

# FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XVIII) AND MENTAL HEALTH PARITY IMPLEMENTATION

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January 9, 2014

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the market reform provisions of the Affordable Care Act, as well as FAQs regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform> and <http://www.cciio.cms.gov/resources/factsheets/index.html>), these FAQs answer questions from stakeholders to help people understand the law and benefit from it, as intended.

## Coverage of Preventive Services

Public Health Service (PHS) Act section 2713 and the interim final regulations relating to coverage of preventive services<sup>1</sup> require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide benefits for, and prohibit the imposition of cost-sharing requirements with respect to, the following:

- Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued on or around November 2009, which are not considered current;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in the current recommendations of the USPSTF.<sup>2</sup>

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<sup>1</sup> 75 FR 41726 (July 19, 2010).

<sup>2</sup> "Women's Preventive Services: Required Health Plan Coverage Guidelines" (HRSA Guidelines) were adopted and released on August 1, 2011, based on recommendations developed by the Institute of Medicine (IOM) at the request of HHS. These recommended women's preventive services are required to be covered without cost-sharing, for plan years (or, in the individual market, policy years) beginning on or after August 1, 2012.

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques to determine any coverage limitations.<sup>3</sup>

These requirements do not apply to grandfathered health plans.<sup>4</sup>

**Q1: On September 24, 2013, the USPSTF issued new recommendations with respect to breast cancer.<sup>5</sup> What changes must plans make to comply with the new recommendations?**

The USPSTF recently revised its “B” recommendation regarding medications for risk reduction of primary breast cancer in women. The September 2013 recommendation now says:

The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.

Accordingly, for plan or policy years beginning one year after the date the recommendation or guideline is issued (in this case, plan or policy years beginning on or after September 24, 2014), non-grandfathered group health plans and non-grandfathered health insurance coverage offered in the individual or group market will be required to cover such medications for applicable women without cost sharing subject to reasonable medical management.

**Limitations on Cost-Sharing under the Affordable Care Act**

PHS Act section 2707(b), as added by the Affordable Care Act, provides that a non-grandfathered group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under sections 1302(c)(1) and (c)(2) of the Affordable Care Act. Section 1302(c)(1) limits out-of-pocket costs and, for small group market plans, section 1302(c)(2) limits deductibles.<sup>6</sup>

For plan or policy years beginning in 2014, the annual limitation on out-of-pocket costs in effect under Affordable Care Act section 1302(c)(1) is \$6,350 for self-only coverage and \$12,700 for

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<sup>3</sup> See 26 CFR 54.9815-2713T(a)(4), 29 CFR 2590.715-2713(a)(4), and 45 CFR 147.130(a)(4).

<sup>4</sup> In addition, the HRSA Guidelines exempt group health plans established or maintained by certain religious employers (and any group health insurance provided in connection with such plans) from any requirement to cover contraceptive services that would otherwise apply. Additionally, accommodations are available for group health plans (and any group health insurance provided in connection with such plans) established or maintained by certain non-grandfathered, non-profit eligible organizations with religious objections to contraceptive services with respect to the requirement to cover contraceptive services. See 78 FR 39870 (July 2, 2013) and <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/preventive-services-guidance-6-28-2013.pdf>.

<sup>5</sup> This Recommendation Statement was first published in *Annals of Internal Medicine* on September 24, 2013. See <http://www.uspreventiveservicestaskforce.org/uspstf13/breastcanmeds/breastcanmedsrs.htm>.

<sup>6</sup> The annual limitation on out-of-pocket costs is also applied to non-grandfathered individual market coverage through the essential health benefits package requirements of PHS Act section 2707(a).

coverage other than self-only coverage. For plan or policy years beginning after 2014, the annual limitation on out-of-pocket costs is increased by the premium adjustment percentage described under Affordable Care Act section 1302(c)(4).

A previous FAQ provided guidance on out-of-pocket maximums for the first year of applicability where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket costs.<sup>7</sup> This guidance generally provided that, for group health plans and group health insurance issuers that utilize more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket costs, only for the first plan year beginning on or after January 1, 2014 (first year of applicability), the Departments will consider the annual limitation on out-of-pocket costs to be satisfied if:

- The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and
- To the extent that the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), that out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302(c)(1) of the Affordable Care Act.

**Q2: After this first year of applicability, are plans and issuers subject to PHS Act section 2707 required to apply the out-of-pocket maximum across all essential health benefits?**

Yes. For plan years beginning on or after January 1, 2015, non-grandfathered group health plans and group health insurance coverage must have an out-of-pocket maximum which limits overall out-of-pocket costs on all essential health benefits (EHB). Because cost-sharing limits in section 1302(c) of the Affordable Care Act apply only to EHB, plans are not required to apply the annual limitation on out-of-pocket maximums to benefits that are not EHB. To determine which benefits are EHB for purposes of complying with PHS Act section 2707, the Departments will consider self-insured group health plans or large group health plans to have used a permissible definition of EHB under section 1302(b) of the Affordable Care Act if the definition is one that is authorized by the Secretary of HHS.<sup>8</sup> Furthermore, the Departments intend to use their enforcement discretion and work with large group market and self-insured plans that make a good faith effort to apply an authorized definition of EHB. This approach is consistent with the

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<sup>7</sup> See Affordable Care Act Implementation FAQs Part XII, Q2, available at <http://www.dol.gov/ebsa/faqs/faq-aca12.html> and [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs12.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html). Transition relief is applicable only for the first plan year beginning on or after January 1, 2014.

<sup>8</sup> The list of the authorized plans for purposes of determining EHB for the large group market and self-funded plans is found at 45 CFR 156.100. See also Frequently Asked Questions on Essential Health Benefits Bulletin, Question 10 (February 17, 2012), available at: [www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf). (For the list of base-benchmark plans adopted by the States for use by non-grandfathered health insurance coverage in the individual and small group markets, see Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 FR 12834 (February 25, 2013), Appendix A: List of Essential Health Benefit Benchmarks. For policy documents containing additional details about the base-benchmark plans, see the National Association of Insurance Commissioners website, available at: [http://www.naic.org/index\\_health\\_reform\\_section.htm](http://www.naic.org/index_health_reform_section.htm).)

approach the Departments have taken with respect to annual and lifetime limits under PHS Act section 2711.<sup>9</sup>

**Q3: Some plans, such as those with multiple service providers, may find it easier to divide the annual limit on out-of-pocket costs across multiple categories of benefits, rather than reconcile claims across multiple service providers. Is this permitted, if the combined out-of-pocket maximum for the year does not exceed the annual limitation under section 1302(c) of the Affordable Care Act?**

Yes. Plans and issuers are permitted to structure a benefit design using separate out-of-pocket limits, provided that the combined amount of any separate out-of-pocket limits applicable to all EHBs under the plan does not exceed the annual limitation on out-of-pocket maximums for that year under section 1302(c) of the Affordable Care Act.<sup>10</sup>

**Q4: If a plan includes a network of providers, is the plan required to count an individual's out-of-pocket expenses for out-of-network items and services toward the plan's annual maximum out-of-pocket limit?**

No. A plan may, but is not required to, count out-of-pocket spending for out-of-network items and services towards the plan's annual maximum out-of-pocket limit. PHS Act section 2707 sets limits on cost sharing with reference to the limitations set forth in section 1302(c) of the Affordable Care Act. Under HHS regulations at 45 CFR 156.130(c) implementing Affordable Care Act section 1302(c), cost-sharing requirements for benefits that are EHB from a provider outside a plan's network of providers are not required to be counted toward the annual limitation on out-of-pocket costs.

With respect to health insurance issuers offering qualified health plans (QHPs) through a Health Insurance Marketplace (Marketplace) only, as noted in the Interim Final Rule on Maximizing January 1, 2014 Coverage Opportunities, 78 Fed. Reg. 76212 (Dec. 17, 2013), HHS strongly encourages QHP issuers to allow enrollees to receive in-network benefits with respect to any provider listed in the version of the provider directory as of the date of that enrollee's enrollment for the beginning months of coverage, in cases where issuers are unable to maintain provider directories in a current status. HHS also urges QHP issuers to temporarily cover non-formulary drugs, as well as drugs that are on a QHP issuer's formulary but typically require prior authorization or step therapy prior to being covered, during the first 30 days of coverage, starting on January 1, 2014. Accordingly, under these limited circumstances, HHS strongly encourages

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<sup>9</sup> Frequently Asked Questions on Essential Health Benefits Bulletin (February 17, 2012), available at: <http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>.

<sup>10</sup> The Departments note, however, that regulations implementing MHPAEA prohibit a group health plan or health insurance coverage in the group or individual market from applying a cumulative financial requirement or treatment limitation, such as an out-of-pocket maximum, to mental health or substance use disorder benefits in a classification that accumulates separately from any such cumulative financial requirement or treatment limitation established for medical/surgical benefits in the same classification. Accordingly, under MHPAEA, plans and issuers are prohibited from imposing an annual out-of-pocket maximum on all medical/surgical benefits in a classification and a separate annual out-of-pocket maximum on all mental health and substance use disorder benefits in the same classification. See 26 CFR 54.9812-1(c)(3)(v), 29 CFR 2590.712(c)(3)(v), and 45 CFR 146.136(c)(3)(v) and 147.160.

QHP issuers to count enrollees' out-of-pocket expenses on these services and items toward the QHPs' annual maximum out-of-pocket limits.

**Q5: Is a plan required to count an individual's out-of-pocket costs for non-covered items or services (such as cosmetic services) toward the plan's annual maximum out-of-pocket limit?**

No. A plan may, but is not required to, count out-of-pocket spending for non-covered services towards the plan's annual maximum out-of-pocket costs. The term "cost-sharing" does not include spending for non-covered services. Under section 1302(c)(3) of the Affordable Care Act, the term "cost-sharing" includes:

- Deductibles, coinsurance, copayments, or similar charges; and
- Any other expenditure required of an individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code (the Code)) with respect to EHB covered under the plan.

The term "cost-sharing" does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services. Nothing, however, prohibits a plan or issuer from counting such expenses toward the plan's annual maximum out-of-pocket limit, particularly in the circumstances described in Q4 above with respect to QHP issuers.

### **Expatriate Health Plans**

A previous FAQ provided guidance and temporary transitional relief regarding the extent to which expatriate health coverage is subject to the provisions of the Affordable Care Act.<sup>11</sup>

**Q6: Can the Departments provide any additional clarification of the definition of an insured expatriate health plan for purposes of the temporary transitional relief, as well as additional clarification of the scope of the relief provided?**

Yes. For purposes of the temporary transitional relief, an insured expatriate health plan is an insured group health plan with respect to which enrollment is limited to primary insureds for whom there is a good faith expectation that such individuals will reside outside of their home country or outside of the United States for at least six months of a 12-month period and any covered dependents, and also with respect to group health insurance coverage offered in conjunction with the expatriate group health plan. The 12-month period can fall within a single plan year or across two consecutive plan years.

Also, the earlier guidance only mentioned subtitles A and C of title I of the Affordable Care Act, but the Departments will also consider the requirements of subtitle D of title I of the Affordable Care Act to be satisfied if a plan and issuer of an insured expatriate health plan complies with the pre-Affordable Care Act version of title XXVII of the PHS Act.

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<sup>11</sup> See Affordable Care Act Implementation FAQs Part XIII, Q1, available at <http://www.dol.gov/ebsa/faqs/faq-aca13.html> and [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs13.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs13.html).

The Departments note that coverage provided under an insured expatriate health plan generally is minimum essential coverage under section 5000A of the Code.

**Q7: Do the Departments intend to issue regulations or provide additional guidance on insured expatriate health plans?**

The Departments continue to consider narrowly tailored guidance with respect to insured expatriate health plans that takes into account the ability of such coverage to reasonably comply with the requirements of subtitles A, C, and D of title I of the Affordable Care Act. The Departments intend that any new regulations or guidance that is more restrictive on plans or issuers will not be applicable to plan years ending on or before December 31, 2016. Insured expatriate health plans may continue to rely on the temporary transitional relief set forth in Affordable Care Act Implementation FAQs Part XIII, Q1 at least through those plan years.

**Wellness Programs**

On June 3, 2013, the Departments issued final regulations<sup>12</sup> regarding nondiscriminatory wellness programs in group health coverage under PHS Act section 2705 and the related provisions of the Employee Retirement Income Security Act (ERISA) and the Code. The final regulations increase the maximum permissible reward under a health-contingent wellness program offered in connection with a group health plan (and any related health insurance coverage) from 20 percent to 30 percent of the cost of coverage, and further increase the maximum permissible reward to 50 percent for wellness programs designed to prevent or reduce tobacco use. The final regulations also address the reasonable design of health-contingent wellness programs and the reasonable alternatives that must be offered in order to avoid prohibited discrimination. In the preamble to the final regulations, the Departments stated that they anticipated issuing future subregulatory guidance as necessary. The following FAQs address several issues that have been raised since the publication of the final regulations.

**Q8: A group health plan charges participants a tobacco premium surcharge but also provides an opportunity to avoid the surcharge if, at the time of enrollment or annual re-enrollment, the participant agrees to participate in (and subsequently completes within the plan year) a tobacco cessation educational program. A participant who is a tobacco user initially declines the opportunity to participate in the tobacco cessation program, but joins in the middle of the plan year. Is the plan required to provide the opportunity to avoid the surcharge or provide another reward to the individual for that plan year?**

No. If a participant is provided a reasonable opportunity to enroll in the tobacco cessation program at the beginning of the plan year and qualify for the reward (*i.e.*, avoiding the tobacco premium surcharge) under the program, the plan is not required (but is permitted) to provide another opportunity to avoid the tobacco premium surcharge until renewal or reenrollment for coverage for the next plan year. Nothing, however, prevents a plan or issuer from allowing rewards (including pro-rated rewards) for mid-year enrollment in a wellness program for that plan year.

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<sup>12</sup> See 78 FR 33158 (June 3, 2013).

**Q9: A plan participant's doctor advises that an outcome-based wellness program's standard for obtaining a reward is medically inappropriate for the plan participant. The doctor suggests a weight reduction program (an activity-only program) instead. Does the plan have a say in which one?**

Yes. The plan must provide a reward for individuals who qualify by satisfying a reasonable alternative standard. If an individual's personal physician states that the outcome-based wellness program is not medically appropriate for that individual and recommends a weight reduction program (an activity-only program) instead, the plan must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Many different weight reduction programs may be reasonable for this purpose, and a participant should discuss different options with the plan.

**Q10: Paragraph (f)(6) of the final regulations provides sample language that may be used to satisfy the requirement to provide notice of the availability of a reasonable alternative standard. Are plans and issuers permitted to modify this language?**

Yes. The final regulations state that the sample language provided in paragraph (f)(6), or substantially similar language, can be used to satisfy the notice requirement. Plans and issuers may modify the sample language to reflect the details of their wellness programs, provided that the notice includes all of the required content described in paragraphs (f)(3)(v) or (f)(4)(v), as applicable, of the final regulations. Additional sample language is available in examples illustrating the final regulations' requirements for outcome-based wellness programs.<sup>13</sup>

### **Fixed Indemnity Insurance**

Fixed indemnity insurance provided under a group health plan meeting the conditions outlined in the Departments' regulations<sup>14</sup> is an excepted benefit under PHS Act section 2791(c)(3)(B), ERISA section 733(c)(3)(B), and Code section 9832(c)(3)(B). As such, it is generally exempt from the health coverage requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code. The Departments have noticed a significant increase in the number of health insurance policies labeled as fixed indemnity insurance.

A previous FAQ provided guidance reiterating that, in order for a fixed indemnity policy to be considered an excepted benefit, it must pay on a per-period basis, and that a fixed indemnity policy that pays on a per-service basis does not meet the conditions for excepted benefits.<sup>15</sup>

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<sup>13</sup> See examples 1, 4, and 6 in paragraph (f)(4)(vi) of the final regulations, published at 78 FR 33158 (June 3, 2013).

<sup>14</sup> See 26 CFR 54.9831-1(c)(4), 29 CFR 732(c)(4), and 45 CFR 146.145(c)(4).

<sup>15</sup> See Affordable Care Act Implementation FAQs Part XI, Q7, available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html> and [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs11.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html).

**Q11: If insurance labeled as fixed indemnity insurance provides benefits other than on a per-period basis, may the insurance nonetheless qualify as excepted benefits?**

Yes. With respect to group health insurance coverage that does not meet the definition of fixed indemnity excepted benefits, coverage that supplements other group health plan coverage may, nonetheless, qualify as supplemental excepted benefits under sections 2722(c)(3) and 2791(c)(4) of the PHS Act, sections 732(c)(3) and 733(c)(4) of ERISA, and sections 9831(c)(3) and 9832(c)(4) of the Code. See 26 CFR 54.9831-1(c)(5); 29 CFR 2590.732(c)(5); 45 CFR 146.145(c)(5); the Department of Labor's Employee Benefits Security Administration's Field Assistance Bulletin No. 2007-04 (available at <http://www.dol.gov/ebsa/pdf/fab2007-4.pdf>); HHS Centers for Medicare & Medicaid Services Insurance Standards Bulletin 08-01 (available at [http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa\\_08\\_01\\_508.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf)); and Internal Revenue Service Notice 2008-23 (available at [http://www.irs.gov/irb/2008-07\\_IRB/ar09.html](http://www.irs.gov/irb/2008-07_IRB/ar09.html)).<sup>16</sup>

Furthermore, HHS intends to propose amendments to 45 CFR 148.220(b)(3) that would allow fixed indemnity coverage sold in the individual health insurance market to be considered to be an excepted benefit if it meets the following conditions:

1. It is sold only to individuals who have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Code;
2. There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;
3. The benefits are paid in a fixed dollar amount regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to an event or service under any other health coverage; and
4. A notice is displayed prominently in the plan materials informing policyholders that the coverage does not meet the definition of minimum essential coverage and will not satisfy the individual responsibility requirements of section 5000A of the Code.

If these proposed revisions are implemented, fixed indemnity insurance in the individual market would no longer have to pay benefits solely on a per-period basis to qualify as an excepted benefit.

Until HHS finalizes this rulemaking related to these proposed amendments, HHS will treat fixed indemnity coverage in the individual market as excepted benefits for enforcement purposes if it meets the conditions above in States where HHS has direct enforcement authority. For States with primary enforcement authority, HHS encourages those States to also treat this coverage as an excepted benefit and will not consider that a State is not substantially enforcing the individual market requirements merely because it does so.

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<sup>16</sup> In addition, benefits offered as supplemental benefits to other coverage may qualify as an excepted employee assistance program (EAP). See 78 FR 77632 (Dec. 24, 2013) (available at <http://www.gpo.gov/fdsys/pkg/FR-2013-12-24/pdf/2013-30553.pdf>), and IRS Notice 2013-54 (available at <http://www.irs.gov/pub/irs-drop/n-13-54.pdf>) and DOL Technical Release 2013-03 (available at <http://www.dol.gov/ebsa/newsroom/tr13-03.html>), Q&A 9.



## **The Mental Health Parity and Addiction Equity Act of 2008**

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) amended the PHS Act, ERISA, and the Code to provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits. In general, MHPAEA requires that the financial requirements (such as coinsurance) and treatment limitations (such as visit limits) imposed on mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits.<sup>17</sup> On November 13, 2013, the Departments published final regulations on MHPAEA, which contain some clarifications regarding the statute's protections.<sup>18</sup>

### **Q12: What was the effect of the Affordable Care Act on MHPAEA?**

The Affordable Care Act builds on MHPAEA and provides that mental health and substance use disorder services are one of ten EHB categories. Under the EHB rule, non-grandfathered health plans in the individual and small group markets are required to comply with the requirements of the parity regulations to satisfy the requirement to provide EHB. In addition, section 1563 of the Affordable Care Act extends the protections of MHPAEA to the entire individual market, both with respect to grandfathered and non-grandfathered coverage.<sup>19</sup> Therefore:

- **For non-grandfathered individual market coverage:** For policy years beginning on or after January 1, 2014, all non-grandfathered individual market coverage that is not otherwise subject to the HHS transitional policy<sup>20</sup> must include coverage for mental health and substance use disorder benefits, and that coverage must comply with the Federal parity requirements set forth in the interim final regulations issued in February 2010. The final regulations apply for policy years beginning on or after July 1, 2014 (which, for calendar year policies, is January 1, 2015).
- **For grandfathered individual market coverage:** Grandfathered individual health insurance coverage is not subject to the EHB requirements and therefore is not required to cover mental health or substance use disorder benefits. However, to the extent mental health or substance use disorder benefits are covered under the policy, coverage must comply with the Federal parity requirements set forth in final regulations for policy years beginning on or after July 1, 2014 (which, for calendar year policies, is January 1, 2015).
- **For non-grandfathered small group market coverage:** For plan years beginning on or after January 1, 2014, all non-grandfathered small group market coverage that is not otherwise subject to the HHS transitional policy must include coverage for mental health

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<sup>17</sup> MHPAEA does not mandate that plans and issuers cover mental health and substance use disorder benefits. It applies only if a plan or issuer provides those benefits.

<sup>18</sup> 78 FR 68240 (November 13, 2013).

<sup>19</sup> In general, grandfathered coverage is coverage provided by a group health plan, or individual health insurance coverage, in which an individual was enrolled on March 23, 2010, and that has since that time not made certain changes in coverage. See section 1251 of the Affordable Care Act and implementing regulations at 29 CFR 2590.715–1251 and 45 CFR 147.140.

<sup>20</sup> Letter to Insurance Commissioners, Center for Consumer Information and Insurance Oversight, November 14, 2013. See <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>.

and substance use disorder benefits, and that coverage must comply with the Federal parity requirements set forth in the interim final regulations issued in February 2010. The final regulations apply for plan years beginning on or after July 1, 2014 (which, for calendar year plans, is January 1, 2015).

Grandfathered small group market coverage is not required to comply with either the EHB provisions or MHPAEA. HHS has also released guidance explaining how the Federal parity requirements will be applied to the Children's Health Insurance Program (CHIP), Medicaid managed-care organizations, and to Alternative Benefit Plans. See the January 16, 2013 letter from CMS to State Medicaid Directors.<sup>21</sup>

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<sup>21</sup> Available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.