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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

RIN 1545-BI70

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB30

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-4140-NC]

45 CFR Parts 144 and 146

RIN 0938-AP65

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

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Request for Information.

SUMMARY: This document is a request for comments regarding issues under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

(MHPAEA). The Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments) invite public comments in advance of future rulemaking.

DATES: Comments must be submitted on or before [insert date 30 days after publication in the **Federal Register**].

ADDRESSES: Written comments may be submitted to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments. Please do not submit duplicates.

Department of Labor. Comments to the Department of Labor by one of the following methods:

- Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.
- Email: E-OHPSCA.EBSA@dol.gov.
- Mail or Hand Delivery: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N-5653, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, Attention: MHPAEA Comments.

Comments received by the Department of Labor will be posted without change to www.regulations.gov and www.dol.gov/ebsa, and available for public inspection at the Public Disclosure Room, N-1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, DC 20210, including any personal information provided.

Department of HHS. Comments to the Department of HHS, identified by CMS-4140-NC by one of the following methods:

- Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.
- Mail: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-4137-NC, P.O. Box 8017, Baltimore, MD 21244-8010.
- Hand or courier delivery. Comments may be delivered to either 7500 Security Boulevard, Baltimore, MD 21244-1850 or Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. For delivery to Baltimore, please call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members. For delivery to Washington, because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain proof of filing by stamping in and retaining an extra copy of the comments being filed.

Inspection of Public Comments. All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all electronic comments received before the close of the comment period on the following public Web site as soon as possible after they have been received:

<http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call 1-800-743-3951.

Internal Revenue Service. Comments to the IRS, identified by REG-120692-09 by one of the following methods:

- Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.
- Mail: CC:PA:LPD:PR (REG-120692-09), Room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.
- Hand or courier delivery: Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG-120692-09), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW, Washington, DC from 9 a.m. to 4 p.m.

FOR FURTHER INFORMATION CONTACT: Mark Connor or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335; Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-6080; Adam Shaw, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (877) 267-2323 extension 61091.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws, including the nondiscrimination protections, may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor’s website (<http://www.dol.gov/ebsa>). In addition, individuals may request a copy of CMS’s publication entitled “Protecting Your Health Insurance Coverage” by calling 1-800-633-4227.

SUPPLEMENTARY INFORMATION:

I. Background

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on October 3, 2008 as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Public Law 110-343).¹ MHPAEA amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code). In 1996, Congress enacted the Mental Health Parity Act of 1996 (MHPA 1996), which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical and surgical benefits. These group market mental health parity provisions were codified in section 712 of ERISA, section 2705 of the PHS Act, and section 9812 of the Code. The enactment of MHPAEA created new requirements and amended several of the existing group market mental health parity provisions.

MHPAEA modifies the original definition of mental health benefits created by MHPA 1996 and adds a definition of substance use disorder benefits. Mental health

¹ A technical correction to the effective date for collectively bargained plans was made by Public Law 110-460.

benefits are defined as benefits with respect to services for mental health conditions, defined under the terms of the plan and in accordance with applicable Federal and State law. Substance use disorder benefits are defined as 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.

While retaining MHPA 1996's requirements for parity in the application of aggregate lifetime and annual dollar limits, MHPAEA adds new requirements. For group health plans (and health insurance coverage offered in connection with group health plans) that provide both medical and surgical benefits and mental health or substance use disorder benefits, MHPAEA requires plans or coverage to ensure that: (1) the financial requirements (including deductibles, copayments, coinsurance, and out-of-pocket expenses, but excluding aggregate lifetime limits and annual limits (which are subject to MHPA 1996's existing 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; (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 (including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment) 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 (4) there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. A financial limit or treatment limit is

considered to be predominant under MHPAEA if it is the most common or frequent of such type of limit or requirement.

MHPAEA requires the criteria for medical necessity determinations made under the plan (or coverage) with respect to mental health or substance use disorder benefits be made available by the plan administrator (or health insurance issuer) 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 must, on request or as otherwise required, be made available by the plan administrator (or issuer) to the participant or beneficiary in accordance with regulations.

Under MHPAEA, in the case of a plan or issuer that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or issuer provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or issuer must 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 MHPAEA and MHPA 1996.

MHPAEA amended the two exemptions in subsection (c) of the group market mental health parity provisions. MHPAEA exempts group health plans (or health insurance coverage offered in connection with such a plan) of a small employer from the requirements of the group market mental health parity provisions for any plan year. A small employer is defined as an employer who employed an average of at least two (or one 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.

MHPAEA also exempts group health plans (or health insurance coverage offered in connection with such a plan) from the requirements of the group market mental health parity provisions if application of the group market mental health parity provisions 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 by an amount that exceeds two percent for the first plan year in which the law applies and one percent for each subsequent plan year. In this case, the requirements of the group market mental health parity provisions do not apply to the plan or coverage during the following plan year, and such exemption applies for one plan year. Of course, an employer may elect to continue to apply mental health and substance use disorder parity with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

Under this cost exemption, determinations as to increases in actual costs under a plan must be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. Exemption determinations must be in a written report prepared by the actuary, which must be maintained by the plan or issuer for six years following the notification of election to implement the exemption. Determinations are to be made after the plan has complied with the requirements of the group market mental health parity provisions for the first six months of the plan year involved.

A plan or issuer that qualifies for and elects to implement the cost exemption must promptly notify the Secretaries of Labor, Health and Human Services, and the Treasury (as appropriate), the appropriate state agencies, and participants and beneficiaries in the plan. The notifications to the Secretaries, which are confidential, must include a description of (1) 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 by the plan or coverage); (2) 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 (for both the plan year upon which a cost exemption is sought and the year prior); and (3) the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan (for both the plan year upon which a cost exemption is sought and the year prior). The Secretaries must make available upon request, but no more frequently than annually, an anonymous itemization of these notifications, including a breakdown of States by the size and type of employers submitting the notification and a summary of the data received. The Secretaries and the appropriate state agencies are authorized by MHPAEA to audit the books and records of a group health plan, or health insurance issuer offering coverage in connection with a plan, relating to an exemption.

As enacted, MHPA 1996 included a sunset provision. This provision was amended several times to extend the sunset date, most recently to December 31, 2008. MHPAEA eliminates the sunset provision, effective January 1, 2009. Thus, the requirements of MHPA 1996 will remain in place, except as modified by MHPAEA.

Generally, the provisions of MHPAEA apply for plan years beginning after October 3, 2009 (for calendar year plans, January 1, 2010).

There is a special effective date rule for group health plans maintained pursuant to one or more collective bargaining agreements (collectively bargained plans) ratified before October 3, 2008 (the date of the enactment of MHPAEA). Under the special rule, MHPAEA's requirements will not apply to plan years beginning before the later of either the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008), or January 1, 2010.² Any plan amendment made pursuant to a collective bargaining agreement solely to conform to requirements added by MHPAEA is not treated as a termination of the agreement.

II. Solicitation of Comments

A. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

Executive Order 12866 requires an assessment of the anticipated costs and benefits of a significant rulemaking action and the alternatives considered, using the guidance provided by the Office of Management and Budget. These costs and benefits are not limited to the Federal government, but pertain to the affected public as a whole. Under Executive Order 12866, a determination must be made whether implementation of MHPAEA will be economically significant. A rule that has an annual effect on the economy of \$100 million or more is considered economically significant.

² This date was changed from January 1, 2009 to January 1, 2010 by Public Law 110-460, enacted on December 23, 2008.

In addition, the Regulatory Flexibility Act may require the preparation of an analysis of the economic impact on small entities of proposed rules and regulatory alternatives. An analysis under the Regulatory Flexibility Act must generally include, among other things, an estimate of the number of small entities subject to the regulations (for this purpose, plans, employers, and issuers and, in some contexts small governmental entities), the expense of the reporting, recordkeeping, and other compliance requirements (including the expense of using professional expertise), and a description of any significant regulatory alternatives considered that would accomplish the stated objectives of the statute and minimize the impact on small entities. The Departments consider a small entity to be an employee benefit plan with fewer than 100 participants.

The Paperwork Reduction Act requires an estimate of how many “respondents” will be required to comply with any “collection of information” requirements contained in regulations and how much time and cost will be incurred as a result. A collection of information includes recordkeeping, reporting to governmental agencies, and third-party disclosures. The Departments have current approval for information collection requirements related to the increased cost exemption under MHPA 1996.

The Departments are requesting comments that may contribute to the analyses that will be performed under these requirements, both generally and with respect to the following specific areas:

(i) What policies, procedures, or practices of group health plans and health insurance issuers may be impacted by MHPAEA? What direct or indirect costs would result? What direct or indirect benefits would result? Which stakeholders will be impacted by such benefits and costs?

(ii) Are there unique costs and benefits for small entities subject to MHPAEA (that is, employers with greater than 50 employees that maintain plans with fewer than 100 participants)? What special consideration, if any, is needed for these employers or plans? What costs and benefits have issuers and small employers experienced in implementing parity under State insurance laws or otherwise?

(iii) Are there additional paperwork burdens related to MHPAEA compared to those related to MHPA 1996, and, if so, what estimated hours and costs are associated with those additional burdens?

B. Comments Regarding Regulatory Guidance

The Departments are seeking comments to aid in the development of regulations regarding MHPAEA. To assist interested parties in responding, this request for information describes specific areas in which the Departments are particularly interested; however, the Departments also request comments and suggestions concerning any area or issue pertinent to the development of regulations.

Specific Areas in Which the Departments Are Interested Include the Following:

1. The statute provides that the term “financial requirement” includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit. The statute further provides that 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. Do plans currently impose other types of financial requirements or treatment limitations on benefits? How do plans currently apply financial requirements or treatment limitations to (1) medical and surgical benefits and (2) mental health and substance use disorder

benefits? Are these requirements or limitations applied differently to both classes of benefits? Do plans currently vary coverage levels within each class of benefits?

2. What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?

3. What information, if any, regarding the criteria for medical necessity determinations made under the plan (or coverage) with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

4. What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

5. To gather more information on the scope of out-of-network coverage, the Departments are interested in finding out whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. If so, how is such coverage the same as or different than out-of-network coverage provided for medical and surgical benefits?

6. Which aspects of the increased cost exemption, if any, require additional guidance? Would model notices be helpful to facilitate disclosure to Federal agencies,

State agencies, and participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption?

Signed at Washington, DC this 24th day of December 2008.

Nancy J. Marks

*Division Counsel/ Associate Chief Counsel,
Tax Exempt and Government Entities,
Internal Revenue Service,
Department of the Treasury.*

Signed at Washington, DC this 12th day of January, 2009.

W. Thomas Reeder

*Benefits Tax Counsel,
Department of the Treasury.*

Signed at Washington, DC this ___21 st_____ day of ___April_____, 2009.

Alan D. Lebowitz

*Deputy Assistant Secretary for Program Operations,
Employee Benefits Security Administration,
U.S. Department of Labor.*

Dated: __March 9, 2009__

Charlene Frizzera
Acting Administrator,
Centers for Medicare & Medicaid Services.

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