U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

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April 14, 2016

The Honorable Orrin G. Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
House of Representatives

Subject: *Department of Health and Human Services, Centers for Medicare & Medicaid Services: Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans*

Pursuant to section 801(a)(2)(A) of title 5, United States Code, this is our report on a major rule promulgated by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) entitled "Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans" (RIN: 0938-AS24). We received the rule on March 29, 2016. It was published in the *Federal Register* as a final rule on March 30, 2016. 81 Fed. Reg. 18,390.

The final rule implements certain mental health parity requirements as applied to Medicaid and the Children's Health Insurance Program (CHIP). Specifically, this final rule implements requirements of the Pete Domenici Mental Health Parity and Addiction Equity Act of 2008[1] to: (1) Medicaid managed care organizations; (2) Medicaid benchmark and benchmark-equivalent plans; and (3) the Children's Health Insurance Program.

Enclosed is our assessment of CMS's compliance with the procedural steps required by section 801(a)(1)(B)(i) through (iv) of title 5 with respect to the rule. Our review of the procedural steps taken indicates that CMS complied with the applicable requirements.

[1] Pub. L. No. 110-343, §§ 511–512, 122 Stat. 3765, 3881–3893 (Oct. 3, 2008).

If you have any questions about this report or wish to contact GAO officials responsible for the evaluation work relating to the subject matter of the rule, please contact Shirley A. Jones, Assistant General Counsel, at (202) 512-8156.

signed

Robert J. Cramer
Managing Associate General Counsel

Enclosure

cc: Agnes Thomas
Regulations Coordinator
Department of Health and Human Services

ENCLOSURE

REPORT UNDER 5 U.S.C. § 801(a)(2)(A) ON A MAJOR RULE
ISSUED BY THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
CENTERS FOR MEDICARE & MEDICAID SERVICES
ENTITLED
"MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAMS;
MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008;
THE APPLICATION OF MENTAL HEALTH PARITY REQUIREMENTS
TO COVERAGE OFFERED BY MEDICAID MANAGED CARE
ORGANIZATIONS, THE CHILDREN'S HEALTH INSURANCE
PROGRAM (CHIP), AND ALTERNATIVE BENEFIT PLANS"
(RIN: 0938-AS24)

(i) Cost-benefit analysis

The Centers for Medicare & Medicaid Services (CMS) estimated the benefit, costs, and transfers of this final rule. CMS expects this final rule will benefit approximately 22.3 million Medicaid beneficiaries and 880,000 Children's Health Insurance Program (CHIP) beneficiaries in 2016, based on service utilization estimates from 2012 Medicaid and CHIP enrollment. CMS expects that a significant benefit associated with the application of the parity requirements under this final rule will be derived from applying parity requirements to the quantitative treatment limits such as annual or lifetime day or visit limits. According to CMS, applying parity requirements to visit or stay limits will help ensure that vulnerable populations have better access to appropriate care according to CMS. CMS also estimated the costs for fiscal years 2016 through 2020, which totaled $166.5 million, $175.2 million, $185.3 million, $196.8 million, and $208.3 million in each respective year. CMS estimated that the total annualized transfers from the federal government to providers from 2016 to 2020 would be $126.5 million at a 7 percent discount rate and $126.8 million at a 3 percent discount rate. CMS estimated that the total annualized transfers from state governments to providers from 2016 to 2020 would be $58.5 million at a 7 percent discount rate and $59 million at a 3 percent discount rate.

(ii) Agency actions relevant to the Regulatory Flexibility Act (RFA), 5 U.S.C. §§ 603-605, 607, and 609

CMS determined that this final rule will not have a significant economic impact on a substantial number of small entities. CMS also determined that this final rule will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

(iii) Agency actions relevant to sections 202-205 of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. §§ 1532-1535

CMS determined that the total costs to the states for this final rule will be $68 million, which is less than the Act's inflation-adjusted threshold of $144 million, and therefore determined that this final rule is not subject to the Act.

(iv) Other relevant information or requirements under acts and executive orders

Administrative Procedure Act, 5 U.S.C. §§ 551 et seq.

On April 10, 2015, CMS published a proposed rule. 80 Fed. Reg. 19,418. CMS received a total of 158 comments from state agencies, advocacy groups, health care providers, health insurers, health care associations, and the general public. CMS responded to comments in the final rule.

Paperwork Reduction Act (PRA), 44 U.S.C. §§ 3501-3520

CMS determined that this final rule contains information collection requirements under the Act. CMS estimates that the total annual recordkeeping and reporting burden will be 48,217 hours for a total cost of $492,864, the state share of which is $193,119. CMS stated it will submit these requirements to the Office of Management and Budget (OMB) for review under OMB Control Numbers 0938-1280 and 0938-1148.

Statutory authorization for the rule

CMS promulgated this final rule under the authority of section 1102 of the Social Security Act. 42 U.S.C. § 1302.

Executive Order No. 12,866 (Regulatory Planning and Review)

CMS determined that this final rule is economically significant under the Order and submitted it to OMB for review.

Executive Order No. 13,132 (Federalism)

CMS determined that this final rule has federalism implications, because it has direct effects on the states, the relationship between the federal government and states, or on the distribution of power and responsibilities among various levels of government. However, CMS also determined that the federalism implications of this final rule are substantially mitigated because, with regards to managed care organizations (MCOs), alternative benefit plans, and CHIP, the agency expects that many states already offer benefits under their state plan and MCO contracts that meet or exceed the federal mental health parity standards that would be implemented in this rule. CMS stated that, throughout the process of developing these regulations and to the extent feasible, it has attempted to balance the latitude for states to structure their state plan services and MCO contracts according to the needs and preferences of the state, and the Congress' intent to provide uniform minimum protections to Medicaid and CHIP beneficiaries in every state. By doing so, it is CMS's view that this final rule complies with the requirements of the Order.