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Mental Health Parity and the Patient Protection and Affordable Care Act of 2010

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Summary

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as modified by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010) contains a number of provisions that generally combine to extend the reach of existing federal mental health parity requirements. Prior to 1996, health insurance coverage for mental illness had historically been less generous than that for other physical illnesses. Mental health parity is a response to this disparity in insurance coverage, and generally refers to the concept that health insurance coverage for mental health services should be offered on par with covered medical and surgical benefits.

Prior to enactment of the ACA, two major mental health parity laws had been passed at the federal level, and together created the federal mental health parity requirements. These two laws are the Mental Health Parity Act of 1996 (MHPA, P.L. 104-204), which requires parity in annual and aggregate lifetime limits, and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343), which expands parity requirements to treatment limitations, financial requirements (e.g., co-payments), and in- and out-of-network covered benefits. Neither of these laws mandates the coverage of any specific mental health condition; rather, where an insurer chooses to cover both mental health and medical and surgical benefits, they are required to do so in compliance with these parity requirements.

The ACA contains a number of provisions which, when considered together, achieve two key goals with respect to mental health parity: (1) they expand the reach of the applicability of the federal mental health parity requirements; and (2) they create a mandated benefit for the coverage of certain mental health and substance abuse disorder services (to be determined through rulemaking) in a number of specific financing arrangements. PPACA expands the reach of federal mental health parity requirements to three main types of health plans: qualified health plans as established by the ACA; Medicaid non-managed care benchmark and benchmark-equivalent plans; and plans offered through the individual market. The ACA did not alter the federal mental health parity requirements with respect to CHIP plans, but the application of the requirements to CHIP plans, as required in law prior to the ACA, is explained here in detail. This report also analyzes the impact of the ACA on the existing small employer exemption under federal mental health parity law.

Contents

Background 1
Federal Mental Health Parity Law Prior to the ACA 2
The Mental Health Parity Act (MHPA) of 1996 3
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) 3
Federal Mental Health Parity Law and the ACA 4
Coverage Mandate for Mental Health Services for Certain Plan Types 5
Qualified Health Plans and Mental Health Parity 6
Extension of Federal Mental Health Parity Requirements to Plans in the Individual Market and the Small Employer Exemption 7
Expansion of Federal Mental Health Parity Requirements to Certain Medicaid Plans and the Medicaid Expansion Population 8
CHIP, Federal Mental Health Parity Requirements, and the ACA 9
Conclusion 10

Tables

Table 1. Plans Impacted by the ACA Expansion of Federal Mental Health Parity Requirements and Mandated Coverage of Mental Health Services 5
Table 2. Applicability of Federal Mental Health Parity Requirements to Medicaid Coverage Arrangements 9

Contacts

Author Contact Information 10
Acknowledgments 11

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as modified by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010) contains a number of provisions that generally combine to expand the reach of federal mental health parity requirements as established by the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).[1] In addition, while the ACA does not create an explicit federal-level mandated benefit for mental health and substance abuse disorder services, it does create one for certain health plan types.

This report provides a brief background on mental health parity and the policy discussion around parity in health insurance coverage; an overview of federal mental health parity law prior to the enactment of the ACA; and an analysis of the impact of the ACA on federal mental health parity law.

Background

Prior to 1996, health insurance coverage for mental illness had historically been less generous than that for other physical illnesses. This has generally been reflected either by a complete lack of coverage of a particular mental health condition or related services or by a differential structuring of coverage terms for mental health benefits relative to benefits for medical and surgical services. For example, prior to the enactment of the federal mental health parity laws, health plans often chose to impose lower annual or lifetime dollar limits on mental health coverage; to limit treatment of mental health illnesses by covering fewer hospital days and outpatient office visits; and to increase cost sharing for mental health care services relative to medical or surgical services. In addition, in- and out-of-network coverage has often been variable between mental health and medical and surgical services.

Mental health parity is a response to this disparity in insurance coverage, and generally refers to the concept that health insurance coverage for mental health services should be offered on par with covered medical and surgical benefits. Policymakers have developed three general approaches to achieving parity, based broadly on two dichotomous distinctions: namely, whether the approach mandates coverage and whether the approach requires parity coverage.[2] Specifically, parity laws may require insurers to cover certain, or all, mental illnesses (mandated coverage); laws also may or may not require parity coverage.

Policies including any type of coverage mandate for mental illnesses, and requiring parity coverage, are defined as taking a *full parity* approach. Policies which include any type of coverage mandate for mental illnesses, and which do not require parity coverage, are defined as taking a *minimum mandated benefit* approach. Finally, policies which do not include coverage mandates for mental illnesses, but which require parity coverage, are defined as taking a *mandated offering parity* approach.

[1] MHPA and MHPAEA together require parity coverage in the following four areas: financial requirements, treatment limitations, in- and out-of-network benefits, and annual and lifetime aggregate limits. When this report uses the term "federal mental health parity requirements," it will be referring to parity in these four areas, as required by MHPA and MHPAEA. The ACA did nothing to alter or modify the content of the federal mental health parity requirements themselves.

[2] Full parity (or parity) coverage may be defined as coverage requiring benefits for mental health illnesses that are on par with those for physical illnesses in terms of three coverage provisions: treatment limitations (i.e., number of covered visits); annual and lifetime dollar limits; and financial requirements (i.e., copayments, coinsurance).

Federal mental health parity law prior to the ACA employed a mandated offering parity approach; it did not mandate coverage of any specific mental health or substance abuse disorder service, but it did require that where an insurer covered by the law chose to cover both mental health and medical and surgical benefits, they had to do so in compliance with the federal mental health parity requirements.

The ACA contains a number of provisions which, when considered together, achieve two key goals with respect to mental health parity: (1) they expand the reach of the applicability of the federal mental health parity requirements; and (2) they create a mandated benefit for the coverage of certain mental health and substance abuse disorder services (to be determined through rulemaking) in a number of specific financing arrangements. Importantly, the ACA *does not include* an explicit or comprehensive coverage mandate for mental health services at the federal level; it only contains separate provisions which, when considered together, mandate coverage of mental health services for certain plans.[3] In addition, the ACA *does not modify* the federal mental health parity requirements themselves; rather it contains several provisions which expand the applicability of said requirements to a number of specific financing arrangements.

Federal Mental Health Parity Law Prior to the ACA

Two major mental health parity laws passed at the federal level prior to enactment of the ACA, and together establish the federal mental health parity requirements. These two laws are MHPA, which requires parity in annual and aggregate lifetime limits, and MHPAEA, which expands the federal parity requirements to include parity in treatment limitations, financial requirements, and in- and out-of-network covered benefits. Neither of these laws mandates the coverage of any specific mental health condition; rather, where an insurer chooses to cover both mental health and medical and surgical benefits, they are required to do so in compliance with these parity requirements. Recent data indicate that approximately one-third of employers with more than 50 employees have modified their benefits in response to MHPAEA. Of this group, a small percentage has elected to drop coverage for mental health and substance use disorder services in response to the requirements in MHPAEA, while the majority has instead responded by eliminating limits on coverage or increasing utilization management of benefits.[4] The ACA requires coverage of (as of yet unspecified) mental health and substance use disorder services by certain plans, including those plans to be offered through the Exchanges. It is

Federal Mental Health Parity Requirements

Federal law requires certain insurers, when the insurer chooses to cover mental health and substance use disorder services, to offer coverage of those services at parity with medical and surgical services, and specifically in the following four areas:

(1) Annual and Aggregate Lifetime Limits

(2) Treatment Limitations

(3) Financial Requirements

(4) In- and Out-of-Network Covered Benefits

[3] For this reason, existing federal mental health parity law may still be characterized as taking the mandated offering parity approach.

[4] "Employer Health Benefits 2010 Annual Survey." The Kaiser Family Foundation and Health Research and Educational Trust. Accessed on January 3, 2010 at http://ehbs.kff.org/pdf/2010/8085.pdf. Specifically, the survey found that 31% of firms with more than 50 workers changed their benefits in response to the MHPAEA (those firms with 50 or fewer employees are exempt from the requirements of MHPAEA). Of this 31%, 5% dropped coverage for mental health services; 66% eliminated limits on coverage; and 16% increased utilization management of benefits.

unclear what impact these requirements will have on plans' decisions to retain or drop coverage of mental health and substance use disorder services once they go fully into effect in 2014.

The Mental Health Parity Act (MHPA) of 1996

MHPA (P.L. 104-204) was the first federal mental health parity law. MHPA employs a mandated offering parity approach, with no coverage mandates, but requiring partial parity. It achieves this by mandating that annual and aggregate lifetime dollar limits on coverage for mental health services under group health plans and health insurance issuers offering group health coverage offering mental health coverage be no less than those for medical and surgical services. MHPA, as well as federal parity legislation introduced in later Congresses, amends the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) to apply the parity coverage requirements to all group health coverage arrangements governed by these statutes.[5] MHPA establishes a small employer exemption, which was further amended by MHPAEA, exempting employers with between 2 and 50 employees from the federal mental health parity requirements. MHPA also contains a cost exemption, also further amended by MHPAEA, allowing group health plans that experience a cost increase of at least 1% as a result of complying with the act to be exempt from parity requirements. Since its enactment, MHPA, which originally sunset in 2001, received annual extensions through the end of 2008. The sunset provision in MHPA was repealed by MHPAEA.

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

MHPAEA (P.L. 110-343) expands the scope of mental health parity requirements at the federal level, and includes substance use disorders within its scope. It expands on the MHPA requirement of parity in aggregate lifetime and annual limits requiring, in addition, parity in treatment limitations, financial requirements, and in- and out-of-network benefits.[6] MHPAEA amends the small employer exemption added by MHPA to include employers with only one employee seeking group insurance in those states where small groups are permitted to include a single individual and defining small employer per PHSA Sec. 2791(e)(4).[7] MHPAEA also significantly amends MHPA's cost exemption to clarify its parameters. In addition, the federal mental health parity requirements established by MHPA and MHPAEA do not apply to the individual market.

[5] In general, while ERISA covers private-sector employee benefit plans, it does not cover governmental plans, church plans, or insurance issuers providing group health coverage, and coverage in the individual market, including some governmental plans. The IRC covers group health plans, including church plans, but does not cover health insurers. The PHSA covers plans that are offered by state-licensed insurance carriers. The requirements of the PHSA may apply to church plans if the plan provides coverage through a health insurer. For more information, please see CRS Report R40635, *Employment-Based Health Coverage and Health Reform: Selected Legal Considerations*, by Jennifer Staman and Edward C. Liu.

[6] PHSA Sec. 2726 defines treatment limitation as "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." Financial requirement is defined as including deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an annual limit and an aggregate lifetime limit.

[7] The term "small employer" is defined at PHSA Sec. 2791(e)(4), as amended by ACA Sec. 1563, to mean, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

Prior to the enactment of the ACA, all of the federal mental health parity requirements were codified at PHSA Sec. 2705 (the ACA redesignates PHSA Sec. 2705 as PHSA Sec. 2726). Also prior to the ACA, all Medicaid managed care plans and all CHIP plans that chose to cover mental health services were required to comply with some or all of the federal mental health parity requirements. Medicare, offered to beneficiaries through either traditional fee-for-service or stand-alone Medicare Advantage (managed care) plans, is not required to comply with the federal mental health parity requirements to any extent.

Federal Mental Health Parity Law and the ACA

Generally, the effect of the mental health parity provisions in the ACA is to extend the applicability of the federal mental health parity requirements, and to mandate coverage of certain (to be specified) mental health services by specific plan types (see **Table 1**). In particular, several questions are raised by the expansion of the applicability of the federal mental health parity requirements.

Specifically, the ACA expands the reach of federal mental health parity law to three main types of plans: qualified health plans (QHPs), as established by the ACA; Medicaid non-managed care benchmark and benchmark-equivalent plans; and plans offered through the individual market.[8] The ACA modifies existing parity law to require compliance with the federal mental health parity requirements by plans offered through the individual market. It appears, however, that the small employer exemption in federal parity law remains in effect, and in fact, that the definition of small employer was expanded, per the ACA. Beginning in 2014, QHPs purchased through an Exchange must cover mental health services (to be determined through rulemaking), and must offer these services in compliance with the federal mental health parity requirements.[9] The interaction between this requirement, and the apparent continued existence of the small employer exemption, raises considerations that may need to be reconciled through rulemaking. Medicaid benchmark and benchmark-equivalent plans, that are not managed care plans and that offer mental health services, must do so in compliance with the federal mental health parity requirements for financial requirements and treatment limitations. The ACA did not alter the applicability of parity requirements with respect to the Children's Health Insurance Program (CHIP), but the application of federal mental health parity requirements to CHIP plans, as required in law prior to the ACA, is explained here in detail.

[8] Although the ACA directly amends the PHSA, conforming amendments in the law extend the new provisions to plans governed both by ERISA and by the IRC (ACA Sec. 1563(e) and (f)).

[9] The ACA will enable and support states' creation by 2014 of "American Health Benefit Exchanges." An exchange cannot be an insurer, but will provide eligible individuals and small businesses with access to insurers' plans in a comparable way. The exchange will consist of a selection of private plans as well as "multi-state qualified health plans," administered by the Office of Personnel Management. Individuals will only be eligible to enroll in an exchange plan if they are not enrolled in Medicare, Medicaid, or acceptable employer coverage as a full-time employee. Based on income, certain individuals may qualify for a tax credit toward their premium costs and a subsidy for their cost-sharing; the credits and subsidies will be available only through an exchange. States will have the flexibility to establish basic health plans for low-income individuals not eligible for Medicaid. For more information, please see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind and Bernadette Fernandez.

In addition, the ACA mandates coverage of certain mental health services specifically for QHPs; Medicaid benchmark and benchmark-equivalent plans; and new plans in the individual and small group markets.

Table 1. Plans Impacted by the ACA Expansion of Federal Mental Health Parity Requirements and Mandated Coverage of Mental Health Services

Plan Type	Expansion of Parity Requirements	Coverage Mandate
Medicaid Non-Managed Care Benchmark and Benchmark Equivalent Plans	ACA Sec. 2001(c)	ACA Sec. 2001(c)
Qualified Health Plans	ACA Sec. 1311(j)	ACA Sec. 1301(a)(1)(B)
Individual Plans	ACA Sec. 1563(c)(4)	N/A[a]
New Small Group and Individual Plans	N/A[b]	ACA Sec. 1201, adding New PHSA Sec. 2707(a)

Source: CRS analysis.

a. A coverage mandate applies to *new* plans offered through the individual market.

b. The federal mental health parity requirements are expanded by the ACA to apply to *all* plans offered through the individual market.

Coverage Mandate for Mental Health Services for Certain Plan Types

When considering coverage for mental health and substance abuse services, there are two main issues that are generally considered: whether a mandate for coverage exists (or coverage is voluntarily offered) and whether those services, if covered, are covered at parity with services for medical or surgical services. Federal mental health parity law prior to the ACA, as mentioned above, does not include any mandate for coverage, but does require that when such benefits are offered, they be offered at full parity. The ACA, on the other hand, creates a coverage mandate for mental health and substance abuse services broadly for QHPs.[10] It also extends this coverage mandate to Medicaid benchmark and benchmark-equivalent plans as well as to plans offered in the small and individual group market (but not self-insured plans).[11] It does this by defining essential health benefits (EHB), which it then requires to be offered by various plan types.

Specifically, the ACA establishes and defines QHPs in Sec. 1301. QHPs are those plans that meet specific statutorily defined requirements, and which are therefore allowed to be offered through Exchanges (although they may also be offered outside of an Exchange). ACA Sec. 1301(a)(1)(B) requires all QHPs to provide a specific set of defined benefits, the EHB. The EHB are broadly defined by ACA Sec. 1302(b), which outlines a series of 10 general categories of types of care,

[10] The offering of qualified health plans is not limited to the Exchanges; such plans may also be offered outside of the Exchanges.

[11] PHSA Sec. 2707 requires all health insurance issuers that offer health insurance coverage in the individual or small group market to ensure that such coverage includes the essential health benefits package.

including "mental health and substance use disorder services, including behavioral health treatment."[12] Therefore, mental health and substance abuse services are a category of covered services within the EHB that are required to be offered by the QHPs; however, the scope of covered services under this subsection must be defined through the rulemaking process. The statute does not mandate coverage for any specific service or treatment; it instead requires coverage to be provided for services within all 10 broad categories (i.e., ambulatory patient services, emergency services, laboratory services, etc.). The statute requires the Secretary to ensure that the scope of the essential health benefits package (EHBP) be equal to the scope of benefits provided under a typical employer plan, and outlines a series of required elements for consideration in determining the EHBP.

ACA Sec. 2001(c) requires all Medicaid benchmark and benchmark-equivalent plans to offer at least the EHB by January 1, 2014. In addition, new PHSA Sec. 2707(a), as added by the ACA, requires new plans offered by a health insurance issuer through the individual and small group markets to include coverage of the EHB (also by January 1, 2014).

While these provisions do not equate with a comprehensive federal-level mandate to cover mental health services, they together have the effect of creating a federal-level requirement for coverage of mental health benefits by a sizable portion of insurers.

Some states mandate coverage of certain mental health conditions through their parity laws. Questions may be raised with respect to state mandated benefits, including those for mental health conditions, and plans offered through Exchanges. ACA Sec. 1311(d)(3), as amended by ACA Sec. 10104(e), authorizes a state to require that a QHP offered in that state cover certain benefits that are in addition to the EHB as defined by ACA Sec. 1302(b). However, if a state makes such a requirement, the state is then required to assume the cost of those additional benefits. The state may do so either by making payments directly to an individual enrolled in a QHP, or directly to the QHP on behalf of an enrolled individual.

Qualified Health Plans and Mental Health Parity

Requiring QHPs to cover mental health and substance abuse services in some capacity is a separate issue from that of requiring the provision of parity coverage.

To address this, ACA Sec. 1311(j) requires federal mental health parity requirements to apply to all QHPs in the same manner and to the same extent that such requirements apply to health insurance issuers and group health plans. QHPs offered by the Exchanges will be provided through both the small group and individual markets; large group plans may have less of an incentive to participate (and will only be allowed to beginning in 2017), primarily because one of the key advantages of participating in an Exchange is the risk pooling it will offer to enrollees in small group plans and individual plans. The exemption of small employers from the federal mental health parity requirements may impact some plans offered through the Exchange. A discussion of the potential interaction between this ACA Sec. 1311(j) and the small employer exemption in federal mental health parity law (at PHSA Sec. 2726(c)) is discussed in more detail below.

[12] ACA (P.L. 111-148), Sec.1302(b)(1)(E)).

Extension of Federal Mental Health Parity Requirements to Plans in the Individual Market and the Small Employer Exemption

Federal mental health parity law prior to the ACA contained a specific exemption for small employers (those with between two and 50 employees). It also applied to group health plans, or health insurance coverage offered in connection with such a plan, and not to health insurance coverage in the individual market. The small employer exemption extends to those states where the small employer definition includes self-employed individuals ("groups of one").

ACA Sec. 1563(c)(4) conforms PHSA Sec. 2726 to extend the federal mental health parity requirements to the individual market.[13] This section replaces existing references in PHSA Sec. 2726 to group health plans with the following language: "a health insurance issuer offering group or individual health insurance coverage." This effectively extends these requirements to plans in the individual market.

However, it appears that the ACA conforming amendment does not explicitly remove the small employer exemption, found at PHSA Sec. 2726(c)(1). The language of this subsection, as modified by the ACA conforming amendment, now reads as follows (emphasis added by CRS):

> SMALL EMPLOYER EXEMPTION- This section shall not apply to any group health plan (or a health insurance issuer offering group or individual health insurance coverage) *for any plan year of a small employe*r (as defined in section 2791(e)(4)),14 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.

Thus, based on this amended statutory language, it appears that the small employer exemption under federal mental health parity law may remain in effect. In addition, the definition of "small employer" at PHSA Sec. 2791(e)(4), as amended by ACA Sec. 1563, is expanded to mean an employer who employed an average of at least 1, but not more than 100, employees. The definition of small employer prior to ACA only included employers with an average of 2, but not more than 50, employees. Therefore, it appears that the small employer exemption not only remains in effect, but now will apply to a wider range of employers.[15] Importantly, however, until 2016, the states have the option of using the definition of small employer that existed in law prior to ACA for plans offered through an Exchange.[16]

If this is the case, because the small employer exemption (and the amended definition of small employer) includes self-employed individuals, questions may arise with respect to whether this language results in plans offered to individuals seeking coverage on the individual market having

[13] The ACA redesignates PHSA Sec. 2705 as PHSA Sec. 2726. These sections contain the federal mental health parity requirements.

[14] See note 9.

[15] PHSA Sec. 2726(c)(1) may need to be modified to reflect the inclusion of groups of one in the amended definition of small employer (at PHSA Sec. 2791).

[16] Recent guidance published by the Department of Labor states that the small employer exemption remains in effect post-ACA. However, this guidance states that the modified definition of "small employer" per ACA Sec. 1563 only applies to those plans governed by the PHSA (i.e., nonfederal governmental plans), while the original definition (of 50 or fewer employees) applies to those plans governed by ERISA and the IRC. See "FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation." Accessed on January 3, 2010, at http://www.dol.gov/ebsa/faqs/faq-aca5.html.

to comply with the federal mental health parity requirements, in contrast with plans offered to single individuals seeking group coverage in their capacity as an employer, which may not have to comply with the federal parity requirements.

In addition, assuming the continued existence of the small employer exemption, one question that arises is whether, in light of ACA Sec. 1311(j), small employer QHPs (offered inside or outside of an Exchange) might be exempt from the federal mental health parity requirements. As discussed above, Sec. 1311(j) applies the requirements found in newly designated PHSA Sec. 2726 to "qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans." The ACA does not specify whether applying the mental health parity provisions to QHPs "in the same manner and to the same extent" would include application of the small employer exemption.

Expansion of Federal Mental Health Parity Requirements to Certain Medicaid Plans and the Medicaid Expansion Population

Medicaid may be offered either in the form of traditional state plan benefits or by enrolling state-specified groups in benchmark or benchmark-equivalent coverage.[17] Either of these options may be provided through managed care plans ("Medicaid managed care plans").

Prior to the ACA, federal law required all Medicaid managed care plans providing both medical and surgical benefits and mental health or substance use disorder benefits to comply with the federal mental health parity requirements found in the PHSA.[18] This requirement applies to any managed care plan offered through either traditional Medicaid, as well as through the alternative state options of Medicaid benchmark or benchmark-equivalent plans.

The ACA expands certain of the federal mental health parity requirements to Medicaid benchmark and benchmark-equivalent plans, which are not Medicaid managed care plans, and which provide both medical and surgical benefits as well as mental health or substance use disorder benefits.[19] Importantly, it appears that ACA Sec. 2001 only requires these Medicaid plans to comply with the parity requirements specifically for treatment limitations and financial requirements. Treatment limitations are defined in PHSA Sec. 2726 as "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." Financial requirements are defined in PHSA Sec. 2726 as "deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit." Plans that offer Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT), as defined in Medicaid statute, are deemed to meet the parity requirement.[20] This is in contrast with the requirement placed on Medicaid managed care plans (described above), which does not deem plans offering EPSDT services as being in compliance with parity requirements.

[17] For more information on Medicaid benchmark and benchmark-equivalent plans and the ACA, please see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

[18] SSA Sec. 1932(b)(8)

[19] ACA Sec. 2001(c)(3)

[20] ACA Sec. 2001 adds this language to existing SSA Sec. 1937 (Medicaid Statute), and it appears that it will need to be conformed to reflect the ACA's redesignation of PHSA Sec. 2705 to PHSA Sec. 2726.

It therefore appears that Medicaid benchmark or benchmark-equivalent plans, that are not Medicaid managed care plans, are not required to comply with the federal requirements for parity in annual and lifetime limits and for in- and out-of-network covered benefits, per ACA Sec. 2001(c). This is in contrast with Medicaid managed care plans, which are required to comply with the totality of federal mental health parity requirements.

In addition, it is unclear whether the parity requirements in Sec. 2001(c) extend to plans that are not managed care plans, but that are offered under traditional Medicaid as opposed to through the benchmark or benchmark-equivalent option. It is also unclear what effect requiring any type of Medicaid plan to adhere to federal mental health parity requirements, but then deeming those plans which offer EPSDT services as meeting these requirements, which they are required by law to do, will have on the actual terms of coverage for mental health and substance abuse services for Medicaid enrollees.

ACA Sec. 2001(a)(2)(A), in conjunction with ACA Sec. 2001(c), has the effect of expanding the requirement for compliance with certain of the federal mental health parity requirements to all "newly eligible" Medicaid populations (up to or at 133% of federal poverty level), as added by the ACA, who would be enrolled through benchmark or benchmark-equivalent non-managed care plans.

Table 2. Applicability of Federal Mental Health Parity Requirements to Medicaid Coverage Arrangements

	Traditional Medicaid Coverage	Benchmark or Benchmark Equivalent Medicaid Coverage
Fee-for-Service	No Compliance Required	Partial Compliance Required *(financial requirements and treatment limitations)*
Managed Care	Full Compliance Required	Full Compliance Required

Notes: CRS analysis.

CHIP, Federal Mental Health Parity Requirements, and the ACA

The CHIP statute contains two provisions, enacted prior to the ACA, extending and applying the federal mental health parity requirements to CHIP plans. Although the ACA does not affect federal mental health parity requirements as they apply to CHIP plans, it appears that these two existing statutory provisions in SSA Title XXI may need to be conformed to reflect redesignations made by the ACA.

The first relevant provision is found at SSA Sec. 2103(c)(6), stating that in cases where a State child health plan provides both mental health or substance abuse disorder benefits and medical and surgical benefits, the plan must comply with PHSA Sec. 2705 with respect to both financial requirements and treatment limitations. This is the same language that was added by ACA Sec. 2001 to extend federal mental health parity requirements to Medicaid non-managed care benchmark and benchmark-equivalent plans, and therefore has similar limitations (see analysis above). As is the case with ACA Sec. 2001 with respect to Medicaid non-managed care benchmark and benchmark-equivalent plans, SSA Sec. 2103(c)(6)(B) deems CHIP plans that

offer EPSDT, as defined in Medicaid statute, as satisfying the parity requirement described in SSA Sec. 2103(c)(6)(A).[21] Since this provision appears to require adherence with only a subset of the federal mental health parity requirements, it is unclear whether offering EPSDT services would fulfill the subsequent requirement for compliance with the full set of parity requirements, found at SSA Sec. 2103(f)(2) and described in more detail below.

In addition, SSA Sec. 2103(f)(2) requires all coverage offered under SSA Sec. 2103 to comply with the requirements of subpart 2 of part A of Title XXVII of the PHSA (Sec. 2705 was contained here, prior to the passage of the ACA). This has the effect of requiring CHIP plans to comply with all, and not only with the financial requirements and treatment limitations as in SSA Sec. 2103(c)(6), of the federal mental health parity requirements.[22]

Conclusion

In sum, the changes made by the ACA represent an expansion of the application of the federal mental health parity requirements established by MHPA and MHPAEA. They extend these requirements to plans in the individual market; to QHPs; and to additional Medicaid plan types and to certain of the Medicaid expansion populations. In addition, provisions in the ACA act together to create a mandate for coverage of certain mental health services (to be determined through rulemaking) that applies to specific plan types. While this is not a comprehensive federal-level coverage mandate, it represents a significant change from federal law prior to the ACA.

Changes made by the ACA to existing federal mental health parity law, while extending the requirements to the individual market, appear to maintain the small employer exemption. Federal mental health parity requirements are extended to all qualified health plans, as established by the ACA; however, questions may be raised about how small employer plans in the Exchange may be affected. In addition, it appears that certain of the federal mental health parity requirements are extended to Medicaid non-managed care benchmark and benchmark-equivalent plans, but it appears that certain are not. It is unclear whether federal mental health parity requirements extend to non-managed care plans offered under traditional Medicaid. Finally, the CHIP statute contains two separate parity related provisions, one which appears to have a more limited reach, and a second which appears to apply the requirements in their entirety to CHIP plans.

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[21] It appears that this provision may need to be conformed with the ACA's redesignation of PHSA Sec. 2726.

[22] The fact that there are two provisions in this statute, both addressing the issue of requiring CHIP plans to comply with the parity requirements, raises questions about which would be controlling. That statutory analysis is beyond the scope of this report.

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