

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