DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
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Date: April 22, 2016

Subject: Standardized Options and Mental Health and Substance Use Disorder Services; Mental Health Parity

The final HHS Notice of Benefit and Payment Parameters for 2017 (2017 Final Payment Notice), published on March 8, 2016,[1] defines at 45 CFR 155.20 a standardized option as a qualified health plan (QHP) with a standardized cost-sharing structure specified by HHS in rulemaking, offered for sale through an individual Marketplace. In the 2017 Final Payment Notice preamble, HHS defines six standardized options—one at each of the bronze, silver, three silver cost-sharing reduction (CSR) variations, and gold metal levels. Each standardized option has a fixed deductible, fixed annual limitation on cost sharing, and fixed copayment or coinsurance for a key set of essential health benefits (EHB) that comprise a large percentage of the total allowable costs for an average enrollee. This key set of EHB includes mental health/substance use disorder (MH/SUD) services.

Generally, under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and implementing regulations,[2] financial requirements (such as deductible, coinsurance, or copayment) and quantitative treatment limitations (such as day or visit limits) that apply to MH/SUD benefits must be no more restrictive than the "predominant" financial requirements or quantitative treatment limitations that apply to "substantially all" medical/surgical benefits in a classification.[3] A type of financial requirement or quantitative treatment limitation is considered to apply to "substantially all" medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification. The level that is considered "predominant" is the level that applies to more than one-half of medical/surgical benefits in a classification subject to the financial requirement or quantitative treatment limitation. Further, each type of financial requirement is treated separately and is subject individually to the "substantially all/predominant" test. For example, a copayment

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Final Rule (81 FR 12204); March 8, 2016. See https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017

[2] See 45 CFR 146.136. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program; Final Rule (78 FR 68240); November 13, 2013. See https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf

[3] The rules divides benefits into six classifications: outpatient, in-network; outpatient, out-of-network; inpatient, in-network; inpatient, out-of-network; emergency services; and prescription drugs. Furthermore, plans can elect to break out the outpatient classification into two sub-classifications for the purpose of the parity analysis: office visits and other outpatient services. *Id.*

may apply to MH/SUD benefits only if copayments apply to at least two-thirds of all medical/surgical benefits in a classification, and the level of copayment for MH/SUD benefits must be no greater than the level that applies to more than one-half of the medical/surgical benefits with a copayment in the classification.[4] The determination of the portion of medical/surgical benefits subject to the financial requirement or treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year.

In designing the standardized options, it was HHS's intent that overall cost sharing for in-network, outpatient MH/SUD *office visits* be no more restrictive than the cost sharing for the lowest cost medical/surgical *office visits* in terms of the *total out-of-pocket cost per visit*. MH/SUD services are a critical part of the coverage offered by QHPs, and HHS intends to ensure that those services are available to enrollees without undue financial restrictions. We are making the following two clarifications with respect to the standardized option cost-sharing structures.

The first clarification is with respect to all standardized options. We clarify that in the 2017 Final Payment Notice, the cost-sharing value assigned to in-network, outpatient MH/SUD services in each of the standardized options applies to in-network, outpatient MH/SUD *office visits* only. It does not apply to other in-network, outpatient MH/SUD services. For in-network, outpatient MH/SUD services other than MH/SUD office visits, the standardized option's coinsurance rate and deductible applies. This is consistent with HHS's intent in designing the standardized options to treat outpatient MH/SUD *office visits* similarly to the lowest cost medical/surgical *office visits* in terms of total out-of-pocket cost per visit.

The second clarification is with respect to the bronze standardized option only. The first three in-network, outpatient medical/surgical primary care office visits in the HHS bronze standardized option are subject to a $45 copayment, not subject to deductible or coinsurance, with all other in-network, outpatient medical/surgical benefits subject to deductible and 50% coinsurance after the deductible has been met. In-network, outpatient MH/SUD office visits in the HHS bronze standardized option are subject to a $45 copayment only, and are not subject to deductible or coinsurance. HHS believes that applying a $45 copayment only to an in-network, outpatient MH/SUD office visit would in almost all cases be less restrictive as a measure of total out-of-pocket cost per visit than applying the deductible and 50% coinsurance after the deductible has been met.

Under the MHPAEA final regulations, the substantially all/predominant test must be applied separately to each type of financial requirement in a classification (that is, separately to copayments and coinsurance). In the case of the bronze standardized option, copayments apply to less than two-thirds of in-network, outpatient medical/surgical office visits, and therefore would appear to raise an issue regarding the MHPAEA substantially all/predominant test, despite the fact that applying a $45 copayment would in almost all cases be more favorable in terms of total out-of-pocket cost per visit to the consumer than applying the deductible and 50% coinsurance.

[4] For this purpose, benefits expressed as subject to a zero level of a type of cost-sharing requirement are treated as benefits not subject to that type of cost-sharing requirement. *Id.*

To provide clarity with respect to this issue, HHS will allow health insurance issuers to offer the bronze standardized option QHP for 2017. This guidance applies only to the bronze standardized option QHP for 2017; it does not apply to other plans and coverage. HHS intends to modify the parameters of the standardized options for future benefit years to address this issue.