaries, applicable State and local regulatory bodies, and the National Association of Insurance Commissioners concerning the requirements of this section and shall provide assistance concerning such requirements and the continued operation of applicable State law. Such guidance and information shall inform participants and beneficiaries of how they may obtain assistance under this section, including, where appropriate, assistance from State consumer and insurance agencies.”;

(7) by striking “‘mental health benefits’” and inserting “‘mental health and substance use disorder benefits’” each place it appears in subsections (a)(1)(B)(i), (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C); and

(8) by striking “‘mental health benefits’” and inserting “‘mental health or substance use disorder benefits’” each place it appears (other than in any provision amended by the previous paragraph).

(b) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—Section 2705 of the Public Health Service Act (42 U.S.C. 300gg–5) is amended—

(1) in subsection (a), by adding at the end the following:

“(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

“(ii) 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 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.”;

(2) in subsection (b), by amending paragraph (2) to read as follows:

“(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).”;

(3) in subsection (c)—

(A) in paragraph (1), by inserting before the period the following: “(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)”;

(B) by striking paragraph (2) and inserting the following:

“(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 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.”;

(4) in subsection (e), by striking paragraph (4) and inserting the following:

“(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.”;

(5) by striking subsection (f);

(6) by striking “‘mental health benefits’” and inserting “‘mental health and substance use disorder benefits’” each place it appears in subsections (a)(1)(B)(i), (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C); and

(7) by striking “‘mental health benefits’” and inserting “‘mental health or substance use disorder benefits’” each place it appears (other than in any provision amended by the previous paragraph).

(c) AMENDMENTS TO INTERNAL REVENUE CODE.—Section 9812

of the Internal Revenue Code of 1986 is amended—

(1) in subsection (a), by adding at the end the following:

“(3) FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.—

“(A) IN GENERAL.—In the case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan 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, and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

“(ii) 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 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 shall be made available by the plan administrator in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan 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 to the participant or beneficiary in accordance with regulations.

“(5) OUT-OF-NETWORK PROVIDERS.—In the case of a plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan provides coverage for medical or surgical benefits provided by out-of-network providers, the plan 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.”;

(2) in subsection (b), by amending paragraph (2) to read as follows:

“(2) in the case of a group health plan that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan relating to such benefits under the plan, except as provided in subsection (a).”;

(3) in subsection (c)—

(A) by amending paragraph (1) to read as follows:

“(1) SMALL EMPLOYER EXEMPTION.—

“(A) IN GENERAL.—This section shall not apply to any group health plan for any plan year of a small employer.

“(B) SMALL EMPLOYER.—For purposes of subparagraph (A), the term ‘small employer’ means, with respect to a calendar year and a plan year, an employer who employed an average of at least 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer and rules similar to rules of subparagraphs (B) and (C) of section 4980D(d)(2) shall apply.”; and

(B) by striking paragraph (2) and inserting the following:

“(2) COST EXEMPTION.—

“(A) IN GENERAL.—With respect to a group health plan, if the application of this section to such plan 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 during the following plan year, and

such exemption shall apply to the plan 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 involved regardless of any increase in total costs.

“(B) APPLICABLE PERCENTAGE.—With respect to a plan, 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 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 for a period of 6 years following the notification made under subparagraph (E).

“(D) 6-MONTH DETERMINATIONS.—If a group health plan seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan has complied with this section for the first 6 months of the plan year involved.

“(E) NOTIFICATION.—

“(i) IN GENERAL.—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 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;

“(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 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.”;

(4) in subsection (e), by striking paragraph (4) and inserting the following:

“(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.”;

(5) by striking subsection (f);

(6) by striking “‘mental health benefits’” and inserting “‘mental health and substance use disorder benefits’” each place it appears in subsections (a)(1)(B)(i), (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C); and

(7) by striking “‘mental health benefits’” and inserting “‘mental health or substance use disorder benefits’” each place it appears (other than in any provision amended by the previous paragraph).

(d) REGULATIONS.—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), respectively.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section 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), 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 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, 2009.

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.

(f) ASSURING COORDINATION.—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) 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.

(g) CONFORMING CLERICAL AMENDMENTS.—

(1) ERISA HEADING.—

(A) IN GENERAL.—The heading of section 712 of the

Employee Retirement Income Security Act of 1974 is amended to read as follows:

“SEC. 712. PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.”

(B) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by striking the item relating to section 712 and inserting the following new item:

“Sec. 712. Parity in mental health and substance use disorder benefits.”

(2) PHSA HEADING.—The heading of section 2705 of the Public Health Service Act is amended to read as follows:

“SEC. 2705. PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.”

(3) IRC HEADING.—

(A) IN GENERAL.—The heading of section 9812 of the Internal Revenue Code of 1986 is amended to read as follows:

“SEC. 9812. PARITY IN MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS.”

(B) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of such Code is amended by striking the item relating to section 9812 and inserting the following new item:

“Sec. 9812. Parity in mental health and substance use disorder benefits.”

(h) GAO STUDY ON COVERAGE AND EXCLUSION OF MENTAL HEALTH AND SUBSTANCE USE DISORDER DIAGNOSES.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study that analyzes the specific rates, patterns, and trends in coverage and exclusion of specific mental health and substance use disorder diagnoses by health plans and health insurance. The study shall include an analysis of—

(A) specific coverage rates for all mental health conditions and substance use disorders;

(B) which diagnoses are most commonly covered or excluded;

(C) whether implementation of this Act has affected trends in coverage or exclusion of such diagnoses; and

(D) the impact of covering or excluding specific diagnoses on participants’ and enrollees’ health, their health care coverage, and the costs of delivering health care.

(2) REPORTS.—Not later than 3 years after the date of the enactment of this Act, and 2 years after the date of submission

the first report under this paragraph, the Comptroller General shall submit to Congress a report on the results of the study conducted under paragraph (1).

....

PUBLIC LAW 110–343—OCT. 3, 2008 122 STAT. 3933

LEGISLATIVE HISTORY—H.R. 1424:

HOUSE REPORTS: No. 110–374, Pt. 1 (Comm. on Education and Labor), Pt. 2 (Comm. on Ways and Means), and Pt. 3 (Comm. on Energy and Commerce).

CONGRESSIONAL RECORD, Vol. 154 (2008):

Mar. 5, considered and passed House.

Oct. 1, considered and passed Senate, amended.

Oct. 3, House concurred in Senate amendments.

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arrangement for purposes of section 409A of the Internal Revenue Code of 1986.

Approved October 3, 2008.

PUBLIC LAW 110–460—DEC. 23, 2008 122 STAT. 5123

LEGISLATIVE HISTORY—S. 3712:

CONGRESSIONAL RECORD, Vol. 154 (2008):

Nov. 20, considered and passed Senate.

Dec. 10, considered and passed House.

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Public Law 110–460

110th Congress

An Act

To make a technical correction in the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. TECHNICAL CORRECTION IN MENTAL HEALTH PARITY EFFECTIVE DATE.

Section 512(e)(2)(B) of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (subtitle B of title V of division C of Public Law 110–343) is amended by striking “January 1, 2009” and inserting “January 1, 2010”.

Approved December 23, 2008.

Ante, p. 3891.

Dec. 23, 2008

[S. 3712]

ATTACHMENT C

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 1396u-2(b)(8). COMPLIANCE WITH CERTAIN MATERNITY AND
MENTAL HEALTH REQUIREMENTS

I. 42 U.S.C.S Sec. 300gg-5: Title XXVII – Requirements Relating to Health Insurance Coverage, Part A, Subpart 2 – Other Requirements, Sec. 2705 – Parity in the Application of Certain Limits to Mental Health Benefits, of the Public Health Service Act

A. Current Law Prior to Application of the Wellstone Domenici Act

42 U.S.C.S Sec. 300gg-5. Parity in the application of certain limits to mental health benefits [Caution: See prospective amendment note below.]

(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) [Deleted]

History (Applicable to Sections A (Current Law) and B (Revised 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

(Emphasis added. Lexis Nexis)

B. Amendment to Title XXVII, Part A, Subpart 2, Sec. 2705 of the Public Health Service Act included in the Wellstone-Domenici Act (Note: These amendments will take effect no later than January 1, 2010.)

1. Prospective amendment:

Amendment of section, applicable with respect to group health plans for plan years beginning after the date that is 1 year after enactment. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(b)(1)-(4), (6), (7), 122 Stat. 3885, 3888 (applicable with respect to group health plans for plan years beginning after the date that is 1 year after enactment, as provided by § 512(e) of such Act, which appears as a note to this section), provides:

"Section 2705 of the Public Health Service Act (42 U.S.C. 300gg-5) is amended--

"(1) in subsection (a), by adding at the end the following:

" '(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

" '(ii) 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 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.';

"(2) in subsection (b), by amending paragraph (2) to read as follows:

" '(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).';

"(3) in subsection (c)--

"(A) in paragraph (1), by inserting before the period the following: "(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)"; and

"(B) by striking paragraph (2) and inserting the following:

" '(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 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.";

"(4) in subsection (e), by striking paragraph (4) and inserting the following:

" '(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.';

"(6) by striking "mental health benefits" and inserting "mental health and substance use disorder benefits" each place it appears in subsections (a)(1)(B)(i), (a)(1)(C), (a)(2)(B)(i), and (a)(2)(C); and

"(7) by striking "mental health benefits" and inserting "mental health or substance use disorder benefits" each place it appears (other than in any provision amended by the previous paragraph)."

Amendment of section heading, applicable with respect to group health plans for

plan years beginning after the date that is 1 year after enactment. Act Oct. 3, 2008, P.L. 110-343, Div C, Title V, Subtitle B, § 512(g)(2), 122 Stat. 3892 (applicable with respect to group health plans for plan years beginning after the date that is 1 year after enactment, as provided by § 512(e) of such Act, which appears as 42 USCS § 300gg-5 note), provides:

"The heading of section 2705 of the Public Health Service Act is amended to read as follows:

"Sec. 2705. Parity in mental health and substance use disorder benefits."

2. Amendments (Applicable to Sections I. A (Current Law) and I. B (Revised 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 Sections A (Current Law) and B (Revised 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)

C. Mental Health and Addiction Treatment Requirements of the Public Health Service Act After the Effective Date of the Wellstone Domenici Act

1. Mark-Up of Text

[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~~ mental health and substance use disorder 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~~ 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~~ mental health or substance use disorder 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~~ 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 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 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 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 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 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 (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 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 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.~~

"(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]”

2. Final Text

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.

(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 or substance use disorder 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 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 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 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 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).

(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 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 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]

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

42 U.S.C.S. 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.

(Lexis Nexis)



COMMUNITY ADVOCATES
Public Policy Institute

Exhibit 2

**Letter from Clarke Cagey,
Centers for Medicare & Medicaid Services,
to David R. Riemer,
Community Advocates Public Policy Institute,
Dated November 24, 2009**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations, Family and Children's Health Programs Group

NOV 24 2009

Mr. David R. Riemer
Director of Policy and Planning
Community Advocates Public Policy Institute
744 North 4th Street, Suite 200
Milwaukee, WI 53203

Dear Mr. Riemer:

Thank you for your letter of inquiry regarding the impact of the Paul Wellstone and Pete Domenici Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA) on Medicaid Managed Care Organizations' (MCO) coverage of mental health and substance use disorder services, and the coverage of specific health services that a State is granted approval by the Secretary to provide under individual demonstration projects authorized under section 1115 of the Social Security Act (the Act).

Section 2705 of the Public Health Service Act, as amended by MHPAEA, does not address providing a broad range of mental health services, or include a requirement even to provide such services. Instead, it indicates that financial limitations (e.g., copayments, deductibles) and treatment limitations (e.g., number of visits) cannot be more restrictive for mental health benefits than they are for the "predominant" requirements that apply to substantially all medical and surgical benefits. Further, there cannot be limitations that apply only to mental health and substance use disorder services. MHPAEA applies to group health plans as cited in the Public Health Services Act (cited as 42 U.S.C.S. Section 300gg-5 "Parity in application of certain limits to mental health benefits" in Medicaid this application would apply to managed care entities. The answer to your inquiry about the MHPAEA provisions being applicable to Medicaid managed care organizations is yes, under Medicaid, this application would apply to managed care entities.

The CMS is aware of the complexities associated with this provision. Therefore, CMS is collaborating with the Departments of Labor and Treasury to develop regulations to implement MHPAEA. We are currently reviewing and assessing the implications of the MHPAEA provisions as they relate to required parity between physical health and mental health services under the Medicaid and Children's Health Insurance Programs (CHIP). The Departments of Health and Human Services, Treasury, and Labor published a Request for Information in the Federal Register on April 28, 2009, seeking guidance for use in implementing the MHPAEA provisions. On November 4, 2009, CMS released a State Health Official letter to provide preliminary guidance to the extent that the MHPAEA requirements apply to State Medicaid programs under title XIX of the Act. I have enclosed a copy of the letter for your review. CMS intends to release additional information related to the application of these provisions to Medicaid and CHIP within the next several months based upon our ongoing work with the Department to ensure coordinated policy.

Page 2 – Mr. David R. Riemer

I hope this information is helpful to you. If you have any questions regarding this letter, please contact Edward Hutton, Acting Director of the Division of State Demonstrations and Waivers, at 410-785-6616 or email him at edward.hutton@cms.hhs.gov.

786-6616

Sincerely,

A handwritten signature in black ink, appearing to read 'Clarke Cagey', with a long horizontal flourish extending to the right.

Clarke Cagey
Acting Director

Enclosure

cc:

Senator Herb Kohl, Wisconsin

Jason Helgeson, Wisconsin Medicaid Director

James Jones, Wisconsin Deputy Medicaid Director

Maria Reed, CMS Central Office

Verlon Johnson, CMS Region V

Cynthia Garraway, CMS Region V

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

SHO 09-014
CHIPRA #9

November 4, 2009

Dear State Health Official:

The purpose of this letter is to provide general guidance on implementation of section 502 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, which imposes mental health and substance use disorder parity requirements on all Children's Health Insurance Program (CHIP) State plans under title XXI of the Social Security Act (the Act). This letter also provides preliminary guidance to the extent that mental health and substance use disorder parity requirements apply to State Medicaid programs under title XIX of the Act.

Statutory Basis for CHIPRA Parity Requirement

Section 502 of CHIPRA amended section 2103(c) of the Act to incorporate, by reference, provisions added to section 2705 of the Public Health Service (PHS) Act by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Public Law 110-343. Prior to MHPAEA, the PHS Act required parity in annual or lifetime dollar limits between mental health and medical/surgical benefits (as a result of the Mental Health Parity Act of 1996). MHPAEA expanded the application of the existing mental health parity requirements in section 2705 to substance use disorder benefits, and added new requirements such as:

- Financial requirements (e.g., co-payments) that are applied to mental health or substance use disorder benefits must be no more restrictive than the predominant financial requirements that are applied to substantially all medical/surgical benefits.
- Treatment limitations (e.g., numbers of visits or days of coverage) that are applied to mental health or substance use disorder benefits must be no more restrictive than the predominant treatment limitations that are applied to substantially all medical/surgical benefits.
- No separate financial requirements or treatment limitations can apply only to mental health or substance use disorder benefits.
- When out-of-network coverage is available for medical/surgical benefits, it also must be available for mental health or substance use disorder benefits.

The MHPAEA was enacted on October 3, 2008, and will be effective for group health plans for plan years beginning after October 3, 2009. The Departments of Health and Human Services (HHS), Labor and the Treasury will jointly publish regulations on the application of MHPAEA to group health plans.

Application to Medicaid

The MHPAEA requirements apply to Medicaid only insofar as a State's Medicaid agency contracts with one or more managed care organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs), to provide medical/surgical benefits as well as mental health or substance use disorder benefits. In this case, those MCOs or PIHPs must meet the parity requirements of MHPAEA, as incorporated by reference in title XIX of the Act, for contract years beginning after October 3, 2009. MHPAEA parity requirements do not apply to the Medicaid State plan if a State does not use MCOs or PIHPs to provide these benefits.

Application to CHIP

The application of MHPAEA to CHIP is somewhat broader. Section 2103(c)(6) of the Act applies the MHPAEA requirements to the entire "State child health plan" including, but not limited to, any MCOs that contract with the State CHIP program. Specifically, section 502 of CHIPRA requires that State child health plans comply with the requirements of section 2705(a) of the PHS Act "in the same manner" as such requirements apply to a group health plan. Therefore, if a CHIP State plan provides both medical/surgical benefits and mental health or substance use disorder benefits, any treatment limitations, lifetime or annual dollar limits or out-of-pocket costs for both types of benefits must comply with the provisions added to the PHS Act by MHPAEA. Section 502 of CHIPRA also specifies that State CHIP plans are deemed to satisfy the mental health and substance use disorder parity requirements if they provide coverage of Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefits (as defined under title XIX of the Act). This requirement was effective as of April 1, 2009.

Implementation of MHPAEA Requirements

States will need to begin to assess their own compliance with the MHPAEA parity requirements prior to the issuance of MHPAEA regulations. For States that use MCOs or PIHPs to provide Medicaid benefits, a review of current contract language with the plans should occur before the next contract year begins to ensure that MHPAEA parity requirements are in place.

Similarly, each State will need to review its CHIP plan to determine if the CHIP State plan imposes more restrictive requirements on mental health or substance use disorder benefits than on medical/surgical benefits. As noted above, any State that either operates its CHIP program as an expansion of its Medicaid program, or which provides coverage of EPSDT benefits as defined under title XIX of the Act in its separate or combination CHIP program, already will be in compliance with these mental health and substance use disorder parity requirements.

Until the MHPAEA regulations are issued or other guidance is provided, States will not have detailed information regarding how specific provisions in MHPAEA will be interpreted. However, section 3(d)(2) of CHIPRA provides that Federal financial participation in both CHIP and Medicaid shall not be denied if States make a good faith effort to comply with the requirements prior to the issuance of any regulations or guidance implementing the provisions in question. Examples of what might be considered a good faith effort could include States providing an assurance in their CHIP State plan that there is no significant difference in cost

sharing, lifetime or annual dollar limits, or treatment limits (e.g. the number of inpatient days) between mental health/substance use disorder benefits and medical/surgical benefits.

In addition, section 3(b) of CHIPRA addresses the situation in which States need to pass legislation in order to bring their CHIP plans into compliance. In that case, a State will not be found to be in violation of the statutory requirements before its next legislative session, as long as it notifies the Secretary of HHS, and she concurs that legislation is needed. If your State requires such legislation, please submit a letter to the Center for Medicaid and State Operations to that effect as soon as possible. The letter should include the provision in question, the reason that State legislation is required for compliance, and the date the State will begin implementing the provision. For States with annual legislative sessions, this date must be no later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after February 4, 2009 (the date CHIPRA was enacted). For States that have a 2-year legislative session, each year of the session is considered a separate regular session for this purpose.

Additional policy guidance will be provided on this issue after the MHPAEA regulation is published. However, in the meantime, we encourage all States to begin a dialogue with their Centers for Medicare & Medicaid Services regional office concerning their timeline for complying with these parity requirements.

If you have any questions on the information provided in this letter, please send an email to CMSOCHIPRAQuestions@cms.hhs.gov or contact Ms. Maria Reed, Deputy Director, Family and Children's Health Programs Group, at 410-786-5647.

Sincerely,

/s/

Cindy Mann
Director

Page 4 - State Health Official

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christine Evans, M.P.H.
Director, Government Relations
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy



COMMUNITY ADVOCATES
Public Policy Institute

Exhibit 3

**Letter from David R. Riemer,
Community Advocates Public Policy Institute,
to Adam Shaw,
Centers for Medicare & Medicaid Services,
Dated May 19, 2009**



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).

Mr. Adam Shaw
May 19, 2009
Page 2

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.

Mr. Adam Shaw
May 19, 2009
Page 5

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
Director of Policy and Planning

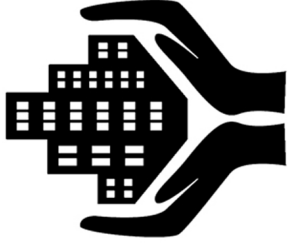
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Attachment

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.

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).

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 Act³

42 U.S.C.S. Sec. 300gg-5. 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 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 cover-

Amended Law After the Wellstone-Domenici Act Takes Effect⁴

[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 mental health and substance use disorder benefits.

(a) In general.

(1) Aggregate lifetime limits. In the case of a group health plan (or health insurance plan) that provides both medical and surgical benefits and ~~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 benefits~~ mental health or substance use disorder benefits.

(B) Lifetime limit. If the plan or cover-

Final Text of Amended Law After the Wellstone-Domenici Act Takes Effect

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.

(1) Aggregate lifetime limits. In the case of a group health plan (or health insurance 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 or substance use disorder benefits.

(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.

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

(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

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; 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.

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~~(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

(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.

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“(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 coordi-
nated enforcement strategy that avoids du-
plication 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