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General Comment

On behalf of the Trustees of the Electrical Welfare Trust Fund, we are submitting the attached Comment in response to the issuance of the Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410–5451 (February 2, 2010).

Thank you for your consideration of our Comment.

Sincerely,

McChesney & Dale, P.C.

By: Michael F. Smith

Attachments

EBSA-2009-0010-DRAFT-0590.1: Comment on FR Doc # 2010-2167

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Re: MHPAEA Interim Rules Comment

Dear Mr. Lebowitz:

On behalf of the Trustees of the Electrical Welfare Trust Fund, we are submitting the enclosed Comment in response to the issuance of the Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410–5451 (February 2, 2010).

Thank you for your consideration of our Comment.

Sincerely,

McChesney & Dale, P.C.

Michael F. Smith

Enclosure

Comment on the Interim Final Rules ("Interim Rules") Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")

Comment: The Final Rules implementing the MHPAEA should clarify that a plan that conditions the provision of mental health and/or substance use disorder benefits upon a participant's receipt of a pre-certification for treatment from an Employee Assistance Program does not violate the MHPAEA.

A. Introduction

This Comment is submitted on behalf of the Trustees of the Electrical Welfare Trust Fund (the "Fund"), a health and welfare fund established and maintained as the result of collective bargaining between the Local 26, International Brotherhood of Electrical Workers, and the National Electrical Contractors Association, Washington, D.C. Chapter. The Fund sponsors a self-funded multiemployer health and welfare plan that offers mental health and substance use disorder benefits to its participants.

The Fund's health and welfare plan is able to offer its participants mental health and substance use disorder benefits through the use of pre-certification and referral services offered by its Employee Assistance Program (EAP). The EAP serves as a gateway to mental health and substance use disorder treatment benefits for plan participants. Through the use of this structure, the plan guides participants with mental health or substance use disorder needs to appropriate treatment providers. This ensures that participants are advised of treatment providers that can best assist them with their specific mental health or substance use disorder issue, and mitigates expenses to the Fund from participants that would otherwise visit treatment providers that are not positioned correctly to assist the participant. The EAP structure also increases the likelihood that participants will seek mental health treatment, despite the stigma that is often associated with seeking treatment for mental health issues.

For many years, this structure has worked well for the plan and its participants. The plan has been able to afford to offer mental health and substance use disorder benefits to its participants, and the plan's participants have been able to enjoy these benefits, and the additional benefit of guidance to treatment providers that are well-positioned to handle their needs.

The Fund's objective in submitting this Comment accords with a primary objective of the MHPAEA: to assure that participants will continue to have access to generous mental health and substance use disorder benefits through their group health plan. The Fund submits this Comment to request that the Final Rules clarify that a plan structure, such as the Fund's, in which mental health and/or substance use disorder benefits are conditioned upon a participant's receipt of a pre-certification for treatment from an EAP, complies with the MHPAEA. In general, the Fund's Comment is based upon four broad points:

- The Fund's EAP structure is not a treatment limitation under the terms of the MHPAEA.

- The Fund's EAP structure is not a treatment limitation under the terms of the Interim Rules. Further, only under an *ultra vires* implementation of the MHPAEA can the Fund's EAP structure be considered a prohibited treatment limitation.

- The Fund's EAP structure serves as a gateway to mental health and substance use disorder benefits. Its prohibition would adversely affect the Fund's ability to cover these benefits. Separately, its prohibition would adversely affect the ability of the Fund's participants to receive appropriate mental health and substance use disorder treatment.

- The Fund's EAP structure is a clinically appropriate standard of care through which participants are encouraged to seek help, and are guided to appropriate treatment providers. It is a structure suited to the specialized needs of participants in need of mental health and/or substance use disorder treatment, for which a comparable counterpart in the field of medical/surgical treatment does not exist.

For the legal and practical reasons more fully described below, the Fund respectfully submits that its requested clarification is consistent with both the letter of the law, and the goals of the MHPAEA.

B. Statutory Provisions

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, that such plan or coverage shall ensure that:

- the treatment limitations 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 (or coverage), *and*

- there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

The MHPAEA 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."

C. Interim Rules

Released on February 2, 2010, the Interim Rules add to the statute's definition of "treatment limitation." The Interim Rules provide that:

> Treatment limitations include limits *on benefits based* on the frequency of treatment, number of visits, days of coverage, *days in a waiting period*, or other similar limits on the scope or duration of treatment. *Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation.*

75 Fed. Reg. at 5431. (Additions to statutory text in italics). After introducing the concepts of quantitative and nonquantitative treatment limitations, the Interim Rules provide that the MHPAEA's general parity requirement shall be applied with respect to nonquantitative treatment limitations as follows:

> A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

Id. at 5436. The Interim Rules provide an illustrative list of nonquantitative treatment limitations:

> Nonquantitative treatment limitations include—
>
> (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
>
> (B) Formulary design for prescription drugs;

(C) Standards for provider admission to participate in a network, including reimbursement rates;

(D) Plan methods for determining usual, customary, and reasonable charges;

(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and

(F) Exclusions based on failure to complete a course of treatment.

Id. The Interim Rules further provide the following illustrative example of an offending nonquantitative treatment limitation related to an EAP:

> *Example 5.* (i) *Facts.* An employer maintains both a major medical program and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical program only after exhausting the counseling sessions provided by the EAP. No similar exhaustion requirement applies with respect to medical/surgical benefits provided under the major medical program.
>
> (ii) *Conclusion.* In this *Example 5,* limiting eligibility for mental health and substance use disorder benefits only after EAP benefits are exhausted is a nonquantitative treatment limitation subject to the parity requirements of this paragraph (c). Because no comparable requirement applies to medical/surgical benefits, the requirement may not be applied to mental health or substance use disorder benefits.

Id. The Interim Rules invite comments on whether additional examples would be helpful to illustrate the application of the nonquantitative treatment limitation rule to other features of medical management or general plan design. Id. at 5416.

D. Suggested Plan Structure

The Final Rules implementing the MHPAEA should clarify that a plan that conditions the provision of mental health and/or substance use disorder benefits upon a participant's receipt of a pre-certification for treatment from an EAP does not violate the MHPAEA.

Specifically, the Final Rules should clarify that the following type of plan structure (the "Suggested Plan Structure") does not violate the MHPAEA: Under the

terms of the plan, the EAP is not a provider of mental health or substance abuse treatment. Rather, the EAP guides participants to appropriate mental health or substance use disorder treatment providers, and provides the pre-approval/certification required by the plan for the benefits to be covered. (The participants are free to choose their specific treatment provider.) This specialized structure is not applied outside the context of mental health/substance use disorder treatment.

E. Explanation

The Suggested Plan Structure does not constitute a treatment limitation under the terms of the MHPAEA or the Interim Rules. In addition, the Suggested Plan Structure is an important aspect of the Fund's health and welfare plan that allows the Fund to offer generous mental health and substance use disorder benefits, and it increases the likelihood that participants will seek treatment and will be guided to treatment providers that can best assist them with their needs.

1. MHPAEA

The Suggested Plan Structure does not constitute a "treatment limitation" under the terms of the MHPAEA. The MHPAEA 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." The Suggested Plan Structure does not, in any way, limit:

- the frequency of treatment;
- the number of visits; or
- the days of coverage.

The only possible way it could constitute a treatment limitation would be that it is a "*similar limit* on the scope or duration of treatment." The Suggested Plan Structure does not, in any way, limit the duration of a participant's treatment (such as the number of visits or days of coverage). Therefore, the only remaining possible violation would be that it is a "*similar limit* on the scope of treatment" (such as the frequency of treatment). The phrase "similar limit" refers back to the treatment limitations provided earlier in the sentence: frequency of visits, number of visits, and days of coverage. These are all restrictions on covered treatment a participant is receiving that limit the extent to which benefits are available. The Suggested Plan Structure does not limit the frequency of visits, number of visits, days of coverage, or place any other similar limit on the scope or duration of treatment. Only through an *ultra vires* implementation of the statute could the Departments prohibit the Suggested Plan Structure as a limitation on the scope or duration of treatment that is similar to the banned statutory limitations dealing with the frequency of visits, number of visits, or days of coverage.

The requested clarification that the Suggested Plan Structure complies with the MHPAEA is also consistent with the law's legislative history. After the Mental Health Parity Act of 1996 prohibited plans from imposing annual or lifetime dollar limits on mental health coverage that is more restrictive than those imposed on medical and surgical coverage, many health plans used loopholes in the law to impose other restrictions and limitations on mental health benefits. The legislative history, **see** Emergency Economic Stabilization, Pub.L.No. 110-343, House Report 110-374, (Part 1), IV. Statement and Committee Views, speaks to the types of loopholes and workarounds the MHPAEA was designed to eliminate:

- Loopholes in MHPA have created a system where employers routinely limit mental health benefits more severely than medical and surgical coverage, most often by restricting the number of covered outpatient visits and hospital days and by imposing far higher cost sharing requirements.

- In 2002, the Kaiser Family Foundation/Health Research and Educational Trust conducted an employer survey which found that while 98 percent of workers with employer-sponsored health insurance had coverage for mental health care, 74 percent of those covered workers were subject to an annual outpatient visit limit, and 64 percent were subject to an annual inpatient days limits.

- Employers and insurance companies routinely discriminate against mental health coverage when it comes to reimbursing individuals for their mental benefits. Insurers routinely increase patients' costs for mental health treatment by limiting inpatient days, capping outpatient visits, and requiring higher co-payments than for physical illnesses.

- These loopholes allow employers and insurance companies to deny mental health coverage to individuals and families most in need of it.

Accordingly, as reflected in the MHPAEA's definition of "treatment limitation," the House Report notes in Title I, Purposes, that the MHPAEA seeks to:

> [I]ncrease access to mental health treatment by prohibiting group health plans (or health insurance coverage offered in connection with a group health plan) from imposing financial requirements (including deductibles, co payments, coinsurance, out-of-pocket expenses, and annual lifetime limits) or *treatment limitations (including limitations on the number of visits, days of coverage, frequency of treatment, or other similar limits on the scope and duration of treatment)* on mental health benefits that are more restrictive than those restrictions applied to medical and surgical benefits. (Emphasis added).

Both the plain language of the statute and its legislative history support the view that the Suggested Plan Structure does not constitute a treatment limitation that limits the frequency of treatment, number of visits, or days of coverage, or that it constitutes a similar limit on the scope or duration of treatment.

2. The Interim Rules

A. Treatment Limitation

The Suggested Plan Structure also does not constitute a "treatment limitation" under the Interim Rules. The Suggested Plan Structure does not relate to any type of quantitative limit, such as a limit on the number of visits, so the only possible treatment limitation it could be is a nonquantitative treatment limitation. However, as explained above, the Suggested Plan Structure does not limit either the scope, or the duration, of benefits for treatment under the plan. Therefore, it is not a nonquantitative treatment limitation.

Similarly, the Suggested Plan Structure is not contemplated in the illustrative list of nonquantitative treatment limitations provided in the regulation. 75 Fed. Reg. at 5436. The illustrative list does not list anything similar to the Suggested Plan Structure. The six items in the list are:

> 1. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
>
> 2. Formulary design for prescription drugs;
>
> 3. Standards for provider admission to participate in a network, including reimbursement rates;
>
> 4. Plan methods for determining usual, customary, and reasonable charges;
>
> 5. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and
>
> 6. Exclusions based on failure to complete a course of treatment.

The items contained in the illustrative list do not suggest that the Suggested Plan Structure is a nonquantitative treatment limitation. They do not discuss requiring a pre-certification from an EAP program, and do not discuss any type of health plan provision that is possibly analogous to the Suggested Plan Structure upon which we seek

clarification. The Fund's EAP referral and pre-certification system is not a medical management standard to limit or exclude benefits. Rather, it is a structure to facilitate entry into mental health and substance use disorder treatment, to guide participants to treatment providers that can help them, and to ensure that the provision of generous mental health and substance use disorder benefits is financially viable for the Fund.

The Interim Rules' illustrative list of nonquantitative treatment limitations is further illustrated in the Interim Rules with five examples. 75 Fed. Reg. at 5436. As recited above, in the Interim Rules' Example 5, participants are eligible for mental health or substance use disorder benefits under the major medical program only after exhausting the counseling sessions that are available through the plan's EAP. The Interim Rules state that in this example, because no comparable requirement applies to medical/surgical benefits, that "limiting eligibility for mental health and substance use disorder benefits only after EAP benefits are exhausted is a nonquantitative treatment limitation subject to the parity requirements of this paragraph (c)." Id. The preamble to the Interim Rules states that in this example, requiring participants to exhaust the EAP benefits makes the EAP a gatekeeper. Id. at 5416. The preamble adds that:

> [I]f similar gatekeeping processes with a similar exhaustion requirement (whether or not through the EAP) are not applied to medical/surgical benefits, the requirement to exhaust mental health or substance use disorder benefits available under the EAP would violate the rule that nonquantitative treatment limitations be applied comparably and not more stringently to mental health and substance use disorder benefits.

It would appear that Example 5 is an illustration of item six from the illustrative list of nonquantitative treatment limitations, an "exclusion based on failure to complete a course of treatment." That is, the participants in Example 5 are not eligible for benefits unless they complete/exhaust the course of treatment available under the EAP program.

Unlike Example 5, in which an EAP is utilized as a gatekeeper to mental health and substance use disorder benefits, the Fund's EAP is a gateway to mental health and substance use disorder benefits. As explained further below, it: increases the likelihood that participants will seek mental health or substance use disorder treatment; ensures that participants are guided to treatment providers that can best assist them with their specific mental health or substance use disorder issue; and, allows the provision of mental health and substance use disorder benefits to be financially viable for the Fund.

The Suggested Plan Structure makes use of an EAP, but does not contain a gatekeeper exclusion based upon failure to complete a course of treatment, and does not contain a "treatment limitation" prohibited under the MHPAEA or the Interim Rules. The Fund, therefore, requests clarification that its Suggested Plan Structure is compliant.

B. Regulatory Exception

Assuming, for the sake or argument, that the Suggested Plan Structure somehow constitutes a treatment limitation under the MHPAEA, the regulatory exception for clinically appropriate standards of care would make the Suggested Plan Structure permissible. The Interim Rules provide that the MHPAEA's general parity requirement shall be applied with respect to nonquantitative treatment limitations as follows:

> A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, *except to the extent that recognized clinically appropriate standards of care may permit a difference.*

Id. at 5436. (Emphasis added). Thus, a group health plan may not impose a nonquantitative treatment limitation unless:

1. The processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are *comparable to* the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits; *and*

2. The processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are *applied no more stringently than* the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits.

Id. (Emphasis added). An exception to the rule exists, however, to the extent that recognized clinically appropriate standards of care may permit a difference. Id.

Therefore, in the event that the Departments view the Suggested Plan Structure as a nonquantitative treatment limitation, we suggest that the Final Rules implementing the MHPAEA should clarify that the Suggested Plan Structure satisfies the regulatory exception, because it represents a recognized clinically appropriate standard of care that may permit a difference.

Guidance to an appropriate provider of mental health or substance use disorder treatment is recognized as vital to the successful provision of treatment. In *Mental Health: A Report of the Surgeon General*, a collaboration between the Substance Abuse and Mental Health Services Administration, and the National Institutes of Health (*available at http://www.surgeongeneral.gov/library/mentalhealth/home.html*), the Surgeon General explains that the mental health service system is highly fragmented, and that many who seek treatment are bewildered by the maze of paths into treatment, while others in need of care are stymied by a lack of information about where to seek effective and affordable services. **See** *Mental Health: A Report of the Surgeon General* at Chapter 8. Similarly, Americans are often unaware of the choices they have for effective mental health treatment. Id. In addition, the stigma associated with mental disorders serves as a barrier to seeking care. Id. at Chapters 1 and 6. The Surgeon General's report notes that adequate mental health treatment resources for large population groups require a wide range of services in a variety of settings, with sufficient flexibility to permit movement to the appropriate level of care. Id. at Chapter 6.

In view of these considerations, it is apparent that the Suggested Plan Structure is a clinically appropriate tool to ensure that participants are encouraged to seek help, and are guided to an appropriate treatment provider. As the Surgeon General's report notes, "the availability of services organized in ways that reduce stigma—*such as employee assistance programs*—can provide *important gateways* to further treatment when necessary." Id. (Emphasis added). Indeed, the report notes that it is essential that first-line contacts recognize mental illness and mental health problems, respond sensitively, know what resources exist, and make proper referrals. Id. at Chapter 8. Channeling participants to an EAP increases the probability that they will seek mental health care, and guides them to an appropriate level of care.

A procedure by which a participant seeking mental health or substance use disorder treatment receives an initial screening and referral through an EAP (or other similar type of counselor) is a recognized clinically appropriate standard of care. For example, in *Mental Health Standards of Care: An Integrated Approach to Serving Diverse Communities in New York State* (Revised September 2009) (*available at http://www.health.state.ny.us/diseases/aids/resources/docs/mental_health_services.pdf*), the New York State Department of Health AIDS Institute states that the full continuum of mental health services includes initial screening and referral. Similarly, the U.S. Department of Health and Human Service's "Model Plan for a Comprehensive Drug-Free Workplace Program"[1] (*available at:*

[1] The Model Plan's "Forward" explains that the Model Plan was developed by a Federal interagency coordinating group composed of representatives of the Department of Health and Human Services, Office of Personnel Management, and Department of Justice and distributed to Federal agencies by the National Drug Policy Board to provide a prototype for developing a drug-free workplace plan. Noting that many private and non-Federal public sector employers were seeking advice and guidance in developing and implementing programs for achieving a drug-free workplace, the National Institute on Drug Abuse made the model available to the public.

http://www.workplace.samhsa.gov/FedPgms/Pages/Model_Plan.aspx) indicates that Employee Assistance Counselors shall serve as the initial point of contact for employees that seek or are referred for counseling. **See** Title VI, Special Duties and Responsibilities. Similarly, the "Model Plan for a Comprehensive Drug-Free Workplace Program" states that EAP "plays an important role in preventing and resolving employee drug use by, among other things, "making referrals to appropriate treatment and rehabilitative facilities." **See** Title III, Employee Assistance Programs. In addition, in its publication, "Documenting the Value of Employee Assistance Programs" (*available at http://www.foh.dhhs.gov/whatwedo/EAP/EAPvalue.pdf*), Federal Occupational Health (FOH), a non-appropriated agency and a service unit within the Department of Health and Human Services, demonstrates that it has determined that the best standard of care to help Federal employees is: (1) an EAP provided assessment of issues related to mental health or substance abuse; followed by (2) referral for treatment.

The Suggested Plan Structure provides a strong incentive for plan participants to receive a clinically appropriate standard of care. *Mental Health: A Report of the Surgeon General*, "Model Plan for a Comprehensive Drug-Free Workplace Program," and the Department of Health and Human Services' Federal Occupational Health unit each recognize initial screening and referral through an EAP as an important, and by logical extension, clinically appropriate, standard of care. The Suggested Plan Structure reflects the prevailing research and information about the most effective provision of mental health and substance use disorder coverage.

Prevailing standards teach that the Suggested Plan Structure is a clinically appropriate tool to ensure that participants are encouraged to seek help, and are guided to appropriate treatment providers, and that a comparable clinical structure does not exist for medical/surgical benefits. Therefore, in the event that the Departments view the Suggested Plan Structure as a nonquantitative treatment limitation, we suggest that the Final Rules implementing the MHPAEA should clarify that the Suggested Plan Structure satisfies the regulatory exception, because it represents a recognized clinically appropriate standard of care that may permit a difference.

3. A Gateway, not a Gatekeeper

The Fund suggests that the Final Rules clarify that the Fund's Suggested Plan Structure is permissible under the MHPAEA. Unlike Example 5 in the Interim Rules, in which a health plan uses its EAP plan as a gatekeeper to mental health and substance use disorder benefits, the Fund's EAP is a gateway to mental health and substance use disorder benefits. As noted above, the Surgeon General has found that in a country where:

- the mental health service system is highly fragmented;
- many who seek treatment are bewildered by the maze of paths into treatment;

- others in need of care are stymied by a lack of information about where to seek effective and affordable services;
- Americans are often unaware of the choices they have for effective mental health treatment;
- the stigma associated with mental disorders serves as a barrier to seeking care; and
- adequate mental health treatment resources require a wide range of services in a variety of settings, with sufficient flexibility to permit movement to the appropriate level of care,

that employee assistance programs can provide important gateways to treatment.

As suggested in the Surgeon General's report, the Fund's EAP structure increases the likelihood that participants will seek mental health treatment, and ensures that participants are guided to treatment providers that can best assist them with their specific mental health or substance use disorder issue. **See also,** Conlin, P., Amaral, T., and Harlow, K., *The value of EAP case management*, EAP ASSOCIATION EXCHANGE, May/June 1996, at 2-15 (study of Southern California Edison employee claims data suggests that EAP was successful in referral of employees to the most appropriate provider to deliver treatment for substance abuse issues, resulting in significant cost savings). Moreover, by mitigating expenses to the Fund from participants that would otherwise visit treatment providers that are not positioned correctly to assist the participant, the EAP referral and pre-certification structure provides the Fund the financial ability to offer mental health and substance use disorder benefits to its participants. **See** id., **see also** Every, D.K. & Leong, D.M., *Exploring EAP cost-effectiveness: Profile of a nuclear power plant's internal EAP*, EMPLOYEE ASSISTANCE QUARTERLY, 10(1) (1994), at 1-12 (finding that at Virginia Power, EAP referred clients has significantly lower medical costs than a comparison group of employee users of behavioral health services who had not used the EAP); **see also** Stern, L, *Why EAPs are worth the investment*, BUSINESS AND HEALTH, Washington DC, 1990, at 14-19 (reporting upon a study at McDonnell-Douglas finding that the medical costs for EAP referred cases for alcohol, tobacco, and drug dependency and psychiatric conditions was significantly lower than for a control group of employees utilizing health services without first using the EAP).

The MHPAEA was designed to eliminate "loopholes [that] allow employers and insurance companies to deny mental health coverage to individuals and families most in need of it." **See** Emergency Economic Stabilization, Pub.L.No. 110-343, House Report 110-374, (Part 1), IV. Statement and Committee Views. The Suggested Plan Structure is the antithesis of such a loophole. From both the Fund's, and the participant's perspective, it is a gateway to the provision of mental health and substance use disorder benefits. It allows the provision of mental health and substance use disorder benefits to be financially viable for the Fund, and increases the chances that a participant will seek, and benefit from, mental health or substance use disorder treatment. As the Surgeon General's Report explains:

- [T]he availability of services organized in ways that reduce stigma—such as employee assistance programs—can provide important *gateways* to further treatment when necessary.

- [L]ong term case studies of managed care's impact on access find that the probability of using mental health care—especially outpatient care—*increases* after managed behavioral health care is implemented in private insurance plans.

See *Mental Health: A Report of the Surgeon General* at Chapter 6. (Emphasis added). Similarly, in the concluding passage of the final chapter of the Surgeon General's Report, "A Vision for the Future," the Surgeon General notes that recent research suggests that the effectiveness of mental health care treatment has increased in recent years, while expenditures have fallen. The Surgeon General concludes as follows:

> In light of cost-containment strategies of managed care, concerns about undertreatment still are warranted for individuals with the most severe mental disorders, but high-quality managed care has the potential to effectively match services to patient needs.

Id. at Chapter 8. As in the Surgeon General's vision for the future, the Suggested Plan Structure effectively matches services to patient needs, while also mitigating costs, thereby allowing the plan to offer generous mental health and substance use disorder benefits.

F. Conclusion

The Suggested Plan Structure is not an evasive loophole or gatekeeper to be shut down. It is the gateway through which a self-funded health and welfare plan is able to offer generous mental health and substance use disorder benefits. For the legal and practical reasons outlined in this Comment, the Fund respectfully requests that the Final Rules clarify that the Suggested Plan Structure complies with the MHPAEA.

For the reasons described in this Comment, the Fund is operating under the understanding that it is in compliance with the MHPAEA and the Interim Rules. If the Departments believe otherwise, the Fund kindly requests that it be specifically informed.