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Office of Health Plan Standards and Compliance Assistance
Employee benefits Security Administration
Room N-5653
US Department of Labor
Attention: RIN 1210-AB30
200 Constitution Avenue NW
Washington DC 20210

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4140-IFC
P.O. Box 8016
Baltimore MD 21244-1850

U.S. Department of the Treasury
Internal Revenue Service
Attention: CC:PA:LPD:PR (Reg-120692-09)
Room 5205
P.O. Box 7604
Ben Franklin Station
Washington DC 20044

Dear Sir or Madame:

Magellan Behavioral Health (Magellan) welcomes the chance to comment on the Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (IFR). Magellan is one of the largest carve-out managed behavioral health care organizations (MBHO) in the country. As a carve-out organization, we are responsible for the administration of the behavioral health benefits provided by our customers to group health plan members. Magellan customers include both health plans and employers, covering approximately 40 million members nationwide.

Magellan has long demonstrated its strong commitment to mental health parity in many ways, including testifying in favor of parity legislation before Congress in 2001 and actively supporting passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (MHPAEA); we were very pleased when Congress finally passed this comprehensive parity law. However, we were dismayed to see the Departments release regulations under MHPAEA as interim final rules requiring implementation without having first solicited any comments from the industry, provider, and advocate communities. We have significant concerns with the IFR and believe that it does not accurately reflect the intent of Congress in passing MHPAEA. Because feedback was not obtained prior to promulgation of the regulations, the IFR is ambiguous in several places and does not translate well to the manner in which group health plans are structured and managed. It is clear that there are areas where the Departments would have benefited from a much better understanding of the current environment for managing behavioral health benefits and medical/surgical benefits. We believe that broad and comprehensive input on proposed regulations would have enabled the Departments to fashion alternative regulatory provisions that would satisfy the ultimate purposes of MHPAEA without the complexity and confusion for plans and MBHOs created by the IFR.

The release of these regulations in interim final form violated the Administrative Procedures Act (APA), which requires good cause for any dispensation of the APA's prior notice and comment requirements. To the contrary, there was no good cause to issue the MHPAEA regulations as interim final rules. The preamble to the IFR states that "These rules are being adopted on an interim final basis because the Secretaries have determined that without prompt guidance some members of the regulated community may not know what steps to take to comply with the requirements of MHPAEA, which may result in an adverse impact on participants and beneficiaries with regard to their health benefits under group health plans and the protections provided under MHPAEA. Moreover, MHPAEA's requirements will affect the regulated community in the immediate future." 75 Fed. Reg. 5419. Quite the opposite, plans were required to comply with MHPAEA for new benefit plans and renewals after October 3, 2009, meaning that most plans have already taken steps to comply with MPHAEA for their 2010 plan year, and those good faith compliance efforts were successfully undertaken without any confusion and without the aid of any prompt guidance from the Departments. Therefore, the notice and public procedure thereon required by the APA were neither impracticable, nor unnecessary, nor contrary to the public interest - - the hallmarks of the good cause exception. We urge you to follow your legal obligations under the APA, withdraw the IFR, issue new proposed regulations based upon the comments submitted on the IFR, and then carefully consider the comments received in response to the proposed regulation before promulgating a final regulation. We also ask that you allow for at least a one year time period for compliance from the effective date of the final regulations to allow adequate time to make changes to benefit structures, obtain state regulatory approval where required, and to make necessary information technology changes.

PREAMBLE

The Regulations should not Address Scope of Services.

The Departments note that the IFR does not address the scope of services issue and invite comments on whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage. 75 Fed. Reg. 5416 and 5417 (Feb. 2, 2010). While MHPAEA does include a reference to "limits on the scope … of treatment" in the definition of "treatment limitations" [discussed further below on pages 7-8], MHPAEA contains

no mention of a mandate to extend the scope of services covered by group health plans, a concept sufficiently momentous that it would have been expressly stated by Congress if intended. Instead, it is clear from express language in both the statutory language and the legislative history that Congress intended plans to have full discretion to define which mental health or substance abuse benefits they will cover, if any, and that there is no federal mandate to provide any mental health or substance abuse benefit. Mandating coverage for specific disorders or treatments through a regulation would clearly exceed the Departments' regulatory authority since such a mandate is not contemplated in the statute.

To the contrary, MHPAEA is quite explicit that the parity requirements are limited in their reach and extent. As codified, together with the 1996 Mental Health Parity Act, the statute explicitly prohibits construing anything in the combined parity law "as affecting the terms and conditions of the plan or coverage relating to [mental health and substance abuse benefits] under the plan or coverage, except as provided in subsection (a)."[1] This language unequivocally precludes transforming the limited statutory requirements for parity into mandates to cover specific treatments or treatment settings. The only terms and conditions affected by MHPAEA are those set forth in subsection (a): financial requirements [(a)(3)(A)(i)], treatment limitations[(a)(3)(A)(ii)], and coverage of out-of-network providers [(a)(5)].

The legislative history for MHPAEA, as reflected in the 2007 Senate Committee Report on the bill that became MHPAEA, makes clear that MHPAEA does not establish a mandate for coverage of particular behavioral health treatments or treatment settings. This report expressly disclaims such a mandate in the following statement: "The provision would apply to benefits for any mental health condition that is covered under the group health plan. The bill would not require plans to offer mental health benefits, *nor would it require that those plans cover all types of mental health services or ailments if the plan covered any mental health services or ailments*." (Sen. Rep. No. 110-53, 110th Cong., 1st Session (2007) at p. 7)(emphasis added).

Moreover, most plans subject to state insurance laws already are obligated by state law to cover a minimum scope of services. Full or limited mental health and/or substance use disorder mandated benefit laws exist in 45 states and the District of Columbia. These state mandates, which outline the diagnosis and coverage expectations for insured plans operating from the particular state, remain in effect and serve to work with MHPAEA to set out the requirements for plans operating in the various states.

Given the absence of authority for the Departments to establish mandates and the existence of relevant state mandates, promulgation of mandates related to scope of services is neither appropriate nor necessary.

The Departments Significantly Underestimated the Costs Associated with Implementing the IFR.

The cost estimates discussed in the IFR are seriously flawed in many ways. The Departments themselves tout the practices of MBHOs and expressly rely on the ability of MBHOs to contain costs under the new parity requirements:

[1] Codified at 26 U.S.C. §9812 ; 29 U.S.C. §1185a (b)(2); 42 U.S.C. §300gg-5(b)(2).

"Since the early 1990s, many health insurers and employers have made use of specialized vendors known as behavioral health carve-outs to manage their mental health and substance abuse benefits. They use information technology, clinical algorithms and selective contracts to control spending on mental health and substance abuse treatment. There is an extensive literature that has examined costs savings and impacts on quality of these organizations. Researchers have reviewed this literature and estimated reductions in private insurance spending at 20%-48% compared to fee-for-service indemnity arrangements." 75 Fed. Reg. 5422 (Feb. 2, 2010).

"The OPM encouraged its insurers to consider carve-out arrangements when implementing the parity directive in 2000 for the FEHBP. This is because of the ability of behavioral health carve-outs to use utilization management tools to control utilization and spending in the face of reductions in cost-sharing and elimination of limits. Thus, parity in a world dominated by behavioral carve-outs has meant increased utilization rates, reduced provider fees, reduced rates of hospitalization and fewer very long episodes of outpatient care. Intensive treatment was more closely aligned with higher levels of severity." *Id.*

The cost estimates presented in the IFR are based primarily on the experiences of the FEHBP and of some insured plans in states with parity mandates. This reliance is flawed if the IFR provision regarding so-called nonquantitative treatment limitations restricts our ability to manage behavioral health benefits, because the FEHBP was a managed plan for which benefit management techniques were used and none of the state laws limit or prohibit management of behavioral health benefits. Neither, therefore, is a good indicator of additional claims costs plans will experience in connection with unmanaged benefits in the face of the nonquantitative treatment limitations section of the IFR.

Even the parity advocates pointed to utilization management as a mitigating factor regarding the anticipated costs of parity: "Parity advocates, however, insist that most of these predictions are way out-of-date, based on parity's impact on indemnity plans that had little control over spending. Now with managed care, they say, cost increases will be nonexistent or minimal. They claim that all the evidence thus far points to a conclusion that parity barely increases overall costs and possibly even lowers them -- and almost certainly lowers them if one factors in the indirect savings to employers from reduced absenteeism and higher productivity as workers who had mental or substance abuse problems return to work sooner in improved health" (Mental Health Parity What Can It Accomplish in a Market Dominated by Managed Care?, Alan L. Otten, June 1998) More succinctly, according to Roland Sturm, a prominent researcher at the Rand-UCLA Research Center on Managed Care for Psychiatric Disorders quoted in the Otten article, "[i]f you want parity and are willing to take managed care, costs are not going to go through the roof. … If you stick with fee-for-service, no managed care, they will."

With the creation of the nonquantitative treatment limitations category, some of the very benefit management practices that the Departments praise in the IFR preamble are in jeopardy. The impact of the IFR on utilization management techniques is unclear. Because utilization management techniques for medical/surgical and behavioral health treatments differ significantly, an "apples to apples" comparison is not possible; some interpretations of the IFR therefore conclude that the IFR effectively prohibits all management of behavioral health benefits. Without effective utilization management techniques, costs will increase.

The cost estimates also do not take into account the impact of restrictions on other practices deemed by the Departments to be nonquantitative treatment limitations, such as formulary design

for prescription drugs and provider reimbursement rates. For example, any required changes to provider reimbursement will obviously have a significant cost impact for plans as well as for consumers who pay coinsurance based on those reimbursement rates and resulting premiums increases. Alteration of the methods by which plans apply the techniques included as nonquantitative treatment limitations under the IFR were not contemplated in the cost studies relied upon by the Departments; however, such alteration will have a very real impact on costs.

The cost studies are further uninstructive in other areas. Notably, parity requirements were applied only to in-network benefits under the FEHBP. According to a report by the U.S. Department of Health and Human Services, "while all plans complied with the parity policy for services offered by in-network providers, *no plan* extended parity to care delivered by out-of-network providers." *Evaluation of Parity in the Federal Employees Health Benefits (FEHB) Program: Final Report* (2004) (emphasis added.). A number of the state parity mandates also permit plans to limit benefits to in-network providers. For plans subject to the IFR, it is the out-of-network benefit that presents the greatest risk for runaway costs. Yet, that risk was not measured in the studies relied upon by the Departments. Finally, as the Departments acknowledge, few of the state parity laws mandate as extensive coverage as MHPAEA. *Id.*, footnote 15.

Overall, neither the parity measures applied to the FEHBP nor parity requirements under state laws is comparable to the parity standards required under the IFR; therefore, the cost impact results from these studies have little useful or predictive value for the probable cost impacts that plans will experience by implementing the IFR requirements, particularly surrounding nonquantitative treatment limitations.

The Departments' Estimates of Legal Costs Associated with IFR Compliance are a Minor Fraction of the Real Costs.

The Departments seriously underestimate the legal costs associated with compliance: "The Departments assume that the average burden per plan will be one-half hour of a legal professional's time at an hourly labor rate of $120 to conduct the compliance review and make the needed changes to the plan and related documents. This results in a total cost of $27.8 million in the first year. The Departments welcome public comments on this estimate." 75 Fed. Reg. 5426. This estimate is woefully inadequate, with regard to the estimates of both fees and hours. We believe the actual internal and external legal costs will be exponentially higher. To-date we have spent hundreds of hours of attorney time in addressing the IFR, and we are far from done with the legal work that will be necessary as part of our implementation efforts. In addition, attorneys for our customer health plans and employer groups have also spent many hours, with the number varying depending on the complexity of their benefit plan(s). The analysis is not complete, so the hours will continue to add up. It seems that the Departments assume that this review will be conducted by the plans' internal counsel. This is likely true for larger plans, although even those plans may seek outside legal advice on some of the ambiguous issues. Even when this legal work is handled in-house, the compliance activities will take a significant number of hours to complete, creating a strain on the company's legal resources.

Many of the employer plans do not have internal, employed attorneys on staff to assist with this. Those plans are using outside law firms to advise them on the necessary changes to their benefit plans. These plans will pay rates much higher than the $120 per hour referenced in the IFR and will require much more than just one-half hour of attorney time. In our experience, typical law firm fees

range from $185 to over $700 an hour per attorney, depending on the firm and geographic region and experience of the attorney; we have yet to find a firm with a rate as low as $120 per hour for attorney time. Employment and benefits law is very specialized and these firms tend to be at the higher end of the range for fees. A firm that we use as external employment and benefits counsel has a range of $360 an hour for junior associates to $725 an hour for partners. Given the complexity of these regulations and the ambiguity in some of the language, legal analysis and advice is needed on much of the regulatory requirements.

MEANING OF TERMS

The IFR Inappropriately Expands the Definitions of "Mental Health Benefits" and "Substance Use Disorder Benefits."

The MHPAEA statute vests in plans full discretion to define mental health benefits and substance abuse benefits so long as plan definitions comply with applicable law: MHPAEA defines "mental health benefits" as "benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law" and "substance use disorder benefits" as "benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State Law." But, the IFR hampers and constrains the plan discretion granted by Congress by appending additional external referents for defining what constitutes a mental health condition: "Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines)." Similar language referencing the DSM, ICD and state guidelines appears in the substance use disorder definition as well. These additional criteria go beyond the terms of the MHPAEA statute and are contrary to Congress' intent. The Senate explicitly rejected requiring plan definitions to conform to the DSM when it rejected the language in HR 1424 that would have required coverage for all DSM conditions.

Also, the addition of the references to DSM and ICD is causing confusion with regard to how some disorders are classified because some disorders in the DSM have purely medical treatments associated with them, such as detoxification related to acute substance use, medical sequelae of eating disorders, and medical complications of psychotropic drug use, etc.

Autism coverage is an ICD/DSM diagnosis that illustrates the confusion caused by tying the definition of "mental health benefit" to the DSM and ICD. Children with autism generally receive medical services, such as neurological examinations, speech therapy, and occupational therapy, as well as behavioral health treatments. If a plan covers these medical services, is the plan then required to provide the behavioral health coverage for this condition? This is unclear under the IFR. Further complicating the issue, some states specifically define autism as a medical condition. For example, the District of Columbia mandate for insured plans to provide coverage for habilitative services for children with birth defects under the age of 21 includes autism as a birth defect. D.C. Code § 31-3271. The habilitative services that plans are required to cover are "services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function." It is difficult to conceive that a state mandate to provide what are traditionally physical health services could now be construed to also require coverage of mental health services simply because autism is a DSM diagnosis. Discussions

by plans of a bill currently pending before the D.C. legislature to add a mandate to cover applied behavior analysis (ABA) for autistic children up to $25,000 annually reflect considerable uncertainty about the legality of the dollar cap on ABA services due to the ambiguity caused by including the DSM and ICD in the IFR definition of "mental health benefits." In addition to the District of Columbia, at least 13 other states have bills pending that contain dollar caps for either ABA services or autism coverage as a whole. These states have not addressed the application of federal parity to these caps when conducting their cost analyses and leave plans without clear direction.

In these cases where state guidelines and DSM are in conflict, the IFR gives no indication which should prevail for the handling of these benefits. In addition, a number of the existing state mandates are only for ABA type services; these services are more analogous to medical/surgical services like physical therapy or occupational therapy than traditional mental health services. Some states seem to be trying to define ABA as a medical type service in their definitions, presumably in order to preserve dollar caps for this service. Because costs for ABA services can quickly add up, these states seek to balance mandating some ABA services against keeping health plan premium costs at a reasonable level for other plan members. As it stands today, the impact of the IFR on these mandates is uncertain and the interpretation by state regulators may vary state by state.

We recommend that the Departments withdraw the DSM and ICD references in the meanings given to "mental health benefits" and "substance use disorder benefits." While we appreciate the Departments' interest in preventing plans from arbitrarily recharacterizing benefits to be "medical" in order to avoid having to satisfy parity requirements, the approach chosen by the Departments is overly prescriptive and creates confusion. We believe that the Departments' objective can be met by simply holding plans to the concept of reasonableness in defining what is and is not a behavioral health benefit.

The IFR Inappropriately Expands the Definition of "Treatment Limitations."

The MHPAEA definition of "treatment limitations" is: "Treatment limitation – 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." 29 USCS § 1185a (a)(3)(B)(iii). The IFR appropriately clarifies this definition by adding "days in a waiting period" as an additional example but then goes on to arbitrarily expand the statutory definition to incorporate an entirely new concept – nonquantitative treatment limitations, which are in stark contrast to "quantitative treatment limitations that are expressed numerically," and "otherwise limit the scope or duration of benefits for treatment under a plan."

By inventing this new concept of nonquantitative treatment limitations, the definition of "treatment limitations" used by the Departments now goes well beyond the scope of the language or intent of MHPAEA. The MHPAEA definition does not merely reference *other* limits on the scope or duration of treatment; if it did, the IFR's amplification to include non-numerical issues might have some merit. But the statute did not stop with "other;" the definition referenced "other *similar* limits on the scope or duration of treatment." By use of the term "similar," Congress clearly intended to address only certain kinds of treatment limitations; namely, those that are similar to the limits itemized in the statutory definition. All of the limitations named in the statutory definition are indisputably numerical, quantitative limitations; the only limitations that can reasonably be considered similar are other numerical, quantitative limitations. Even if the "illustrative list" of processes and practices the IFR lumps together to try to explain its concept of "non-quantitative

treatment limitations" could legitimately be considered to be treatment limitations – which, as discussed below, we dispute -- these processes and practices clearly bear no resemblance at all to the limitations identified in the statutory definition; by definition, they are not numerical.

Although the Departments clearly recognize the numerical nature of the treatment limitations listed in the statutory definition, they disregard the framework of the statutory definition and fabricate an entirely new definition. The Departments do not have discretion to simply disregard Congress' intentional use of the word "similar." The purpose of regulations is to clarify statutes, not to create entirely new legal requirements. MHPAEA does not require elimination of any and all plan features and practices that may incidentally result in non-coverage of particular services. MHPAEA is quite specific in the types of changes required to bring behavioral health benefits into parity with medical/surgical benefits. There is nothing at all in the legislative history or language of MHPAEA that contemplates any treatment limitations other than numerical treatment limitations. This concept was not included in or contemplated in the cost analysis performed by the Departments. Moreover, the behavioral health community had no opportunity to comment on this concept due to the promulgation of this regulation as an interim final rule. We urge you to remove all references to nonquantitative treatment limitations in the IFR.

The IFR's Establishment of Benefit Classifications is Overly Prescriptive and Results in Inappropriately in Mandating Benefits.

The general parity requirement of paragraph (c)(2) of the IFR contains the basic mandate of MHPAEA regarding financial requirements and treatment limitations for behavioral health benefits being no more restrictive than those that meet the predominant/substantially all test for medical/surgical benefits, but introduces the concept of "classifications" to apply the parity requirement. While this approach would seem to be sensible and more rational than comparing financial requirements and treatment levels across all levels and types of care, the particular classifications selected and their ramifications for plan design are problematic.

MHPAEA does not include any prescribed benefit classification scheme within which parity requirements must be satisfied. Instead, recognizing that there are not always common characteristics between medical/surgical treatments and behavioral health treatments, Congress left the determination of these issues to plans. While initial drafts of the House bill did contain proposed benefit classifications, Congress ultimately rejected this approach as unnecessary. Indeed, the committee report on the Senate bill that ultimately led to MHPAEA expressly declared that plans would not be deprived of discretion in this regard by the parity law:

> This section does not prohibit health plans from:
>
> 1. negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits or
> 2. managing the provision of mental benefits in order to provide medically necessary treatments under the plan (as a means to contain costs and monitor and improve the quality of care) or
> 3. *taking into consideration similar treatment settings or similar treatments when applying the provisions of this section***.**
>
> Sen. Rep. No. 110-53, 110th Cong., 1st Session, Part VII, Section-by-Section Analysis, Section 2 (2007) (emphasis added).

Allowing plans discretion to determine which treatments and treatment settings are sufficiently similar to permit rational comparisons for purposes of satisfying the parity requirements, rather than

mandating review within narrow mandated benefit classifications, better aligns the MHPAEA parity objectives with the real-world treatment environments that patients encounter.

The Departments' arbitrary creation of six discrete benefit classifications into which every single possible treatment or treatment setting must fit has not only exceeded the parameters of MHPAEA but has created surprise and confusion for plans. There are many behavioral treatments that simply do not fit any of the six classifications prescribed by the IFR. For example, behavioral health residential treatment care does not involve the same level of medical specialty, intensity of care, or costs as either inpatient hospitalization or outpatient visits, so why must this type of treatment be forced into one of these classifications for purposes of parity? A better match for residential treatment would be to medical treatment at skilled nursing facilities; indeed, some plans have in the past covered residential treatment facilities as a type of skilled nursing facility. With the classifications dictated by the IFR, such a benefit design – which in no way discriminated against behavioral health benefits – is no longer possible. Similarly, administration of electroconvulsive therapy (ECT) or a psychological test such as the MMPI does not require the same level of medical specialty, intensity of care, or costs as PCP visits – which are usually the most common outpatient care -- so why must these behavioral health services be considered outpatient care for purposes of parity? In the example of ECT this procedure is more analogous to outpatient surgery. For ECT the patient is not permitted to eat/drink prior to the procedure. Anesthesia medication is applied via an IV catheter inserted into a vein. A muscle relaxant is also given. Electrodes monitor the patient heart (EKG), brain waves (EEG – electroencephalogram), and muscle movement in the foot (EMG – electromyelogram). Patient receives oxygen via a mask. After the ECT treatment the patient is closely monitored by nurses in a recovery room for approximately 45 minutes following the procedure. The whole process is very much like most outpatient surgery procedures. While the plans may impose financial requirements or treatment limitations on the medical/surgical outpatient procedures, plans are prevented from doing so for the behavioral health services since the entire outpatient category must be considered as a whole and the 'substantially all' and 'predominant' tests do not permit exceptions for these types of services. The Departments even acknowledge that it is not possible to fit all behavioral health treatments into the medical model: "The Departments recognize that not all treatments or treatment settings for mental health conditions or substance use disorders correspond to those for medical/surgical conditions." 75 FR 5416. Yet, rather than allowing plans to identify common features to perform rational comparisons of similar, corresponding treatments, the Departments have burdened plans with the obligation to selectively assign all treatments and treatment settings to six arbitrary and incomplete categories that do not adequately address the types of behavioral health care that patients need.

Furthermore, the inclusion of prescription drugs as one of the six mandated classifications was completely unanticipated and goes well beyond the focus and intent of MHPAEA. MHPAEA makes no mention or consideration at all of prescription benefits. Not only do the Departments exceed their authority in creating this classification, but their creation of a prescription drugs classification as a subset of both medical/surgical and behavioral health benefits unnecessarily distorts benefit plan design. Prescription drug benefits are almost universally administered by plans completely separate from either medical/surgical benefits or behavioral health benefits. Rather than comprising a classification within medical/surgical and behavioral health benefits, prescription drug coverage is a totally separate set of benefits alongside and on par with both medical/surgical and behavioral health benefits. Requiring plans to realign their benefit design in this fashion without any prior hint of concerns of inequality related to prescription benefits and no legislative history indicating that Congress wished to address this area is especially inappropriate considering the lack

of notice and opportunity to be heard by the affected industry, the provider community, or the advocates. In addition, adding prescription drugs as a classification that plans must take into account in plan design creates yet another set of costs that were not included in the studies on which the Departments rely for the analysis of parity costs.

Our most serious concern with the impact of the six classifications is the IFR's application of the classification concept to create, silently, a benefit mandate, wholly contrary to the purpose and intent of MHPAEA. Paragraph (c)(2)(ii)(A) requires a plan that provides mental health or substance abuse benefits in any classification to provide mental health or substance abuse benefits "in every classification in which medical/surgical benefits are provided." The federal mental health parity statutes as amended by the MHPAEA explicitly disclaim any mandate for coverage of any mental health or substance abuse benefit:

> "Nothing in this section shall be construed—
> (1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide *any* mental health or substance use disorder benefits" (emphasis added). 29 USC 1185a(b).

But the language of the IFR does just that. An employer with limited resources that wishes to provide at least a minimum level of behavioral health benefits, such as outpatient care, is likely to drop all behavioral health coverage if providing coverage in one classification triggers a requirement to cover all classifications. And, because of the inclusion of prescription drugs as a classification, the mandate goes even further. If a patient's PCP prescribes an anti-depressant and the patient uses plan benefits to obtain the medication, the plan will be deemed to be providing a behavioral health benefit in one of the classifications and therefore will be required to provide benefits in <u>all</u> classifications, even though the plan design contemplated no coverage for behavioral health treatments and even if the PCP prescribed the medication for a condition other than a behavioral health condition, for example, as an aid for sleeping. Plans that currently choose not to cover behavioral health benefits may go even further and drop coverage of behavioral health medications as well. Neither of the results described here would be good for behavioral health patients.

Finally, the consequences of requiring all plan benefits to be placed into one of the six classifications listed in the IFR coupled with the ramifications of the "substantially all" test could be construed as actually creating the opposite of parity. As stated in the IFR's preamble: If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of the medical surgical benefits in a classification, that type of requirement or limitation cannot be applied to mental health or substance use disorder benefits in that classification. 75 FR 5414. This requirement allows for flexibility in the benefit construction for the medical/surgical benefits but not for behavioral health benefits. Even if a particular treatment setting (for example, Residential Treatment Center) within a classification of mental health benefits (here, inpatient, out-of-network) has the exact same financial requirements and treatment limitations as a rationally comparable treatment (in this case, Skilled Nursing Facility) within that same classification for medical/surgical benefits, a plan may still be in violation of the IFR. This is not parity; this is mandated enrichment of behavioral health benefits, which was neither the intent nor the purpose of MHPAEA.

FINANCIAL REQUIREMENTS

The Regulations should Not Prohibit Separate Cumulative Financial Requirements and Treatment Limitations.

The Departments' prohibition of separate cumulative financial requirements and treatment limitations for medical/surgical and behavioral health benefits is a requirement found nowhere in MHPAEA and, further, is contrary to the express language in MHPAEA. After barring more restrictive financial requirements for behavioral health, 29 USC §1185a(a)(3)(A)(i) proscribes "separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits." Parallel language in §1185a(a)(3)(A)(ii) applies to treatment limitations.

Scrutiny of the statutory language reveals the Departments' interpretation to be ill-conceived. If cumulative financial requirements and treatment limitations were intended to be shared, there would be no reason to compare such financial requirements and treatment limitations as applied to behavioral health benefits to such financial requirements and treatment limitations as applied to medical/surgical benefits. Indeed, no comparison is possible with a single, shared benefit term. The "no more restrictive" language would be meaningless unless MHPAEA allowed for financial requirements that were separately applied to behavioral health benefits; if separate requirements are not permitted at all, then there is no basis or need to make them "no more restrictive." Moreover, if the statute were intended to prohibit separate but equal (or lower) cumulative financial requirements, the use of the word "only" in the second phrase in each of the provisions would be meaningless. If Congress had intended to foreclose separate but equal (or lower) cumulative financial requirements, such as cost sharing requirements, MHPAEA would simply prohibit *all* separate cumulative requirements. Instead, MHPAEA prohibits separate financial requirements that are applicable *only* to behavioral health benefits.

The Departments should promulgate regulations that give full meaning to Congress' intent as reflected in statutory language. By ignoring the statutory language, the IFR inappropriately renders it meaningless.

Although the Departments do acknowledge that MHPAEA does not prohibit separately accumulating financial requirements and treatment limitations for medical/surgical and behavioral health benefits, IFR paragraph (c)(3)(v) explicitly prohibits separate accumulation, based on the Departments' mistaken assumption that combined accumulation works to the best interest of behavioral health patients. Plans with cumulative financial requirements and treatment limitations now must apply such financial requirements and treatment limitations on a single, combined basis. As a result of the new shared accumulator requirement, MBHOs are faced with the task of developing and implementing IT solutions to permit the wholly separate and distinct claims systems of MBHOs and the medical benefit administrators for each impacted group health plan to interface electronically with each other every single time a claim for either medical/surgical or behavioral health treatment provided to a group health plan member is received so that the MBHO and the medical benefit administrators can each properly apply claims activity to member deductibles, out-of-pocket maximums, and any day or session limits. This has a similar impact on health plans that maintain separate IT systems for their behavioral health and medical/surgical benefits. While seemingly straightforward in concept, the task of requiring multiple different claims systems to "talk to each other" on anything resembling a real-time basis is a task of monumental proportion. The

resulting unnecessary administrative burdens will lead to corresponding cost increases for plans that will undoubtedly be passed on to consumers as premium increases. For example, the medical benefit administrator for one Magellan customer provided the customer an estimate of $400,000 just to establish the required bi-directional accumulator feeds.

The IFR prohibits separate deductibles and out-of-pocket maximums even when the separate behavioral health deductibles and out-of-pocket maximums would be more favorable for plan members. While comorbidity of medical/surgical and behavioral health conditions certainly occurs, it is more common for persons with behavioral health conditions to be "medically healthy." For "medically healthy" individuals, the unified deductible acts as a barrier because the single, combined deductible inevitably will be higher than the stand-alone behavioral health deductible, which in most group health plans is currently much lower than the medical deductible. For "medical healthy" members, the barrier to accessing behavioral health treatment under a single deductible will be higher than the barrier arising from a separate deductible. The combined and, in most cases, higher single deductible for behavioral health and medical/surgical treatments will act as a disincentive for lower income plan members in accessing behavioral health benefits. Similarly, a separate, low out-of-pocket maximum would offer better protection against catastrophic treatment costs to "medically healthy" persons with behavioral health conditions than a single, higher out-of-pocket maximum.

Given the significant costs that plans will expend as a result of the requirement to implement and maintain bi-directional communication with medical benefit administrators, the advantages of separate cumulative financial requirements for medically healthy members, and the statutory support in MHPAEA for allowing separate cumulative requirements, we urge the Departments to reconsider their decision to require combined cumulative requirements and to allow plans flexibility to determine which option to apply based on applicable circumstances.

Clarification of the Kinds of Data Plans may use to Conduct Calculations Prescribed by the IFR is Needed.

In the test prescribed in paragraph (c)(3)(i)(C) of the IFR for determining "substantially all" and "predominant," each plan must perform calculations 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 (or for the portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation." The IFR does not delineate how plans should identify the "dollar amount of … plan payments … expected to be paid;" instead, it allows plans discretion to use "any reasonable method" to do so. IFR paragraph (c)(3)(i)(E).

While we welcome the Departments' approach in allowing plans to exercise discretion, the absence of greater direction in this regard is unfortunately causing confusion regarding the type of data that plans may use for these calculations. We are aware that some health insurers and benefit administrators are simply plugging in aggregate claims data across their book of business for all medical benefits they manage; the resulting conclusions regarding predominant types and levels of financial requirements and treatment limitations applicable to substantially all medical/surgical benefits are based on prevalence across plans, as opposed to prevalence within any particular plan. Others are relying on actuarial methods, using even broader data sources, to project the dollar amounts reasonably expected. Still others are engaged in painstakingly investigating and scrutinizing plan-specific claims data to figure out for each specific plan which financial requirements and

treatment limitations can be applied to behavioral health benefits. Although we believe that each of these methods should be considered reasonable, it is not clear which of these methods the Departments would accept as reasonable and therefore permitted by the IFR.

The source of data permitted by the IFR has a direct, profound impact on the burdensomeness of the required calculations, as described below in these comments. The more specific the data, the more time and effort will be required in performing the calculations.

To dispel the confusion and reduce the burdensomeness of the calculations, we recommend that the Departments retain the plan discretion allotted in paragraph c)(3)(i)(E), but clarify that "any reasonable method" may include actual historical plan-specific claim cost distributions, aggregate expected distribution of claim costs, or any other method reasonably calculated to project expected claims dollars and that the method is not required to be plan-specific.

The Calculation Methodology Prescribed by the IFR, including Plan-to-Plan Analysis, is Overly Complicated and Burdensome.

Paragraph (e) states that the parity requirements must be satisfied separately with respect to each separate combination of benefits that a beneficiary can simultaneously receive. This requirement is overly complicated and burdensome, and the complication is only intensified by the required parity tests established by the IFR in paragraph (c).

Few employers offer only one set of health benefits to their employees, with no opportunity for choice. Instead, most employers provide multiple medical/surgical benefit plan selections (ranging from two to as many as 72, or in some cases even more) and one or more behavioral health benefit plan options. There are numerous different financial requirements and treatment limitations applicable to each of the possible medical/surgical benefit plan choices. For such employers, and the managed care organizations that support them, conducting the tests prescribed in paragraphs (c)(3(i)(A) and (B) for every single medical/surgical benefit package offered by the plan will be extremely burdensome. The burden is further compounded by the sheer multiplicity of benefit choices that employees can make, effectively resulting in hundreds, if not thousands, of individualized benefit plan permutations that must be analyzed for compliance with the parity requirements in the IFR. For example, in order for a plan that offers 72 medical/surgical options to determine the permissible financial requirements, the plan must determine "substantially all" for each of the 72 plans in each of the six classifications, resulting in 432 sets of calculations just to determine "substantially all" for all of the plan options. In addition, if there are different levels for the financial requirements and treatment limitations applicable to substantially all medical/surgical benefits, the plan then must determine which level is predominant for each plan option, raising the number of calculations required to 864. This is an absurd administrative burden that provides no value to the consumer. In a technical advisory meeting in February, the Departments indicated that they did not intend for plans to spend considerable time on administrative tasks, however the current language in the IFR requires just that. Following are descriptions of the enormous challenges involved in marshalling and conducting the analyses for the tests prescribed by the IFR.

Quantitative Tests

Unless plans are permitted to utilize some form of aggregate data, as discussed above, just the initial step of obtaining the data required to conduct the tests will prove a substantial challenge for most employers. Doing so will require culling cost data on thousands of claims from multiple claim

administrators whose claims systems are not configured to report data based on the prescribed classifications and the discrete types of financial requirements and treatment limitations set forth in the IFR, and that may not even have cost data relating to all benefits chosen by each employee. Depending on the extent of managed care carve-outs utilized by an employer, there may be separate claims administrators for radiology benefits, for certain oncology benefits, and for sleep management benefits, in addition to the administrators for all other types of medical/surgical claims. In addition, the ability of the various claim administrators to furnish the data on a timely basis will be significantly impaired by the avalanche of simultaneous requests for similar data by each of their customers subject to the IFR, outside normal business processes, for purposes of parity compliance. Further, parity compliance must now compete for attention with even greater compliance issues arising from passage of the federal health care reform law (the Patient Protection and Affordable Care Act).

Once the data is obtained, the employer must then engage in the mathematical exercises prescribed by the IFR for each separate combination of medical/surgical and behavioral health benefits. Differences among the plan packages in classifying certain services as inpatient or outpatient will complicate the analyses. This requires a significant upfront investment from the health plans and other medical benefit administrators to extract claims data at the benefit category level because, as noted above, claim history is not currently stored at such a detailed level. Each plan design requires manual work (the work is not automatable given the unique medical/surgical benefit designs that are different for each plan especially, at the large group level where plans customize designs) to do the allocations and complete the "substantially all" and "predominant" tests. This contrasts with a common-sense approach that would have plans compare the financial requirements between the medical/surgical benefits and the behavioral health benefits and make a rational and thoughtful judgment about which financial requirements are used substantially all of the time and what levels are predominant.

The Departments suggest in the preamble that employers can minimize some of the complexity by avoiding the "predominant" test and simply defaulting to the richest benefit option for each financial requirement or treatment limitation that meets the "substantially all" test. 75 Fed. Reg. 5414. This is an option that is guaranteed to result in higher benefit costs for the employer – not an attractive option at any time and not at all acceptable in the face of parity-enriched behavioral health benefits with unpredictable cost impacts and a shaky economy with an uncertain future.

"Substantially all" and "predominant" are elastic concepts; if Congress had wanted to specify percents and measurements, it could have easily done so. The regulations should allow similar flexibility and permit plans to adopt a reasonable measurement to ensure substantial parity between like medical/surgical and behavioral health benefits rather than impose the onerous, time-consuming analysis prescribed in paragraph (c)(3)(i) and the micro-managing plan-by-plan requirement prescribed in (e)(1). At a minimum, we recommend that the Departments give plans a choice to utilize the methodology set forth in (c)(3)(i) or, for outpatient benefits, to simply latch behavioral health financial requirements and treatment limitations onto the financial requirements and treatment limitations applicable to PCP services. Absent these changes, we request that the regulations clarify that in using "any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefit," actual historical actual plan-specific claim cost distributions need not necessarily be used if an alternate, aggregate expected distribution of claim costs is reasonable.

Non-Quantitative Tests

The complexity of separate plan-to-plan analysis for the quantitative tests is daunting, but ultimately achievable; the complexity of plan-to-plan analysis in connection with the IFR's newly-introduced category of non-quantitative treatment limitations poses exponentially greater challenges, making achievement of the analyses impracticable. As discussed in more detail later on page 21 of these comments, due to the ambiguous and unfounded nature of the IFR's conceptualization of non-quantitative "treatment limitations," which seriously impairs any ability to analyze them, plans face almost insurmountable obstacles to assembling the relevant information regarding the various terms and conditions that the IFR has dubbed non-quantitative treatment limitations.

Gathering information regarding the existence of "comparable restrictions" applied to medical/surgical benefits in connection with the array of non-quantitative treatment limitations specifically identified in paragraph (c)(4) as well as any unnamed other non-quantitative treatment limitations yields similar challenges to those encountered in assembling data for the quantitative tests from multiple medical/surgical plans and their vendors already overburdened with parity compliance data requests. But, while comparability may be facially apparent for some non-quantitative treatment limitations applied to medical/surgical and behavioral health benefits, for many others, subjective judgment is needed to even hazard a guess as to whether the "restrictions" are comparable. Reaching a conclusion limited to the issue of comparability is likely to require person-to-person communication and discussion on each and every process, strategy, evidentiary standard, and other factor used in applying any particular nonquantitative treatment limitation. Evaluation of the relative stringency of application of a non-quantitative treatment limitation, along with the embedded "processes, strategies, evidentiary standards, or other factors used in applying" it, that is eventually determined to be comparable requires additional consultation between the MBHO and the medical/surgical benefit administrator. This examination must repeatedly occur over and over with respect to each identified non-quantitative treatment limitation along with each associated process, strategy, evidentiary standard, and other factors for each set of medical/surgical benefits.

Even more challenging is the task of gathering information to identify rationales utilized in the administration of medical/surgical benefits to support non-quantitative treatment limitations that may be applied differently to behavioral health benefits. Over and above the administrative burden and serious difficulties encountered in securing information about comparability and stringency in application, obtaining information about the underlying rationales for medical/surgical benefit administration approaches is even more challenging because of a number of factors:

- Because of the significant differences between medical/surgical and behavioral health treatment and the management of benefits for such varying treatments, a common vocabulary or frame of reference does not always exist. Just explaining the nature of each inquiry requires considerable communication and interaction between the medical/surgical side and the behavioral health side.

- The non-quantitative treatment limitations relate to multiple facets of benefit administration; as a result, no one person affiliated with the MBHO is equipped to discuss all of the non-quantitative treatment limitations with the medical/surgical benefit administrators; likewise, no one person affiliated with the medical/surgical benefit administrator is equipped to discuss these issues with the MBHO. Multiple representatives from the medical/surgical benefit administrator and the MBHO must be involved. In some instances, the appropriate representative of the

medical/surgical benefit administrator is not readily apparent. Once identified, availability for discussion and review becomes yet another issue.

- Many "processes, strategies, evidentiary standards, or other factors" used in administering medical/surgical benefits have long histories, and those initially responsible for establishing the approaches of the medical/surgical benefit administrator are long departed from the company; identifying the rationales for applying -- or not applying -- the various non-quantitative treatment limitations to the various medical/surgical benefits is often simply not possible.

- Many "processes, strategies, evidentiary standards, or other factors" used in administering medical/surgical benefits involve trade secrets and other proprietary information that medical/surgical benefit administrators are unwilling to disclose, particularly to a competitor or potential competitor (e.g., provider contracting methodologies).

Assuming that all of the above obstacles can be overcome and that all of the desired information can be obtained, the information produced must be carefully examined to determine if there are rationales that support the use of non-quantitative treatment limitations, including the associated "processes, strategies, evidentiary standards, or other factors," for the plan's behavioral health benefits. Translating the gathered information and attempting to apply it to behavioral health benefits will require intensive clinical research and analysis.

Because of the separate plan-by-plan analysis required by paragraph (e)(1), this daunting exercise must be completed for each separate medical/surgical benefit plan option and the associated benefit administrators and, in some instances, their subcontractors as well. For example, one of Magellan's health plan customers has 60 rented medical/surgical provider networks, each of whose credentialing standards and reimbursement methodologies would require examination for comparability, stringency, and rationales. Doing a professional, thorough job in obtaining and processing the information necessary to assess compliance with the parity requirements applicable to non-quantitative treatment limitations would take years to complete.

Aside from the difficulty in obtaining the necessary information and determining the supportability of the various non-quantitative treatment limitations, the requisite plan-by-plan parity requirement compliance analysis is likely to yield different results for the different medical/surgical benefit packages and therefore require completely different practices for the behavioral health benefit package associated with each set of medical/surgical benefits. For example, preauthorization of behavioral health benefits may be permissible for medical/surgical benefit Option A but not Option B, while retrospective review is permissible for Options A and B but not Option C; or a specified reimbursement methodology is permissible to pay providers for behavioral health services furnished to members administered by medical/surgical benefit administrator X while the exact same providers must be paid under a completely different reimbursement methodology for behavioral health services furnished to members administered by medical/surgical benefit administrator Y. The resulting patchwork of benefits supplied in attempted compliance with the IFR's requirements for non-quantitative treatment limitations will inevitably lead to member, provider, and MBHO staff confusion.

To avoid overloading plans with administrative tasks and causing confusion for members, providers and plan personnel, we recommend that employers be permitted to satisfy MHPAEA by ensuring that their behavioral health benefits are no more restrictive than the predominant benefits applicable to substantially all medical/surgical benefits across all plans provided by the employer.

Guidance is needed for Identifying the Predominant Treatment Limitations and Financial Requirements when a Single Set of Behavioral Health Benefits is Offered with Multiple Medical/Surgical Options.

The Departments recognize in the preamble that an employer may offer numerous medical/surgical benefit packages that are paired with one single behavioral health benefit package. See, e.g., 75 Fed. Reg. 5418. While the preamble notes that the parity requirements must be satisfied with respect to each of the possible combinations of medical/surgical and behavioral health benefits, no guidance is offered as to how the parity requirements can be satisfied if the employer desires to continue providing a single behavioral health benefit option and the results of the "predominant" type and level analysis are different for each of the different medical/surgical benefit packages. For example, assume the analysis reveals that within a particular classification prescribed by the regulation, for medical/surgical Option A, a copayment of $25 is predominant, for Option B, a copayment of $30 is predominant, and for Option C, a coinsurance of 20% is predominant. While it is clear that the copayment for Option A is less restrictive than the copayment for Option B, it is not clear whether the Option A $25 copayment or the Option C 20% coinsurance is less restrictive and which therefore can, or should, be applied to the employer's single behavioral health benefit package. The IFR provides no guidance on how employers can resolve this dilemma.

Requiring employers with single behavioral health benefit packages to instead establish silos of behavioral health benefits to correspond to each of the different medical/surgical benefit options is not an acceptable alternative for some employers. Multiplying the number of behavioral health benefit designs would increase both the cost and the complexity of benefit administration, surely not a result intended or anticipated by the Departments. For example, both MCO and MBHO Customer Service Associates and Care Managers would need additional training and would have to take additional steps to assure that they are consulting the appropriate plan design before quoting eligibility to plan members and providers or making administrative or clinical benefit authorization determinations. The resulting complexity is likely to contribute to higher exposure for human error and longer handle time (both of which affect administrative fees charged to employers). MCOs and MBHOs would also face greater complexity in loading benefits into their claims systems and other computer systems. In addition, employers would need to add detailed information and communication about multiple behavioral health benefit designs in their summary plan descriptions.

In order to preserve the ability of employers to maintain a single set of behavioral health benefits when desired, along with multiple medical/surgical benefit options, we recommend that the IFR be modified to permit employers to:

(i) Utilize actuarial methods to determine which of the predominant levels and types of financial requirements or treatment limitations can be applied; and/or

(ii) Establish maximum quantitative limits for MHSA benefits by testing "substantially all" and "predominant" across an employer's entire population rather than for each specific plan an employee may elect.

The Methodology for Determining the Permissible Financial Requirements and Treatment Limitations should be More Flexible.

The methodology prescribed in paragraph (c)(3) for identifying permissible behavioral health financial requirements and quantitative treatment limitations cannot be employed universally. Rather than allow plans to simply determine if substantially all medical/surgical benefits are subject to a patient cost share and then identify the predominant medical/surgical cost share that can be applied to behavioral health benefits, the IFR creates a new standard – type of financial requirement or treatment limitation – as the unit on which comparisons must be based. By mandating use of this unit to analyze the prevalence of financial requirements and treatment limitations, the IFR creates seriously flawed results in some instances for plans that split the application of copayment and coinsurance to medical/surgical benefits, an increasingly common phenomenon.

While separate analyses for copayment and coinsurance may be appropriate measures in many plans, for some plans, the forced separate analyses create artificially small analytical units that skew the results so that neither copayment nor coinsurance can satisfy the "substantially all" test: If all medical/surgical benefits in a classification are subject to a patient cost share, but copayment and coinsurance are each applied to 50% of the medical/surgical benefits, neither copayment nor coinsurance can satisfy the "substantially all" threshold of 2/3 of the medical/surgical benefit. A plan with this kind of mix of financial requirements for medical/surgical benefits is precluded by the IFR from imposing either copayment or coinsurance to behavioral health benefits, even though *all* medical/surgical benefits require a patient cost share. As discussed above, employers that desire to pair a single uniform set of behavioral health benefits to multiple different medical/surgical benefit designs could encounter a similar anomalous result: if one medical/surgical benefit option applies only coinsurance to all medical/surgical benefits and another applies only copayment to all medical/surgical benefits, although each financial requirement meets the "substantially all" test relative to the individual medical/surgical plan package, neither copayment nor coinsurance can meet the "substantially all" test for both of the medical/surgical offerings paired with the behavioral health benefits. In picking either the copayment or coinsurance, the employer is compliant for the behavioral health benefits paired with the one relevant medical/surgical option but cannot then apply either copayment or coinsurance to behavioral health benefits paired with the other set of medical/surgical benefits. These kinds of anomalous results were not intended by MHPAEA. As noted in the preamble to the IFR[2], the overriding purpose of MHPAEA was to eliminate discrimination against behavioral health benefits. The purpose was not to give behavioral health patients a pass on sharing in the cost of care. We assume that such anomalous results were also not the intention of the Departments.

The history of MHPAEA evidences the legislative intent behind the parity requirement for financial requirements and treatment limitations in the House Energy and Commerce Committee Report that supports this. The report states that: "The purpose of H.R. 1424, the `Paul Wellstone Mental Health and Addiction Equity Act of 2007' is to have fairness and equity in the coverage of mental health and substance-related disorders vis-à-vis coverage for medical and surgical disorders. This bill expands the Mental Health Parity Act of 1996 (Public Law 104-204) by requiring group health plans that offer benefits for mental health and substance-related disorders to do so on similar terms as care for other medical and surgical diseases. The legislation ensures that plans do not charge higher

2 One of Congress' primary objectives in enacting MHPAEA was to improve access to mental health and substance use disorder benefits by eliminating discrimination that existed with respect to these benefits after MHPA 1996. 75 Fed. Reg. 5422 (Feb. 2, 2010).

copayments, coinsurance, deductibles, and impose maximum out-of-pocket limits and lower day and visit limits on mental health and addiction care than the plan has for medical and surgical benefits. After years of discriminatory practices in plan design, health plans will be required to offer parity in treatment of mental illness and medical illness or face penalties by the Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service." (H. Rep. 110-374, Part 3, 110th Cong., 2nd Session (2008)).

Given that the stated goal of Congress in enacting MHPAEA was to eliminate discrimination and barriers for behavioral health treatment, the parity analysis should focus on the burden to the patient rather than the label given to the financial requirement or treatment limitation (e.g., "copayment" vs. "coinsurance"). To cure the flaw in the methodology of the IFR, we recommend that the Departments give plans more flexibility to determine how to best identify substantially all and predominant financial requirements or treatment limitations by allowing plans discretion to:

- Make use of the concept of "type" where medical/surgical benefits have fairly homogenous financial requirements or treatment limitations. With respect to a plan with relatively homogenous patient cost share requirements, separate measurement of copayment and coinsurance will result in a fair picture of which requirement or limit (if either) applies to substantially all medical/surgical benefits; and/or
- Conduct combined analyses of like financial requirements (such as copayment and coinsurance) or treatment limitations to determine which, if any, affects substantially all medical/surgical benefits and is predominant and therefore may be applied to behavioral health benefits; and/or
- Apply the financial requirements and treatment limitations applicable to PCP services to outpatient behavioral health services, and/or;
- Apply the type of financial requirement or treatment limitation that imposes a burden on behavioral health patients that is substantially equivalent to or less restrictive than the burden imposed on medical/surgical patients in the same classification, based on actuarial data.

To give plans this type of flexibility, we recommend creation of a new paragraph (c)(3)(i)(C) substantially as follows:

> (C) Alternative Measurement of "Substantially All" and "Predominant"– (i) If two or more types of financial requirements or treatment limitations are significantly alike, such financial requirements or treatment limitations may be considered together for purposes of the determination described in paragraph (c)(3)(i)(A). Types of financial requirements or treatment limitations are considered significantly alike when they have a common purpose and similar impact on patients, for example, copayment and coinsurance. The plan may include all types of financial requirement or treatment limitation reviewed in making a determination in accordance with paragraph (c)(3)(i)(B) to determine the predominant level and type. The plan may apply a different type of financial requirement or treatment limitation to behavioral health benefits so long as the burden on patients as a result of the selected type of financial requirement or treatment limitation is substantially equivalent to the burden on patients resulting from the predominant medical/surgical financial requirement or treatment limitation; and/or
>
> (ii) Unless there is good reason to suspect that the financial requirements and quantitative treatment limitations applicable to primary care physicians (PCPs) are not the predominant

financial requirements and treatment limits applicable to substantially all medical/surgical benefits in accordance with the tests set forth in paragraphs (c)(3)(i)(A) and (B), the financial requirements and treatment limitations applicable to in-network and out-of-network PCPs may be applied to the corresponding in-network and out-of-network outpatient behavioral health benefits.

The Requirement for Annual Re-Calculation of "Substantially All" and "Predominant" should be Removed.

The methodology prescribed in IFR paragraph (c)(3) for identifying permitted behavioral health financial requirements and quantitative treatment limitations will result in instability in behavioral health benefit plan designs because the calculations are wholly dependent on the range and distribution of medical/surgical costs, which may vary from year to year, changing which financial requirements and treatment limitations apply to "substantially all" medical/surgical benefits and which is the "predominant" level. For example, if the administrator of medical/surgical benefits implements an increase in reimbursement to certain specialty providers that provide services subject to coinsurance, coinsurance at the level applied to those services may become predominant for a plan for which the analysis the previous year indicated a different level of coinsurance for behavioral health benefits or even resulted in applying copayment to behavioral health. Or, an epidemic or other phenomenon affecting utilization of medical/surgical treatment might cause a spike in certain treatments that result in changing the distribution of costs.

Because paragraph (c)(3)(i)(C) requires the analysis to be conducted for each plan year, behavioral health benefit schedules can end up flip-flopping from year to year, solely because of changes affecting medical/surgical benefits that may be outside the control of the plan sponsor or MBHO. Such changes will result in confusion to plan members and providers; possible uncertainty for MBHO staff responsible for advising members and providers; costs for plan sponsors to repeatedly modify plan documents and issue new summary plan descriptions or material modification summaries; and costs for MBHOs to repeatedly reconfigure computer systems and retrain staff.

Constant readjustment of behavioral health benefits was not intended by MHPAEA. MHPAEA was aimed at eliminating discrimination and creating equivalency, not in creating annual disruption of benefit plan designs. We are confident that these anomalous results were also not the intention of the Departments.

In addition to the instability of benefits, tying the calculations to a "plan year" so that the calculation exercise must be conducted annually creates an unreasonable burden on plans given the complexity of conducting the analyses, particularly where multiple medical/surgical benefit designs must be examined to identify the permitted behavioral health financial requirements and treatment limitations.

At minimum, we recommend that the IFR be modified to provide that the analyses required under paragraph (c)(3)(i) do not have to be repeated for any financial requirement or treatment limitation within a classification for so long as there are no plan design changes affecting the specific financial requirement or treatment limitation within the specific classification for either medical/surgical or behavioral health benefits, regardless of any shifts in costs from year to year.

NONQUANTITATIVE TREATMENT LIMITATIONS

The Parity Standard for Nonquantitative Treatment Limitations Needs Clarification.

The standard set out in the IFR for application of the parity requirements to nonquantitative treatment limitations is different than the standard set out in MHPAEA with regard to treatment limitations. The Departments did not have the authority to create a standard with respect to this supposed subset of treatment limitations that differs from the statutory standard for all treatment limitations. The statutory language requires plans to 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." 29 U.S.C.§1185a(a)(3). The general parity requirement set forth in paragraph (c)(2) of the IFR echoes the statute but goes on to indicate that the application of the requirement to nonquantitative treatment limitations is "addressed in paragraph (c)(4) of this section." The rule set forth in paragraph (c)(4) establishes a totally new test for parity: "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."

Clearly the Departments realized that the statutory standards of "substantially all" and "predominant" would not work with the purported limitations listed as examples of nonquantitative treatment limitations in paragraph (c)(4). Rather than rethinking the inclusion of the nonquantitative treatment limitations concept, the Departments improperly created a new standard to accommodate this newly fashioned subcategory of treatment limitations. The Department's creation of a separate standard has resulted in considerable confusion: impacted plans are unsure whether in creating the new standard in paragraph (c)(4), the Departments intend plans to satisfy an additional standard, which must be met in addition to the "substantially all" and "predominant" standards -- or an alternative test for measuring "substantially all" and "predominant," i.e., as a test parallel to the tests established in paragraph (c)(3) applicable to financial requirements and quantitative treatment limitations.

In addition to the confusion over the applicable test to apply to nonquantitative treatment limitations, compliance efforts will require plans (in coordination with MBHOs) to conduct intensive reviews, discussed in detail above on pages 15-17, all of their individual medical/surgical benefit offerings to determine whether, and how, nonquantitative treatment limitations are applied to medical/surgical benefits, and then whether, and how, such nonquantitative treatment limitations may be applied to the corresponding behavioral health benefits in each classification. This is not an optional exercise; by including items such as provider contracting and usual and customary rates in the list of "non-quantitative treatment limitations," the IFR forces all plans to perform a rigorous analysis on all of these areas - - there is no option to 'drop' these constructs since provider contracting, provider reimbursement, and so on are all integral parts of a health benefit plan. Magellan contracts with numerous employer-sponsored plans and numerous health insurers (each of

which themselves contract with numerous employer-sponsored plans), and each such entity may offer numerous different benefit plan options to their plan members. To conduct the necessary review into how each of these various plans administer their medical/surgical business is extremely complex and prohibitively time-consuming. In addition, this review must take place with no real guidance on what constitutes a nonquantitative treatment limitation. There is so much variation between behavioral health benefits and medical/surgical benefits that a simple "apples to apples" comparison cannot be made.

We urge the Departments to reconsider their unwarranted creation of the subcategory of nonquantitative treatment limitations. In the alternative, if the Departments retain these new requirements in contravention of MHPAEA, we urge the Departments to consider permitting an approach other than a plan-to-plan comparison at the individual plan level for assessment of each of these "limitations." In addition to being prohibitively time-consuming and prohibitively expensive, this behemoth task is further complicated by the reluctance of medical benefit administrators to freely share proprietary information with a carve-out MBHO about such topics as provider contracting and reimbursement methodology. An employer that contracts with several medical/surgical plans and an MBHO may find itself needing to forcefully coordinate this review among its various health benefit vendors and then determine its comfort with the resulting comparisons. This process is highly stressful, burdensome, and costly for employers.

Medical Management is not a Treatment Limitation and should not be Subject to Parity as a Nonquantitative Treatment Limitation.

The illustrative list of nonquantitative treatment limitations includes "Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative." We would first counter the notion that medical management standards related to medical necessity and appropriateness are even "treatment limitations" at all. Medical necessity and appropriateness standards are not used to arbitrarily limit care or randomly deny benefits for services; rather, these strategies are utilized to ensure that proper care is being received by plan members in accordance with clinically appropriate standards. The IFR appears to conclude, based solely on anecdotal statements of patient advocates, that the benefit denial rate for behavioral health is exorbitantly high. The Departments have adopted a mistaken view that significant numbers of plan members are denied access to care as a result of medical management practices. To the contrary, our 2009 outpatient benefit denial rate for lack of medical necessity was less than one percent. Our overall 2008 and 2009 benefit denial rates for all levels of care, in-network and, to the extent required, out-of-network, for all reasons – including, e.g., ineligible patient, non-covered benefit, non-covered provider, and exhaustion of benefits in addition to medical necessity -- were lower than 2 percent. We do not believe our denial rates are anomalous. These extremely low rates of benefit denials illustrate that utilization management is not a process that places barriers on access to care for plan members; instead, this is a process with important clinical benefits used to ensure that plan members are receiving appropriate, high quality care. What the denial rates do not reflect are the number of members guided to more appropriate care, the number of providers guided to furnish more appropriate care, and the sentinel effect on those providers who might otherwise provide inappropriate or unnecessary care. Proper care received early in the process is instrumental in preventing the need for higher levels of care for patients, which is less disruptive to their lives and less costly for the health plan.

Preauthorization requirements for outpatient services are critical tools that ensure that plan members are receiving the type of behavioral healthcare services that they need from the most appropriate level of provider in the most clinically appropriate setting. In addition, concurrent review for higher levels of behavioral health care helps to ensure that members continue to need the level of services that they are receiving. The need to apply concurrent review for behavioral health treatment is a function of differences in payment methodology. Inpatient medical/surgical services are typically reimbursed in accordance with diagnosis-related groups (DRGs), where hospitals are paid a flat rate per case for inpatient hospital care to reward hospitals for their efficiency. Due to the variability in the treatment of behavioral conditions, behavioral health inpatient care is reimbursed on a fee for service rate with the rate paid for each day that the member is in the facility. Unfortunately, without concurrent review, some facilities will keep members in the facility when they no longer need inpatient treatment in order to continue receiving payment. To illustrate the value of utilization management in facilitating plan member access to appropriate care, we are setting forth several examples:

- A member called to request a referral to an outpatient provider for "depression." Discussion with our care manager revealed that the member had been experiencing extensive depressive symptoms for over 4 months with no let-up and the member's job was now at risk. Although the member wanted only "talk therapy" with an outpatient therapist, our care manager was able to convince the member to obtain a medication evaluation as well due to the nature and duration of the symptoms. The care manager referred the member to an outpatient therapist and a psychiatrist for the medical evaluation. As a result of the evaluation, medication was prescribed; the member improved significantly with the combination of therapy and medication.

- A 21 year old severely underweight (BMI of less than 20) member with unbalanced electrolytes, heart murmur, and a history of chest pains requested benefits authorization for a stay at an out-of-state residential treatment center for eating disorders. The member had not had a recent medical evaluation and had not even been seen by a medical doctor in the previous 3 months. The member insisted on traveling across the country to a "fad" treatment facility advertised on TV. Our care manager reviewed the current clinical information with our medical director; both agreed that the member required a more intense level of care with 24 hour medical supervision closer to home. Our clinical team was not certain of the member's current medical condition or how medically stable the member was, and felt it important to have the member's medical condition thoroughly evaluated before the member went to an out-of-network residential facility that did not provide 24-hour medical care. We arranged for the member to obtain inpatient care at a network facility that specializes in eating disorders in the member's own community.

- A member diagnosed with Bipolar Disorder was admitted to an inpatient psychiatric facility during a manic episode but was not prescribed any medication during the first five days of the inpatient stay. Our care manager referred the case for a physician review; our Physician Advisor spoke with the attending physician, who agreed to prescribe mood-stabilizing medications. The member showed clear improvement within one day of initiating medication and was stabilized for discharge within a few more days.

- A member received outpatient electro-convulsive therapy ("ECT") for several years on almost a weekly basis. Because the member's benefit plan had no outpatient pre-

authorization requirement, the member was able to keep going to the same out-of-network provider during this long time period and, as a result, received highly excessive amounts of ECT with no oversight, follow-up, or care coordination. This treatment cost the plan thousands of dollars in unnecessary charges and subjected the member to serious risks of harm from the excessive duration of the treatment.

- A 16 year old diagnosed with a serious case of anorexia was admitted to residential treatment at the same facility on two occasions but made very little progress and was unable to sustain weight gains after discharge. After several months of intensive outpatient treatment, the care manager recognized that the patient was unable to commit appropriately to the changes needed to make progress; the parents' household was fraught with domestic abuse issues and one parent also had an eating disorder. When the family requested a third admission to the same residential treatment facility, our clinical staff determined that the two previous failed stays indicated the need for a serious change in treatment venue and approach; the adolescent was admitted to inpatient treatment. Weekly case management and discussions between the treating doctor at the facility and our medical director focused on the significant parental issues that were affecting the patient. The parents were required to obtain couples counseling. After three months of ongoing treatment, the patient was discharged from inpatient care. Following the discharge, the patient was able to sustain the improvements through appropriate outpatient treatment and follow-up and no further hospitalizations have been required.

Any interpretation of the IFR that results in unnecessary limitation or practical elimination of preauthorization requirements for behavioral health benefits will adversely affect the most vulnerable behavioral health patients because the tools employed to monitor their treatment and assess clinical appropriateness will be gone. The preauthorization process serves to alert us to seriously mentally ill members with diagnoses such as bipolar, schizophrenia and other psychotic disorders, and thereby enables us to initiate efforts to ensure they get appropriate care; eliminating the preauthorization requirement would allow these patients to slip out of our radar and would result in their under-utilization of behavioral health treatment. This is a group of patients who typically tend to underutilize services, resulting in emergency inpatient stays that would have been preventable by continuing outpatient care. With a preauthorization process in place, once an MBHO identifies members with these diagnoses, the members receive 'targeted case management' including intensive follow-up to ensure that they attend therapy and are compliant with their medication regimens. These measures are aimed at improving the patient's condition, providing the appropriate level of care, and avoiding the need for inpatient care, which is more disruptive to the patient's life in addition to being more costly. Without the preauthorization process, plans would have no way to identify those members prospectively in order to put these highly beneficial interventions in place.

Unlike medical/surgical treatment, there are few objective standards for behavioral health treatment. Behavioral health patients may continue treatment unnecessarily because of psychodynamic issues (e.g., dependence on the therapist), loneliness, personal development issues, and other reasons unrelated to medical necessity. For example, our care managers have encountered parents pressing for approval of benefits for residential treatment of their adolescent dependents in a distant state without regard to medical necessity in order to enable the parents to take a vacation or to protect the family from the antisocial adolescent's violence. Utilization management techniques can counter these types of inappropriate benefit use and ill-advised treatment services. In addition, behavioral

health patients frequently have no idea of the appropriate care or how to measure progress in their treatment. Members and their families are frequently lured by seductive advertising on TV or the Internet to travel to resort-like settings in distant, attractive locations promising "treatment" but providing minimal actual health care services.

Oversight of the behavioral health treatment process is needed to prevent unnecessary care and other abuses of health benefit plans. Medical/surgical treatment follows its own course with a far lesser need for oversight; most patients do not seek repeated colonoscopies or chemotherapy unless there is a clear medical/surgical need. If the IFR limits the ability of plans to manage behavioral health benefits, more members are likely to receive unnecessary or inappropriate care, or obtain vacations at resort-like residential settings at the expense of their health benefit plans, and plans are likely to see skyrocketing claims costs, particularly given the removal of day and visit limits. To the extent that there is patient cost sharing in a plan, the inability of plans to limit inappropriate care will result in unnecessary financial costs to members as well.

The Senate Committee Report indicates that MHPAEA was not meant to limit benefit management: "S. 558 does not prohibit group health plans from negotiating separate reimbursement or provider payment rates and service delivery systems, or managing the provision of mental benefits in order to provide medically necessary treatments under the plan." (Sen. Rep. No. 110-53, 110th Cong., 1st Session (2007) at p. 3).

As we discuss above in our comments on the Departments' cost estimate, the preamble expounds at great length on the virtues of managed care, but then the IFR inexplicably takes away most of those same benefit management tools by including utilization review and medical management as nonquantitative treatment limitations.

If the Departments choose to leave in place the nonquantitative treatment limitations, and especially, inclusion of medical management as a nonquantitative treatment limitation, we urge the Departments to clarify this language. Many plans do not apply utilization management to their medical/surgical benefits or they apply concurrent review but not preauthorization. Because most medical/surgical outpatient care is delivered for conditions that are episodic, easily identifiable, have clear treatment methods, and have obvious evidence of completed recovery (e.g., a broken arm; strep throat; conjunctivitis, etc.), there is no need for preauthorization or other utilization management for such cases. This absence of preauthorization or other utilization review in some plans for medical/surgical benefits could lead to a conclusion that no preauthorization or utilization management for the plan's behavioral health benefits is permitted under the IFR. This result would be disastrous for both plans and plan members, because utilization management ensures appropriate clinical care in addition to controlling costs. We urge the Departments to clarify that clinically based utilization management processes are permitted under the "except to the extent that recognized clinically appropriate standards of care may permit a difference" language in paragraph (c)(4), whether or not any utilization management is applied to medical/surgical benefits. We believe that the exception language in paragraph (c)(4) is designed to permit plans to use utilization review and other medical management techniques for behavioral health benefits where there is recognized clinical support for those techniques -- as opposed to arbitrary, discriminatory techniques -- even if those same techniques are not used by the same plans to manage medical/surgical benefits in a particular classification. A number of our health plan and employer customers are seriously contemplating eliminating utilization management, at least for outpatient care, on the recommendation of their legal advisors and benefit consultants who have concluded that outpatient

behavioral health utilization management can no longer be performed. Such benefit plan changes will result in the removal of all measures protecting plans from skyrocketing costs resulting from the elimination of day and visit limits on behavioral health benefits. Without some clarity in this language, litigation is almost a certainty, as some advocacy groups take issue with all management techniques utilized by plans to manage behavioral health benefits.

The Regulations should not Extend to Standards for Provider Admission to Participate in Networks.

Provider network standards are not treatment limitations.

In addition to utilization management standards, the illustrative listing of nonquantitative treatment limitations in subsection (c)(4)(ii) also targets another feature used by MBHOs, and behavioral health carve-outs in particular, and touted by the Departments in the preamble as beneficial for plans and members. In discussing the potential benefits associated with MHPAEA and the IFR, the Departments note that "[t]hese vendors have specialized expertise in the treatment of mental and addictive disorders and organized specialty networks of providers. These vendors are known as behavioral health carve-outs. They use information technology, clinical algorithms and selective contracts to control spending on mental health and substance abuse treatment. There is an extensive literature that has examined the cost savings and impacts on quality of these organizations." 75 Fed. Reg. 5422 (emphasis added). Notwithstanding this positive statement regarding the quality contributions of MBHOs, the Departments appear to believe that MBHOs arbitrarily limit their provider networks and thereby create barriers for plan member access to care; this is simply not true. Magellan and, we believe, other MBHOs strive to have provider networks that reflect adequate numbers of providers and accessibility in all relevant disciplines, in order to meet the wide array of treatment needs of plan members. Because network providers must meet our stringent standards for quality (e.g., education, experience, licensure, etc.), the use of network providers is beneficial to members from a quality perspective as well as benefiting the MBHO and the plan from a financial perspective. Without a robust network we would be forced to reimburse out-of-network providers at higher rates for providing these same services, without any of the quality assurance and oversight promoted by our credentialing process.

Under the terms of the IFR, provider network admission standards may not be imposed with respect to behavioral health benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying such standards are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying provider network admission standards with respect to medical/surgical benefits in the classification.[3] This inappropriately transforms what was intended to be a benefits parity law into a provider parity law. Aside from the obvious distortion of the intent of MHPAEA, there are several issues raised by this proposition.

The definition of "treatment limitations" in MHPAEA reads: 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. As noted previously in these comments, in its definition of "treatment limitations," the IFR appends the novel and completely foreign concept of

[3] The exception for recognized clinically appropriate standards of care which permit a difference would be of no use for this particular example of a nonquantitative treatment limitation, as there is no "standard of care" involved in admitting providers to a network.

'nonquantitative treatment limitations' to the definition of "treatment limitations" as somehow similar to frequency of treatment, number of visits, and days of coverage (all listed in the statutory definition) and somehow limiting the scope or duration of treatment. Even assuming, for the sake of discussion, that the Departments have authority under MHPAEA to create requirements with respect to nonquantitative treatment limitations, the inclusion of provider admission standards within the nonquantitative treatment limitation category is misguided.

Treatment limitations under MHPAEA are all narrow limits that directly affect the quantity and intensity of treatment patients may receive. Provider network admission standards have no rational connection to the quantity and intensity of treatment. Provider network admission standards have no similarity to frequency of treatment, number of visits, days of coverage, or other similar limits. There is no way to reasonably construe that provider network admission standards are any kind of limit on the scope or duration of treatment. The standards used by MBHOs to decide provider admission to participate in their networks (including reimbursement rates) do not determine how many days per week or sessions per year a patient can go to therapy or be hospitalized in a psychiatric facility. The standards used by MBHOs to decide provider admission to participate in their networks, including reimbursement rates, do not affect, influence, or otherwise impact the ability of any member to receive treatment. Therefore, the standards used by MBHOs to decide provider admission to participate in their networks do not satisfy the statutory definition of "treatment limitations" and should be removed from paragraph(c)(4)(ii) of the IFR.

<u>Credentialing of behavioral health providers promotes access to quality care.</u>
If the Departments ultimately choose to retain the concept of nonquantitative treatment limitations and to retain provider network admission standards as a nonquantitative treatment limitation, the Departments should consider the implications of those decisions and provide needed additional guidance and clarification on what is expected of MHBOs in connection with network admission standards. Re-assessment of all behavioral health provider network arrangements, comparison to medical/surgical provider network creation and reimbursement procedures, and then attempted alignment or equalization will be confusing, complex, impractical, and may even create exposure to anti-trust scrutiny for MBHOs.

The standards used by MBHOs to decide provider network admission are designed to ensure that plan members have access to high quality services from qualified practitioners. In establishing a network of behavioral health providers, MBHOs guarantee that each provider in the network has sufficient credentials to provide the appropriate level of care to plan members who need behavioral health treatment.

Access to care is an important consideration for every MBHO. MBHOs ensure that there are enough behavioral health providers at different licensure levels to serve each relevant geographic area they serve. Magellan and many of the other MBHOs are accredited by the National Committee on Quality Assurance (NCQA), an independent, nonprofit organization that assesses and reports on the quality of care delivered by managed care organizations, including MBHOs. NCQA accreditation requires MHBOs to create network density (i.e., number of providers per member) and access (i.e., distance between provider and members) standards. It is also standard practice for many employers and health plans to require specific access and density standards in their contracts with MBHOs. As recognized by the Departments in the IFR preamble, a strong behavioral health provider network that facilitates access to high quality, well coordinated, and cost effective care is one of the primary factors in the success of "parity in a world dominated by behavioral health carve

outs," with "increased utilization rates, reduced provider fees, reduced rates of hospitalization and fewer very long episodes of outpatient care. Intensive treatment was more closely aligned with higher levels of severity." 75 Fed. Reg. 5422. Unfortunately, anecdotal statements seem to have led the Departments to believe that MBHOs engage in discriminatory and inequitable practices in establishing provider networks, when nothing could be further from the truth.

Magellan currently has contracts with approximately 72,000 behavioral health care providers across the nation. Our customers look to us to furnish their members who need behavioral health treatment with behavioral health practitioners and facilities well-qualified with the array of training and experience necessary to provide quality care in the specialized areas of mental illness and substance abuse. This is true for our health plan customers as well as employer customers. The health plans themselves often do not have the comfort level or expertise to create a vibrant and thorough behavioral health provider network. Provider admission to medical/surgical networks is relatively straightforward, because most if not all of the providers admitted to these networks are physicians who are all subject to similar training and licensure standards. Creating a network of behavioral healthcare providers, however, is far more complex. There are many different types of providers who can – and, in the case of certain state mandates, must – be included in behavioral healthcare networks.

For example, while behavioral health provider networks naturally include psychiatrists (who are also MDs), they also include practitioners with doctorates or masters degrees in psychology or counseling and practitioners with masters degrees in social work as well as all sorts of family counselors, marriage counselors, and so on. The background, training and licensing standards for each of these provider types varies widely, both among the types and, when differing state requirements are considered, within each type. Our customers rely on our expertise to conduct the specialized credentialing required to assure that high quality behavioral health care is furnished to plan members.

In addition to the credentialing process that takes place in connection with provider applications for network admission, MBHOs also perform crucial quality assurance and improvement activities with their network providers. For instance, Magellan works in concert with our providers to ensure that they develop evidence-based treatment plans that are appropriate to the specific needs of their patients. Throughout the course of treatment, we engage in concurrent peer-to-peer consultation with behavioral health professionals to ensure that plan members are receiving clinically indicated treatments in the least restrictive and most appropriate environment possible and that those services are delivered in a quality fashion to achieve successful and cost-effective outcomes.

As we have described, the credentialing process for admission into a behavioral healthcare network is significantly more complicated than for a medical provider network. The IFR does not account for this complexity. Literal interpretation of the IFR could cause the behavioral healthcare network admission processes to be viewed as applying more stringent standards than those applied by medical provider networks, subjecting the affected plans to possible regulatory enforcement actions. The effect of attempts at equalization in provider credentialing would likely force MBHOs to operate at the least common denominator by watering down existing robust credentialing standards. This certainly would not be in the best interests of plan members and consumers.

It is understandable that the Departments would have concerns about the impact that an inadequate behavioral health provider network would have on access to behavioral health care services. But, as

noted above, in creating their provider networks, MBHOs ensure that all types of behavioral health providers are available and accessible within defined distances and that all network providers are properly credentialed and qualified to provide the services they render to plan members.

Network adequacy is simply not a parity issue. If a network presents no artificially created barriers to access treatment, the manner in which MBHOs select behavioral health providers to join their networks is irrelevant to plan members -- the intended beneficiaries of MHPAEA; providers were not the intended beneficiaries. We strongly recommend that all references to provider admission standards be removed from the regulation.

The Regulations should not Extend to Standards for Provider Reimbursement Rates.

Network Providers

Paragraph (c)(4)(ii)(C) of the IFR specifies provider reimbursement rates as a component of provider network admission standards that must meet the parity requirements of the IFR. Provider reimbursement rates are not treatment limitations. Like most other MBHOs, Magellan generally reimburses network providers on a fee-for-service basis; capitated fees – which can create incentives for providers to limit care -- are rarely used for behavioral health care. Magellan uses a reimbursement methodology that we have developed over our many years in the behavioral health benefit management industry; this methodology includes adjustment of rates by geographic region and provider licensure status. Without explanation, the IFR calls into question our established practices for the reimbursement of behavioral health providers, both in-network and out-of-network. The IFR inaccurately presupposes that there are standard rates that can easily be applied across all different types of care so that, for example, a network physician is reimbursed at 90% of the standard rates whereas an out-of-network physician is reimbursed at 50%. This is not how provider reimbursement works. At present, there is no generally accepted index on which provider networks can legally rely for reimbursement determinations. Because all medical/surgical and behavioral health benefit administrators use different sources of data and methodologies, there will be variations in rate determinations even before taking the differences between medical/surgical and behavioral health care into account.

Even assuming there could be a consistent base on which to determine reimbursement, the reimbursement model for medical/surgical care is very different from the model for behavioral health reimbursement because behavioral health networks include many different types of providers with highly variable education and training backgrounds, which necessitates multiple levels of contracting and reimbursement strategies. We reimburse for services based on the provider's level of education, specialization, licensure, and experience in addition to the type of the services provided. In the behavioral healthcare area, therefore, the determinations are much more complex. The two areas are simply not comparable.

Adding another layer of confusion, MBHOs such as Magellan typically have more than one customer in each state, and each customer may have more than one medical/surgical benefit package. While reimbursement rates are not the same for each provider, Magellan's network reimbursement schedule anticipates paying the provider the one contracted rate specified in the schedule regardless of the medical/surgical plan in which the behavioral health patients they treat are enrolled. In this way, the provider knows exactly what he/she will be paid for services, regardless of the patient's medical/surgical plan, rather than having to face a variety of payment rates for the exact same services depending on the patient's medical/surgical benefits. If MBHOs are required to

match their rates with the medical/surgical rates under each plan, they will have to replace their existing network rate structures with the medical/surgical rate methodology; behavioral health providers will have to agree to -- and keep track of -- different rates corresponding to each set of medical/surgical benefits for each plan instead of a single rate from the MBHO that is applicable to all plans. This problem would be exacerbated where an MBHO's customer utilizes rented provider networks for medical benefits; as noted above, one Magellan customer utilizes 60 rented networks to provide medical/surgical services. Moreover, provider contracts would require amendment with new reimbursement schedules whenever the MBHO contracts with a new customer. The behavioral health provider fee arrangements would have to correspond with the medical/surgical provider fee arrangements based on the particular medical/surgical provider networks for which the particular patients are eligible. This level of matching would necessitate additional eligibility programming and data capture to ensure that the MBHO claims system recognizes the particular medical/surgical provider network assigned to each plan member. To the extent that the IFR is interpreted to require substitution of medical/surgical fee arrangements for the current MBHO fee-for-service reimbursement structure, a huge corresponding burden would be imposed on behavioral health providers with regard to record-keeping and billing, not to mention confusion regarding what rate of reimbursement they would receive for any given service they render.

Out-of-network providers

The IFR includes plan methods for determining usual, customary, and reasonable (UCR) charges as the fourth item on the illustrative list of nonquantitative treatment limitations in paragraph (c)(4)(ii). Under the terms of the IFR, then, UCR charges may not be imposed with respect to behavioral health benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying such UCR charges to behavioral health benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying UCR charges with respect to medical/surgical benefits in the classification.[4] Again, as with provider network admission standards, this is an "apples to oranges" comparison that is confusing and problematic.

Since one of the main tenets of establishing a network of providers is the commitment by each provider to accept a contracted rate, use of UCR charges for reimbursing providers occurs only in connection with out-of-network providers. Only when faced with reimbursing a provider who has not agreed to a predetermined, contracted rate must a plan resort to UCR charges. Calculation of UCR charges is challenging, as there is no single reliable national database or other resource for plans to utilize.[5] As a result, plans use their own proprietary payment methods for determining UCR. While the reimbursement paid affects providers, the methodology for determining UCR has no bearing on plan member access to behavioral health treatment. Indeed, the very nature of out-of-network benefits effects an expansion of access to treatment -- by permitting members to seek care by any behavioral health provider acting within the scope of an appropriate license for the

[4] As indicated in connection with network provider reimbursement, the exception for recognized clinically appropriate standards of care, which permit differences from medical/surgical practices, would be of no use for this particular example of a nonquantitative "treatment limitation," as there is no "standard of care" involved in reimbursing providers.

[5] In the past, many companies used data from Ingenix, a unit of UnitedHealthcare, as a resource for determining UCR charges; however, allegations of fraud have tarnished the validity of the rates and information in the Ingenix database, and have called into question the practices of companies using Ingenix to reimburse providers. A non-profit alternative to Ingenix has been proposed, but is not yet operational.

service rendered, even if such provider has not met the rigorous quality and credentialing standards of the plan.

In order for an MBHO to ensure the UCR charges used are comparable to, and applied no more stringently than, the UCR charges used for medical/surgical providers, the MBHO would have to obtain the proprietary UCR payment methodology of each corresponding medical/surgical benefit administrator. In addition to the reluctance of medical/surgical benefit administrators to share this proprietary information for competitive reasons, sharing of such information could create an appearance of impropriety and/or antitrust scrutiny, if such activities are viewed as collusion or price-fixing. So long as out-of-network benefits are available, where applicable, and provided in compliance with MHPAEA parity requirements, then the manner in which MBHOs determine UCR charges for non-contracted behavioral health providers is outside the scope of the IFR.

OTHER COMMENTS

The IFR Appropriately Ties MHPAEA Disclosure Requirements to ERISA Disclosure Requirements.

We were pleased to see the requirements under paragraphs (d)(1) and (2) aligned with the existing ERISA requirements for disclosure of medical necessity criteria and denial rationale. As a carve-out to numerous health plans and employers that are subject to these ERISA requirements, our standards are already compliant with these ERISA requirements for all of our business. The vast majority of health plans and employers are already subject to the ERISA requirements. Utilizing these existing standards in the IFR eliminates any additional compliance activities in this area for most plans.

Clarification of the Application of MHPAEA to Non-Traditional Plans is Needed.

Under paragraph (e)(1), a separate parity compliance analysis is required for each unique combination of all the medical/surgical and behavioral health benefit options for which an individual is simultaneously eligible and, further, all of the possible combinations together are considered a single group health plan for purposes of satisfying the IFR's parity requirements. As explained by the Departments in the preamble, the purpose of this provision is to prevent plan sponsors from evading the application of MHPAEA by establishing separate behavioral health plans. Magellan acknowledges the appropriateness of closing this possible loophole, but seeks clarification of the application of this anti-abuse provision to health reimbursement arrangements (HRAs) and other non-traditional group health plans that may evolve in the future.

An HRA is an unfunded medical reimbursement plan in which the employer reimburses medical expenditures up to a specified dollar amount of coverage. Funding of claims occurs on an as needed basis from the employer's general assets and reimbursements are tax-free to employees. In our experience, HRAs are typically paired with high deductible health plans (HDHPs) in order to take advantage of the lower premiums for HDHPs.

Because HRAs are considered group health plans under ERISA, paragraph (e)(1) would require that HRAs be combined with other medical/surgical benefits and behavioral health benefits (e.g., the HDHP) for purposes of analyzing the financial requirements and treatment limitations permissible with respect to the behavioral health benefits to which HRA plan members would be eligible. That

requirement does not pose unique problems for HRAs that cover both medical and behavioral health conditions; the analysis would simply include both the HRA and the HDHP in the review and proceed in the same manner as for a traditional plan.

However, some employers offer HRAs that are limited to medical benefits (while HRAs could also be limited to just behavioral health or another variation, the concern here is in connection with medical/surgical-only HRAs). A medical/surgical-only HRA would fund first-dollar coverage for medical expenses, up to a specified limit at which point the employee is responsible for satisfying a deductible before coverage under the HDHP (covering both medical and behavioral health) kicks in. Behavioral health benefits would be subject to the same deductible and coverage under the HDHP but would not have the advantage of the HRA reimbursements. For example:

	HRA	Shared single deductible	HDHP
Medical/surgical	$1,000 paid by employer at 100%	$1,000 paid by employee	90% paid by plan; 10% by employee
Behavioral health	--		90% paid by plan; 10% by employee

Combined review of the two plans might suggest that the medical/surgical-only HRA must be changed by extending coverage to behavioral health. However, the Departments have expressed the view that where a plan covers medical/surgical benefits and behavioral health benefits and the behavioral health benefits satisfy the requirements under MHPAEA, an employer's provision of additional benefits over and above the group health plan, e.g., an employee assistance program (EAP), does not have to be taken into account in determining compliance. We request clarification whether the same logic applies to a medical/surgical-only HRA that supplements an otherwise parity-compliant HDHP or whether such a pre-deductible HRA must now cover both medical/surgical and behavioral health treatment.

The Language Deeming all Combinations of Benefits to be a Single Group Health Plan should be Modified or Deleted.

Paragraph (e)(1) provides that all combinations of medical/surgical and behavioral health benefits are "considered to be a single group health plan" for purposes of parity. Although we do not believe it to be the Departments' intent, it can be argued that this transforms the anti-abuse provision that requires separate analysis of each combination of medical/surgical and behavioral benefits for which an employee is simultaneously eligible into an analysis simply of the entire universe of benefits provided to employees.

For an employer with multiple group health plans, the implication of this rule appears to be that behavioral benefits for all employees must correspond to the medical/surgical benefits that are most favorable to employees, including employees enrolled in medical plans other than the plan with the most favorable benefits. Members in plans with less generous medical/surgical benefits would receive richer behavioral health benefits, undoubtedly resulting in higher premium costs. Such

results go far beyond the simple and basic parity mandate between medical/surgical and behavioral health benefits intended by Congress in enacting the MHPAEA. MHPAEA is aimed at eliminating discrimination, not at compelling employers to provide the highest possible behavioral benefit. While most employers have historically preferred to standardize behavioral health benefits regardless of the medical/surgical benefit offerings, some may now choose to differentiate by plan in order to mitigate the cost impact of parity. The single plan language appears to deprive employers of the option to offer varying behavioral benefits that are matched on a plan-by-plan basis to medical benefits.

While we appreciate the Departments' anti-abuse concern, we believe that purpose is adequately advanced by the first part of the sentence requiring that all benefits to which an individual would be eligible be combined for parity analysis; the purpose of the additional language deeming all such combinations to be one plan is not clear. The Departments did not articulate a purpose for the language. Given the potential restriction of options to make each plan option internally consistent, we recommend that the phrase "all such combinations are considered for purposes of this section to be a single group health plan" be stricken from paragraph (e)(1).

Clarification of the Application of MHPAEA to Wellness Programs is Needed.

The IFR has a potential chilling effect on the continued emergence of innovative wellness/prevention programs that are a valuable tool in tackling America's skyrocketing health costs. The inclusion of 100% employer-paid wellness benefits in the universe of medical/surgical benefits upon which the substantially all test is calculated under paragraph (c)(3)(i)(A) skews the outcome of the calculation. Employers will be less willing to establish new wellness benefits – and may drop existing medical wellness benefits or impair their effectiveness by attaching patient cost sharing or other limits – when their continued ability to require patient cost share for behavioral health benefits is jeopardized by the absence of patient cost share in connection with medical wellness benefits. While inclusion of 100% employer-paid medical wellness benefits in the (c)(3)(i)(A) calculations may end up depriving plan members of valuable wellness benefits, exclusion of such benefits from the calculation is unlikely to have an adverse effect on behavioral health coverage because few plans would consider eliminating patient cost sharing on medical benefits just to avoid parity requirements.

In addition, the application of MHPAEA to behavioral health wellness programs, such as tobacco cessation programs (which undeniably provide benefits in connection with a diagnosis covered under the DSM), would dictate transformative changes to the wellness programs. Most wellness programs offer short-term interventions, such as education, screening, counseling; the standard limits on wellness programs are unlikely to be consistent with limits applied to substantially all medical benefits. Without limits, many employers are likely to drop the behavioral health wellness benefits rather than establish new unlimited behavioral health benefits. We have received feedback from several customers indicating that they have been advised to drop their wellness programs because of the IFR. We believe that the reasoning that makes parity inapplicable to EAPs applies with equal strength to behavioral health wellness programs. Like an EAP, a behavioral health wellness program comprises an employer's provision of additional benefits over and above the group health plan. We suggest that so long as the group health plan covers behavioral health and the behavioral health benefits satisfy the parity tests, parity requirements should not apply to behavioral health wellness programs that supplement those behavioral health benefits.

We request that the Departments reconsider the inclusion of medical wellness benefits in the calculations under paragraph 3)(i)(A). We also request clarification whether benefits under a behavioral health wellness program that supplements an otherwise parity-compliant group health plan must be in parity with medical/surgical benefits.

The Compliance Date should be Deferred to Allow Time Commensurate with the Complexity of Activities Required by the IFR.

The changes made by the MHPAEA statute are generally effective for plan years beginning after October 3, 2009. In Section 512(d) of MHPAEA, Congress instructed the Departments to issue regulations "[n]o later than 1 year after the date of enactment of this Act." The Departments, however, failed to issue final regulations by the October 3, 2009 deadline. Irrespective of that deadline, MHPAEA itself went into effect on that same one-year anniversary date. Since October 3, 2009, in the absence of regulatory guidance, plans have made good faith efforts to comply with the statute. On April 28, 2009, six months after the passage of MHPAEA, the Departments published a "request for information" in the Federal Register. 74 Fed. Reg. 19,155 (April 28, 2009). The request for information was a four-page document seeking general information pertaining to the clinical and financial effects of implementing the statute. The request did not set forth or even hint at the language of any proposed regulation. On February 2, 2010, four months after their statutory deadline, the Departments issued the IFR. Even though it took the Departments 16 months to promulgate the IFR, they issued this rule with an applicability date of July 1, 2010 for plan years that begin or renew on or after that date. This provided plans with July 1 plan years only five months to review the IFR, attempt to resolve ambiguities, make IT changes, conduct meetings between behavioral health and medical/surgical plans if these are not integrated, redesign benefit plans, revise and re-file plan documents, and address all the other details necessary for compliance. Many states require advance notice to members and providers if changes are made that impact the benefit structure or provider contracts. For example, New Jersey requires 60 days prior notice of material changes to provider contracts. Given all of these factors, this five month timeframe is woefully inadequate.

The Departments appear to be under the impression that most plans will not renew until January 1, 2011 and therefore they will have longer to work on compliance. While this is true, it appears that most health insurance companies have at least some plans that renew July 1. In fact, July 1 is the second most popular plan renewal date after January 1. If a health plan has even one customer with this renewal date, and it appears that more than half of our health plan customers do, then the health plan – and its carve-out MBHO -- needs to be prepared to comply by the July 1 date. Because of uncertainty about the meaning and implications of the IFR and the complexity of the required analyses and other compliance steps, as of the date of these comments, few, if any, of our health plan or employer customers have made decisions regarding new benefit plan designs for the plan year starting July 1; that leaves very little time for any required state filings; revision of employee communications; enrollment; reconfiguration of claims systems; and retraining of staff, as necessary. We urge you to delay the applicability date of these regulations until at least January 1, 2011. Allowing only 5 months for these complex compliance activities is insufficient and unreasonable. While the IFR notes that good faith compliance efforts will be taken into account,[6] it is also noted

[6] Because the statutory MHPAEA provisions are self-implementing and are generally effective for plan years beginning after October 3, 2009, many commenters asked for a good faith compliance period from Departmental enforcement until plans (and health insurance issuers) have time to implement changes consistent with these regulations. For purposes of enforcement, the Departments will take into account good-faith efforts to comply with a reasonable interpretation of the statutory MHPAEA requirements with

that the Departments' acceptance of good faith efforts does not prevent participants or beneficiaries from bringing a private action. The compliance date should be remedied to permit adequate time to thoughtfully and thoroughly address necessary plan changes without risk of litigation.

The compliance date should be further extended if the Departments make any changes in the status of the regulation. We believe that that the Departments violated the Administrative Procedure Act (APA), 5 U.S.C. § 553, by failing to engage in notice and comment rulemaking, resulting in severely flawed regulations, and we therefore urge the Departments to rescind the IFR and promulgate proposed regulations in order to permit feedback from the MBHO and provider communities prior to formulating final regulations. If this should occur, we urge the Departments to permit at least a period of one year from issuance of final regulations for compliance given the complexity of the required changes and the state law filing requirements that must also be met.

Thank You for Considering Our Comments

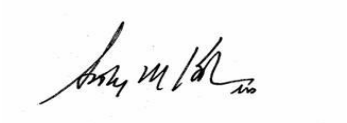
Thank you for the opportunity to present our concerns regarding this important regulation. We urge you to follow your legal obligations under the APA, withdraw the IFR, issue new proposed regulations based upon the comments submitted on the IFR, and then carefully consider the comments received in response to the proposed regulation before promulgating a final regulation. We also ask that you allow for at least a one year time period for compliance from the effective date of the final regulations to allow adequate time to make changes to benefit structures, obtain state regulatory approval where required, and to make necessary information technology changes.

In the alternative, if you elect not to withdraw the IFR, we believe the unnecessary complexity and burdensomeness, as well as the unintended consequences, of the IFR can be cured by:

- Withdrawing the provisions that exceed the clear language and legislative history of MHPAEA;
- Refraining in your formulating new proposed regulations from further inappropriate rulemaking in excess of your authority;
- Substituting the measure of reasonableness on the part of plans and their insurers for the overly prescriptive, plan to plan matching approach adopted in the IFR; and
- Extending the compliance date until at least January 1, 2011.

If you have any questions about our comments, I can be reached at (860) 507-1973.

Sincerely,



Anthony M. Kotin, MD
Chief Medical Officer
Magellan Health Services

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respect to a violation that occurs before the applicability date of paragraph (i) of these regulations. However, this does not prevent participants or beneficiaries from bringing a private action. 75 FR 5419.