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Kaiser Foundation Health Plan, Inc.
Program Offices

May 3, 2010

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4140–IFC
P.O. Box 8016
Baltimore, MD 21244–8010

Office of Health Plan Standards & Compliance Assistance
Employee Benefits Security Administration (RIN 1210–AB30)
Room N–5653,
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

CC:PA:LPD:PR (REG–120692–09)
Room 5205, Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044.

Re: Interim Final Rules under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (Division C of Pub. L. No. 110-343)

Dear Sir or Madam:

Kaiser Permanente offers the following comments in response to the Interim Final Rule ("IFR") under the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* ("MHPAEA") issued February 2, 2010 in the *Federal Register* (*see* 75 Fed.Reg. 5410) by the Departments of Labor, Health and Human Services and Treasury ("Departments").

The Kaiser Permanente Medical Care Program (which offers services to the public under the Program's trade name "Kaiser Permanente") is America's largest private integrated healthcare delivery system, comprising Kaiser Foundation Health Plan, Inc. (and its local subsidiaries, collectively "Health Plan"), the nation's largest nonprofit health plan; the nonprofit Kaiser Foundation Hospitals ("Hospitals"); and the Permanente Medical Groups ("Medical Group"), eight independent physician group practices that contract exclusively with Health Plan to meet the health needs of Kaiser Permanente's 8.7 million members in nine states and the District of Columbia.

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We support the objectives of MHPAEA to achieve consistent minimum parity for mental health and substance use disorder benefits. As an integrated health care delivery system, we also recognize the many challenges in meeting the extensive parity requirements under MHPAEA. We appreciate the opportunity to comments; our recommendations follow:

1. We recommend the Departments allow sufficient additional time for health plans to comply with MHPAEA.

The IFR was issued February 2, 2010 with full compliance required within five months (by July 1, 2010). Most employers, insurers, and plan administrators are already negotiating and establishing health plan designs for the 2011 plan year. Translating the complex requirements of the IFR into benefits design presents substantial administrative challenges for health insurance plans within a very short implementation timeline.

Many requirements are difficult to administer, in part because they are complicated and not clearly defined. The IFR requires a separate parity determination for each plan based on each type of financial requirement (e.g., deductible, co-payment or co-insurance), treatment limitation (e.g., days or visits); benefit category (e.g., in- or out-patient/in- or out-of-network), and the coverage unit (e.g., individual, family, etc.). Calculation must be based on a reasonable estimate of the projected premiums and a subsequent application of the "substantially all" test. The plan then can determine the predominant level (i.e., the financial or treatment limitation that applies to more than one-half of medical/surgical benefits to which the limitation is applicable and apply that limitation to mental health and substance use disorder benefits.

The compliance date should be extended until plan years on or after July 1, 2011 to accommodate the significant challenges in interpreting and implementing the regulatory provisions in the IFR.

2. We recommend that a Final Rule clarify how MHPAEA applies to retiree health coverage.

Employers may establish a separate group health plan to provide benefits to retired employees and their families. The Employee Retirement Income Security Act, Public Health Service Act, and Internal Revenue Code recognize a limited exemption for any group health plan (and health insurance coverage offered in connection with a group health plan) where, on the first day of the applicable plan year, the plan has less than two participants who are current employees.[1].

Thus, certain provisions of these laws, such as the mental health parity requirements, do not apply to "retiree-only" coverage. The Final Rule should clarify that MHPAEA does not apply to plans established separately for retired employees and their families (i.e., "retiree-only" health benefit plans.)

3. We recommend that a Final Rule clearly state that MHPAEA does not apply to "nonquantitative" treatment limitations.

[1] *See* 26 U.S.C. §9831(a)(2), 29 U.S.C. §1191a(a), and 42 U.S.C. §300gg-21(a)

The IFR applies parity requirements to "nonquantitative" treatment limits, which include medical management standards. According to the IFR Preamble, these limits may affect the scope or duration of benefits under a plan and should be included in a plan's determination of parity. In fact, many nonquantitative limits, such as medical management standards, are designed to ensure patients receive appropriate care.

MHPAEA defines a "treatment limitation" as "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." (29 U.S.C. §1185a(a)(3)(B) and 42 U.S.C. §300gg-5(a)(3)(B), *emphasis added*). Congress' intent was to address parity in numerical limits on benefits, such as cost-sharing or treatment limitations. Extending parity requirements to nonquantitative treatment limits is inconsistent with the statutory language addressing determination of parity.[2] The terms "predominant" and "substantially all" rely on numerical (i.e., quantifiable) limits and are not used in the IFR to determine parity for nonquantitative limitations. The Congressional intent that the MHPAEA does not extend to nonquantitative limits is supported by legislative history. (H. Rep. 110-374, Part 3, 110th Cong., 2nd Session (2008)).[3]

The IFR requirements for determining parity in the context of nonquantitative treatment limits are not clearly defined and will be difficult to administer. No clear rules are provided to guide plans in constructing benefit designs in a way that would meet the regulatory expectations. Therefore, we recommend the IFR requirements with respect to nonquantitative treatment limitations should be withdrawn.

Conclusion

We appreciate the opportunity to provide you with information. We would welcome the opportunity to discuss these matters with you further. If you have questions or concerns, please contact me at 510-271-6694 (email: victor.d.sipos@kp.org).

Sincerely,

Victor D. Sipos
Counsel, Legal & Government Relations
Kaiser Foundation Health Plan, Inc.

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[2] (T)he 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. (26 U.S.C. §9812(a)(3)(A)(ii), 29 U.S.C. §1185a(a)(3)(A)(ii), and 42 U.S.C. §300gg-5(a)(3)(A)(ii), *emphasis added*).

[3] The version of the MHPAEA (H.R. 1424) approved by the Energy and Commerce Committee and discussed in the Committee Report included a requirement that group health plans and group health insurers cover all conditions in the Diagnostic and Statistical Manual of Mental Disorders (DSM). This requirement was not included in the final version of the legislation.