DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

29 CFR Chapter XXV

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

45 CFR Subtitle A, Subchapter B

Mental Health Parity and Newborns' and Mothers' Health Protection

AGENCIES: Pension and Welfare Benefits Administration, Department of Labor; and Health Care Financing Administration, Department of Health and Human Services.

ACTION: Solicitation of comments.

SUMMARY: This document is a request for comments regarding issues under the Mental Health Parity Act of 1996 (MHPA) and the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). The Department of Labor and the Department of Health and Human Services (collectively, the Departments) have received comments from the public on a number of issues arising under both MHPA and NMHPA. Further comments from the public are welcome.

DATES: The Departments have requested that comments be submitted on or before July 28, 1997.

ADDRESSES: Written comments should be submitted with a signed original and 2 copies to the Pension Welfare Benefits Administration (PWBA) at the address specified below. PWBA will provide copies to the Department of Health and Human Services for its consideration. All comments will be available for public inspection and copying in their entirety. Comments should be sent to: Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, Room N–5669, U.S. Department of Labor, 200 Constitution Ave., NW., Washington, DC 20210, Attn: MHPA/NMHPA Solicitation of Comments.

All comments received will be available for public inspection at the Public Disclosure Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N–5507, 200 Constitution Ave., NW., Washington, DC 20210. Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department of Health and Human Services offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone (202) 690–7890).

FOR FURTHER INFORMATION CONTACT: Amy Scheingold, Department of Labor, Pension and Welfare Benefits Administration, at 202–219–4377 (not a toll-free number); or Therese Klitenic, Health Care Financing Administration, at 410–786–5942 for inquiries regarding MHPA, or Suzanne Long, Health Care Financing Administration, at 410–786–0970 for inquiries regarding NMHPA (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background

Mental Health Parity Act of 1996

The Mental Health Parity Act of 1996 (MHPA or the Act) was enacted on September 26, 1996 (Pub. L. 104–204). MHPA amended the Public Health Service Act (PHSA) and the Employee Retirement Income Security Act of 1974, as amended, (ERISA) to provide for parity in the application of limits on certain mental health benefits with limits on medical and surgical benefits. Health coverage is regulated in part by the federal government, under the PHSA and ERISA, and other federal provisions including the Internal Revenue Code (Code), and in part by the States.

MHPA provisions are set forth in Title XXVII of the PHSA and Part 7 of Subtitle B of Title I of ERISA. These provisions are not currently contained in the Code. However, the Conference Report states Congress's intention to make conforming changes to the Code as soon as possible in order to implement these provisions under the Code. MHPA provisions are intended to provide parity of mental health benefits with medical and surgical benefits under a group health plan in the application of aggregate dollar lifetime limits and annual dollar limits. A plan providing both medical and surgical benefits and mental health benefits may not impose an aggregate lifetime expenditure limit or annual expenditure limit (as dollars) on mental health benefits if it does not impose such a limit on substantially all of the medical and surgical benefits.

If a group health plan does impose an aggregate lifetime limit or annual limit on medical and surgical benefits, the plan cannot impose any such limit on mental health benefits that is less than that on the medical and surgical benefits. In the case of a plan that has different aggregate lifetime limits, or annual limits, on different categories of medical and surgical benefits, the Departments shall establish rules to calculate an average aggregate lifetime limit, or annual limit, for mental health benefits that is computed taking into account the weighted average of the limits applicable to the different categories.

MHPA does not require a plan or coverage to provide any mental health benefits. Further, MHPA provides that nothing in the Act shall be construed as affecting the terms or 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 such plans or coverage, except as specifically provided regarding parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits. MHPA requirements do not apply to benefits for substance abuse or chemical dependency.

MHPA also provides two exemptions from its parity requirements. The first exemption is for small employers (defined as an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year). 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 one percent.

MHPA provisions are effective for plan years beginning on or after January 1, 1998. The Act includes a sunset provision under which MHPA requirements do not apply to benefits for services furnished on or after September 30, 2001. Accordingly, the Departments are working actively to develop and promulgate the necessary regulations prior to the effective date of the MHPA provisions.

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) was enacted on September 26, 1996 (Pub. L. 104–204). NMHPA amended the PHSA and ERISA to provide protection for mothers and their newborn children with regard to the length of hospital stays following the birth of a child. NMHPA applies to health coverage offered in the large and small group markets, and the individual market.

NMHPA provisions are set forth in Title XXVII of the PHSA and Part 7 of Subtitle B of Title I of ERISA. NMHPA provisions are not currently contained in the Code. These provisions include new rules relating to the minimum time period a mother and a newborn child can spend in the hospital in connection

with the birth of a child. Under NMHPA, group health plans, insurance companies, and health maintenance organizations (HMOs) offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for a minimum period of time. For example, NMHPA provides that coverage for a hospital stay following a normal vaginal delivery generally may not be limited to less than 48 hours for each the mother and the newborn child. Health coverage for a hospital stay in connection with childbirth following a caesarean section generally may not be limited to less than 96 hours for the mother and the newborn child.

NMHPA's requirements only apply to group health plans, insurance companies, and HMOs that choose to provide insurance coverage for a hospital stay in connection with childbirth. NMHPA does not require such entities to provide coverage for hospital stays in connection with the birth of a child. In addition, NMHPA does not prevent a group health plan, insurance company, or HMO from imposing deductibles, coinsurance, or other cost-sharing measures for health benefits relating to hospital stays in connection with childbirth as long as such cost-sharing measures are not greater than those imposed on any preceding portion of a hospital stay.

NMHPA prohibits certain compensation arrangements. Specifically, NMHPA prohibits a group health plan, insurance company, or HMO from providing monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections under the law; prohibits penalizing or otherwise reducing or limiting the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with the law; and prohibits providing incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with the law.

The requirements under NMHPA apply to plans and issuers in the group market for plan years beginning on or after January 1, 1998. For issuers in the individual market, the requirements apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 1998. Accordingly, the Departments are working actively to develop and promulgate the necessary regulations prior to the effective date of the NMHPA provisions.

Economic Analysis/Paperwork Reduction Act Information/Regulatory Flexibility Act Information

Analysis under Executive Order 12866 requires that the Departments quantify the costs and benefits of the proposed regulations and the alternatives considered using the guidance provided by the Office of Management and Budget (OMB). These costs and benefits are not limited to the Federal government, but pertain to the nation as a whole.

The Departments' analysis under the Regulatory Flexibility Act will need to 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 and other compliance requirements (including the expense of using professional expertise), and a description of regulatory alternatives that minimize impact on small entities yet achieve the regulatory purpose.

Paperwork Reduction Act analysis requires that the Departments estimate how many ''respondents'' will be required to comply with the ''collection of information'' aspects of the regulations and how much time and cost will be incurred as a result. A collection of information includes record-keeping, reporting to governmental agencies, and third-party disclosures, such as the certification process.

The Departments are requesting comments that may contribute to the impact analysis that will be performed pursuant to the above mentioned requirements.

Comments

Comments have been received from the public on a number of issues arising under MHPA and NMHPA. The purpose of this announcement is to advise the public that further comments are welcome. In order to assist interested parties in responding, this solicitation of comments describes specific areas in which the Departments are particularly interested. The Departments, however, also request comments and suggestions concerning any area or issue pertinent to the assessment and development of regulatory guidance regarding MHPA and NMHPA. Comments should reference the appropriate question number to aid the Departments in analyzing submissions.

Specific Areas With Respect to MHPA in Which the Departments Are Interested Include the Following

Group health plans are exempt from the provisions of MHPA if the application of its provisions results in an increase in the cost under the plan or coverage of at least one percent.

With respect to this exemption:

1(a) Should the exemption be contingent on formal application and agency approval or some other less formal process such as record keeping and third party disclosure?

1(b) Whether the exemption process is formal or informal, what documentation should be required to support an exemption from MHPA and how should such documentation be subject to independent verification?

1(c) If the exemption process is not contingent on formal application and agency approval, what additional consumer protections should be developed as part of implementing the statute?

2(a) Should the exemption be available based on costs which are prospective, retrospective, or both?

2(b) If prospective, how should the costs be estimated?

2(c) If retrospective, how should costs be measured?

2(d) Should the added costs be calculated from the baseline of no mental health care coverage or current practice, where some coverage is offered but falls short of parity?

3 Should the exemption determinations be made on an annual basis?

In the case of a plan that has different aggregate lifetime limits, or annual limits, on different categories of medical and surgical benefits, MHPA requires the Departments to establish rules to calculate an average aggregate lifetime limit or annual limit for mental health benefits that is computed taking into account the weighted average of such limit applicable to the different categories. With regard to these provisions:

4 How should the weighted average of the limits applicable to the different categories of medical and surgical benefits be computed?

Specific Areas With Respect to NMHPA in Which the Departments Are Interested Include the Following

5 What compensation arrangements should be identified as inappropriate under NMHPA? Please provide specific examples of such arrangements.

6 What issues or concerns should be taken into consideration for establishing how to measure 48 and 96 hours (e.g., when should the 48 or 96 hours begin)?

7 What issues or concerns should be taken into consideration in defining ''attending provider''?

8 What type of benefits should be considered ''in connection with a childbirth''?

Specific Areas with Respect to the Departments' Responsibilities and Analysis Under Executive Order 12866, Paperwork Reduction Act, and Regulatory Flexibility Act in Which the Departments Are Interested Include:

9 What amendments are plans likely to make in response to MHPA and NMHPA, including any amendments designed to offset compliance costs?

10(a) What will be the costs and benefits of compliance with the NMHPA and the MHPA?

10(b) How should these costs and benefits be defined?

10(c) How will these costs and benefits vary with size and other characteristics of plans?

10(d) Would differences in these costs and benefits by plan size or other characteristics suggest additional regulatory flexibility?

11 To what extent are there already voluntary policies in the industry, and/or State or local mandates in place that meet or exceed the NMHPA and MHPA mandates?

12(a) What is the prevalence of mental health benefits among large and small plans?

12(b) Are these benefits typically provided separately from other health benefits?

12(c) Are mental health benefits self-insured and/or administered through third party administrators to a greater or lesser extent than other benefits?

13 What proportion of sponsors of mental health benefits will be eligible for the one percent cost exemption? What types of plans are most likely to be eligible?

14 How would costs and benefits of MHPA and NMHPA vary with alternative policies (including alternative interpretations of the MHPA one percent cost exemption)? What are the implications for access to mental health, maternity, or other categories of health insurance?

15 As a measure of benefits, how many people may enjoy greater access to medically appropriate treatment by providing more equitable annual or lifetime limits for mental health coverage?

All submitted comments will be made part of the record of the preceding referred to herein and will be available for public inspection.

Signed at Washington, DC, this 23rd day of June 1997.

Olena Berg,

Assistant Secretary, Pension and Welfare Benefits Administration, Department of Labor.

Bruce Vladeck,

Administrator, Health Care Financing Administration, Department of Health and Human Services.

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