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Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Re: RIN 1210-AB30
Comments on Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. 75 Fed. Reg. 5410 (February 2, 2010)

This letter responds to the request for comments by the U.S. Departments of the Treasury, Labor, and Health and Human Services (Departments or agencies) regarding the February 2, 2010, Interim Final Rules (Rules) for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). These comments are submitted by the Society for Human Resource Management (SHRM).

SHRM is the world's largest association devoted to human resource (HR) management. Representing more than 250,000 members in over 140 countries, SHRM serves the needs of HR professionals and advances the interests of the HR profession. Founded in 1948, SHRM has more than 575 affiliated chapters within the United States and subsidiary offices in China and India.

Because SHRM members administer both insured and self-insured health care plans, SHRM respectfully submits these comments in an effort to increase the Departments' understanding of the challenges its members face in applying the Rules on a day-to-day basis, as well as some of the unusual and unintended consequences of applying the Rules as we currently understand them. These comments are intended to assist the Departments in revising regulations that promote the MHPAEA goal of parity for mental health and substance use disorder (MHSA) benefits, yet at the same time, request that the Departments take into account the real world difficulties and expense of applying the Rules to multiple plan designs in time to meet an ambitious effective date.

These difficulties are compounded by the fact that the MHPAEA Rules come on the heels of major health care reform requiring comprehensive review and analysis by HR professionals to ensure compliance. In order to ameliorate the challenges and unintended consequences of the Rules, SHRM suggests the following changes:

I. Determining Permissible Financial Requirements and Treatment Limits

MHPAEA states that financial requirements and treatment limits applicable to MHSA benefits can be no more restrictive than the predominant financial requirements or treatment limits applied to substantially all medical and surgical benefits covered by the plan. The Rules further define the terms "substantially all" and "predominant", and add a new dimension to the requirement by applying it within each of six newly identified classifications. In addition, the Rules state that this requirement applies separately for each type of financial requirement (e.g. copayments may not be compared to coinsurance) for each plan offering.

A. Potential for Errors in Mapping Medical Costs to the Six Classifications

To determine whether a plan can apply a financial requirement or treatment limit to MHSA benefits within a classification, the Rules require an estimate of the dollar amount for all medical/surgical plan payments in the classification for the applicable plan year. To develop the estimate, the Rules appear to require that *all* medical costs are mapped to one of the six classifications. The six classifications (in- and out-of-network inpatient and in- and out-of-network outpatient, emergency services and pharmacy) do not fully capture the array of medical/surgical costs a plan pays in a year. As a result, it is difficult to determine the appropriate classification for some medical costs with any degree of certainty that regulators would approve of the mapping. For example, are medications provided on an inpatient basis mapped to the inpatient or pharmacy classification? Are lab and X-ray costs split into inpatient and outpatient categories depending on where they are delivered? How are charges for durable medical equipment and anesthesia for outpatient surgery classified? Where do in-home services fall?

For employers with multiple plans (e.g. one employer has condensed the number of plans for testing down to 95), testing each financial requirement in each classification for each plan offering is burdensome, costly and uncertain. Claims databases are not designed for this type of analysis and data errors are common. Because of the expense of testing and the potential for high penalties (e.g. a single error in plan design, in place for one year, applicable to an employer with 5000 employees or 11,500 members, could result in a penalty of $4,312,500), consultants and medical carriers are reluctant, and in some cases decline, to conduct testing on behalf of a plan.

One way to lessen the confusion of determining permissible financial requirements and quantitative treatment limits would be to apply a comparability approach in which similar service types within classifications are required to have the same financial requirements or treatment limits. For example, within the outpatient classification, financial requirements for medical office visits (e.g. primary care physician (PCP), specialist, chiropractic, and speech or occupational

therapies) would be applied to MHSA office visits (e.g. assessment, psychotherapy, med checks); financial requirements and treatment limits for facility-based outpatient services (e.g. outpatient surgery, cardiac programs) would be applied to facility-based MHSA services (e.g. partial hospital and intensive outpatient programs). To avoid costly, burdensome and error prone testing, plans would be permitted to assign the lowest level of a type of financial requirement or limit.

Alternatively, plans that apply the same financial requirements or treatment limits to services regardless of whether the service is applicable to MHSA or medical could be deemed compliant.

If the data-intensive testing continues to be required, consider a good faith approach to enforcement related to the medical cost estimates and limit penalties to no more than the cost of the error to the impacted membership.

B. Unintended Consequences of "Substantially All" Testing to In-Network Outpatient Classification

When conducting medical cost mapping, the outpatient classification tends to become a catch-all for services, equipment and products that don't fit well into the inpatient, emergency and pharmacy classifications (e.g. home healthcare). The resulting variety of services mapped to the outpatient classification has a corresponding variety of financial requirements. For example, outpatient surgery is frequently associated with co-insurance. Physician office visits are more commonly associated with co-payments. Preventive services may not have any associated financial requirements. Some outpatient services are subject to deductibles, others are not.

Due to this mixture of cost-sharing arrangements, it is common for none of the financial requirements tested to meet the "substantially all" test in the in-network outpatient classification. As a result, no financial requirement may be applied to MHSA in this classification (which will likely include higher cost MHSA services such as intensive outpatient programs, applied behavior analysis and partial hospitalization). This would appear to be an unintended result that goes beyond parity as few medical services are offered without associated financial requirements. If plans remove all limits, apply no financial requirements and are unable to apply utilization management strategies to MHSA outpatient services (see non-quantitative limits section below), the cost impact could be significant and the government's estimates too low.

For other plans, co-insurance alone meets the "substantially all" test in the in-network outpatient classification due to the disproportionate amount of costs associated with outpatient surgery. This testing result means that plans that apply co-payments for primary care physician (PCP) and specialist office visits will need to apply a separate co-insurance for MHSA outpatient office visits. This design also results in members paying more, as copayments are typically less costly to members than co-insurance. This design also creates administrative challenges. For example, which financial requirement would apply if a PCP delivered a MHSA service; the co-

payment or the co-insurance? Would a PCP's office be required to return the copayment if the primary condition treated turned out to be a MHSA condition?

Due to these uncertainties, the outpatient classification should be subdivided into tiers for office visits and facility-based services (such as outpatient surgery). In this way, financial requirements are likely to be more uniform within a tier, and the results of applying the "substantially all" test will be more consistent with medical benefit design. To avoid the result of the "specialist" co-pay becoming the predominant cost share in the office visit tier, regulations could require the lowest cost share to be predominant when this approach is applied. Also, see recommendations above in section A.

To address the problems with administration that arise when PCPs or other non-MHSA professionals deliver MHSA services, we recommend that the only treatments subject to MHPAEA are those that are provided for treatment of a MHSA condition, by a MHSA provider in a MHSA setting.

C. Unintended Consequences of "Substantially All" Testing to the Emergency Services Classification

Unintended results may also occur as a result of applying "substantially all" and "predominance" testing to the emergency services classification. It is atypical for plan designs to treat MHSA emergencies differently from medical emergencies. On the medical side, however, ambulance services are often associated with coinsurance and emergency room charges are associated with co-pays. As a result, only co-pays tend to meet the substantially all test. The result of the testing appears to require that a plan must add a separate co-pay for MHSA ambulance use, when medical ambulance use is associated with co-insurance. It is unclear if this result violates MHPAEA's prohibition against separate cost-sharing requirements that apply only to MHSA. In addition, this design creates significant complications for claims payment. It would become necessary for claims payers to determine whether the ambulance was used for MHSA or medical purposes in order to process the claim and this information may not be readily apparent. For example, if a patient is taken by ambulance to a hospital for treatment of an overdose, the claims processer would need to determine if the overdose was accidental (resulting in a medical claim), the result of addiction (a substance abuse disorder claim), or intentional (potentially resulting in mental health claim) and apply the applicable cost share.

For these reasons, testing should ONLY be required if the plan wants to apply a separate cost share for MHSA emergency services that is different than what's in place for medical emergencies, similar to the regulators' approach to pharmacy benefits.

III. Non-Quantitative Treatment Limits

In our opinion, the inclusion of the set of non-quantitative treatment limits (NQTLs) in the Rules exceeds the scope of regulatory authority defined by the Act. MHPAEA defines a "treatment

limitation" as one that includes limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment. In contrast, the Rules define *two* categories of treatment limits: quantitative and non-quantitative treatment limits. Quantitative treatment limits represent the examples of limits provided by MHPAEA (e.g. treatment frequency, visit and day limits), but the NQTLs represent a second category of non-numerical limits that are not described in the Act and for which there are no examples.

Presumably, this second set of limits is derived from the last phrase of the definition of treatment limits that includes other "similar" limits. But it stretches the meaning of the word "similar" to create a separate category of treatment limits defined by the fact that that those limits do not fit in the first category. Separate standards also had to be created (substantially all and predominant for financial requirements and quantitative treatment limits vs. comparable processes, strategies and evidentiary standards, applied no more stringently for NQTLs) to accommodate the significant differences in these two categories of treatment limitations. Further, many of the processes, strategies and evidentiary standards addressed by the NQTLs are not under employers' control, but relate to the internal processes of medical carriers. As such, the Rules are regulating insurance practices not benefits.

MHPAEA is designed to assure parity of medical and MHSA *benefits*. If Congress had intended for MHPAEA to regulate medical carrier operations and decision-making, they would have said so. Application of the NQTLs unnecessarily complicates, and at times results in a detrimental impact on the processes and strategies designed to assure the quality of MHSA care. Therefore, NQTLs should be removed as requirements under the Rules.

If the Departments are unwilling to remove the NQTLs as requirements, alternative recommendations are delineated below.

A. Unintended Consequences of Network Inclusion Standards and Rates as a NQTL.

As stated above, the Rules define a NQTL as a non-numerical limit on the scope or duration of a benefit and provide only a partial list of those limits. But it is unclear how some of the examples provided limit the scope or duration of a benefit. For example, how do network inclusion standards, including provider reimbursement rates, limit the scope or duration of MHSA services? To the contrary, complying with the requirement for comparable network inclusion standards and rates for medical and MHSA services may result in *creating* limitations on MHSA services and access to them.

Requiring MHSA network inclusion standards to be comparable to medical could limit the available network for MHSA services to only those providers with credentials similar to medical providers. Medical professionals are included in networks based on their license, certification, hospital privileges, and ability to provide 24-hour coverage. MHSA professionals may not be independently licensed, practice in a hospital, or provide a service that requires 24 hour availability. Excluding these providers from MHSA networks may limit the provider types

available to “medical” professionals such as psychiatrists, resulting in less appropriate care at higher costs than needed. It may also cause existing provider shortages to worsen.

The Rules are unclear regarding the level at which provider reimbursement rates must be comparable. If all that is necessary for compliance is that both medical and MHSA rate setting is consistent with a market-based approach, MHSA rate setting processes and resulting fees for the most part will likely remain unchanged. If, however, rate setting must be comparable at a more detailed level (e.g. annual cost of living increases must be applied, tiering of provider fees based on educational degree or license is not permissible), compliant MHSA rate setting processes could inflate the rates paid to providers, resulting in higher out-of-pocket costs for members paying co-insurance, and **creating** barriers to care.

To address these issues, the Rules should be modified to remove network inclusion standards and rate setting from the list of NQTLs. To address Department concerns regarding MHSA treatment access, add access as an example of an NQTL. In this way, if network inclusion standards or rates are negatively impacting access, carriers can adjust them sufficiently to improve access, rather than modifying network standards and rates for the sole purpose of making them comparable to a medical approach.

B. Unintended Consequences of including Medical Management Strategies as a NQTL

An underlying assumption of the requirement that MHSA processes, strategies and evidentiary standards should be comparable to medical, is that medical processes, strategies and protocols are “best” and worthy of emulation by MHSA, unless a national standard can prove otherwise. Mental health advocates have fought against this “medicalization” of MHSA treatment for years.

The medical approach to treatment is a disease-based model that focuses on symptom reduction as a goal. Interventions are primarily biological in nature and imposed on the patient. In general, medical diagnosis and treatment success is confirmed by laboratory, radiology and blood tests. The medical model often places the physician or other medical personnel in a directive role toward a patient, who is expected to passively accept and comply with treatment recommendations. A medical approach to MHSA treatment can be detrimental to outcomes.

In general, MHSA conditions and treatments are inherently different from medical. For MHSA, a recovery-based model is preferred over a medical model, which is focused on the management of symptoms. (President’s New Freedom Commission on Mental Health Care, 7/22/03.) Diagnosis and treatment success are frequently established through structured interviews and self-report. Interventions are cognitive, behavioral, emotional or biological, and outcomes are largely a result of the combination of intervention, the therapeutic relationship, community resources and self-help, which create unique challenges in setting standards for evidenced-based treatments. MHSA treatment is more commonly a collaborative process between the “client” and a licensed or certified non-medical professional, which adapts to accommodate the varying severity

and dangerousness of symptoms manifesting over time. To require application of comparable medical processes, strategies and evidentiary standards to MHSA, ignores the inherent differences in medical and MHSA conditions and associated treatments.

Pre-parity, MHSA care management strategies addressed the unique aspects of MHSA conditions and treatments. For example, plans that require prior authorization of in-network, outpatient MHSA services almost never issue outpatient denials. Instead, prior authorization is used to assess if a member requires more expedited services or a higher level of care than requested, to provide assistance with navigating the confusing array of MHSA provider types and services for those who have not already selected a provider, and to obtain baseline information regarding symptoms against which progress can later be compared. This type of assistance is not required for medical care because most members initially seek services from a PCP who determines a treatment plan that matches the level of need and establishes symptom baselines through medical tests. For MHSA outpatient services, concurrent review is conducted relative to condition-specific practice guidelines to identify ineffective MHSA treatment and to encourage providers to consider alternative treatment strategies.

Requiring comparable medical processes for in-network outpatient services effectively prohibits the use of utilization management for purposes of quality improvement in this classification because medical plans typically do not require prior authorization or concurrent review of outpatient visits. Applying such an approach to MHSA care will leave little to prevent outpatient care from continuing long after the medical necessity for it has ended.

When this prohibition against utilization management is combined with unlimited services and an absence of financial requirements, in-network costs will likely increase rapidly as plans will be required to provide reimbursement for treatment in the absence of a clearly-identified MHSA condition.

A similar problem exists with the out-of-network classifications. In the not so distant past, media stories reported inpatient providers that advertised and recruited troubled adolescents for summer-long stays. Year-long spa “vacations” in the desert were promoted for individuals with any one of multiple addictions (e.g. alcohol, drug and sex). Medical plans infrequently review out-of-network inpatient care for medical necessity, so comparable rules will now be applied to inpatient out-of-network MHSA care. Because there are no lab tests that determine when treatment is complete, members may continue in care long after maximum impact has been reached, leaving plans open to sky-rocketing costs in the out-of-network classification as well.

The Rules should not require medical management strategies to be comparable on a classification by classification basis. To take into account the inherent differences in medical and MHSA conditions and treatments, the Rules should require plans to implement medical management strategies for similar service types and issues (e.g. high cost, high risk, and susceptibility to fraud), regardless of classification.

The Departments should adjust the cost impact estimates of MHPAEA as outpatient services represent approximately half of a plan's MHSA costs when cost shares, limits and management are permitted. In the absence of these strategies, in-network outpatient costs will increase more than original estimates anticipated. In addition, out-of-network costs will also be subject to higher increases than expected.

C. Unintended Consequences of Applying NQTLs on MHSA and Medical Integration

Requiring comparable medical MHSA processes, strategies and evidentiary standards is unlikely to further the integration of MHSA and medical treatments, but instead result in the loss of the specialization necessary to improve MHSA outcomes. This is best illustrated in the increasing inability of MHSA carve-outs (organizations that specialize in the management of MHSA services) to effectively compete with MHSA carve-in programs (medical carriers that manage MHSA benefits as part of the management of medical benefits) in the post-MHPAEA market. The advantages of a MHSA carve-out include more robust MHSA interventions, innovations and research, and a focus on improving outcomes that is not characteristically offered by carve-ins. Carve-outs are well-positioned to integrate MHSA with other health and wellness programs across an employer's population and design MHSA services and programs to match overall members' needs.

To comply with the Rules, the carve-outs must now obtain detailed information about competitors' rate setting processes, network inclusion standards and utilization management approaches to design their MHSA management approach. If there are multiple medical carriers for a single employer, the carve-outs must conduct daily operations in potentially as many different ways as there are carriers. (It is almost impossible to implement a single, "richest" compliant approach for non-quantitative factors. For example, how would the "richest" provider reimbursement strategy be determined? Would a plan select the highest reimbursement rate, which benefits the provider or the lowest reimbursement rate benefiting the member paying co-insurance? Is the richest evidentiary standard a panel of experts or requiring two controlled studies?) The organization's focus becomes matching medical carriers' processes as opposed to best practices for MHSA. When this prospect is combined with required administration for shared deductibles, many employers decide it is most efficient to carve-in MHSA and save the additional fees paid to the carve-out. Alternatively, the carve-ins refuse to cooperate with compliance efforts citing proprietary practices, forcing plans to make a carve-in decision. The result in both cases is a loss of MHSA specialization.

Instead, the Rules should require MHSA programs to operate consistently with applicable medical and MHSA clinical and practice standards, not the operations of a specific medical vendor.

D. Employers' Ability to Comply with Requirements for Comparable NQTLs

On a practical level, many NQTLs are not under the control of an employer, nor does the employer have knowledge of carriers' internal operations. Most employers are unaware whether

plans differentially approach black box warnings for medications commonly used to treat MHSA conditions or more stringently apply medical necessity criteria for MHSA inpatient care than to medical inpatient care. Further, there is no simple way in which the comparability of processes can be determined, other than relying on the carriers' assertion that no differences exist. This is especially difficult if a MHSA carve-out is matching processes of multiple medical carriers, who are potential competitors and motivated to protect proprietary information. Nonetheless, the Rules require employers to pay steep financial penalties for medical and pharmacy vendors' failures to implement comparable processes, strategies and evidentiary standards.

Because employers lack control and knowledge of many NQTLs, the Rules should require employers to take reasonable steps to assure carriers' compliance, but should not hold employers accountable for a carrier's incorrect interpretation or implementation of comparable processes, strategies and evidentiary standards.

IV. Determining Conditions to which MHPAEA Applies

The Rules create a false dichotomy in the approach to determining which conditions are MHSA conditions and therefore subject to MHPAEA. Many MHSA conditions have biological causes or correlates and associated treatments. For example, it is well-established that major depression can have a biological basis and is effectively treated with a combination of medication (a biological intervention) and psychotherapy. Individuals with anorexia may require admission to a general hospital to address the consequences of malnutrition. Children with an autism spectrum disorder may require speech therapy, occupational therapy or rehabilitation. Individuals with addictions may require medical detoxification before treatment for the addictive process can begin.

The Rules indicate that it is only the nature of the condition that determines whether a benefit is subject to MHPAEA, when on a practical level, it is a combination of the nature of the condition, the type of provider, the setting in which treatment occurs, and the symptom treated that determines whether a treatment is MHSA or medical. The Rules can be read to require that medical treatments provided for treatment of MHSA conditions will be subject to MHPAEA. But when the same treatments are provided for medical conditions, they will be subject to medical limits and cost shares. This complexity will be extremely difficult for claims payers to administer correctly and will likely add delays to claims administration so payers can determine which cost sharing and limits should be applied.

For these reasons, the Rules should make only those services delivered for treatment of a MHSA condition, provided by a MHSA provider, for treatment of a MHSA symptom, in an MHSA setting subject to MHPAEA.

V. Continuum of Care

The Rules require that if a plan provides coverage for MHSA conditions in one of the six classifications, coverage must also be offered for each classification in which medical coverage is

offered. The Rules also state that the six classifications are the only classifications used for applying the parity requirements of MHPAEA.

Consistent with these requirements, plans should only be required to cover comparable services in the six classifications. For example, if plans offer coverage for depression, the plan must cover treatment for depression in all six classifications, but may exclude services for which there is no medical comparison. Further, plans should not be required to cover services that fall outside of the six classifications (e.g. foster care, group homes).

VI. Applying MHPAEA to Smoking Cessation Programs

In public meetings, the Departments indicated that MHPAEA applies to smoking cessation programs. This application appears to be an over-reaching interpretation of MHPAEA. Many smoking cessation programs are not part of a group health plan. Instead, they consist of telephonic coaching or web-based, educational programs offered to help participants curb smoking habits in the absence of a MHSA condition. The time-limited services are not delivered by MHSA professionals and are often offered at no cost to the member. Applying MHPAEA to these programs would be akin to applying MHPAEA to weight loss programs such as Jenny Craig or Weight Watchers when no underlying medical condition exists that requires treatment.

In addition, it does not seem reasonable to require that if nicotine replacement drugs are a covered benefit that plans should be required to cover services in all six classifications for smoking cessation services. There is no recognized standard indicating that inpatient services for smoking cessation are medically necessary or should be covered.

The Rules should make clear that behavior change coaching and support programs that address behaviors such as smoking cessation, weight loss and exercise are not subject to MHPAEA unless those interventions are implemented as treatment strategies to address an underlying MHSA condition.

VII. Cost Exemption

Given the unanticipated requirements that limit a plans ability to manage outpatient and out-of-network MHSA services combined with the absence of financial requirements (in some classifications) and potentially higher provider reimbursement costs, MHPAEA's cost exemption holds increased importance to employers implementing a compliant MHSA design. But the cost exemption is more complicated and onerous than the cost exemption contained in the Mental Health Parity Act of 1996 (MHPA 1996). At the outset, clarification is needed regarding when the plan's 2 percent cost increase must occur: one interpretation would require this increase in the first plan year when the MHPAEA requirements apply (generally, plan years beginning on or after October 3, 2009); another interpretation would require this increase in the first plan year involved in an initial exemption request. SHRM believes that the intent of this provision was to require the 2 percent cost increase in the first plan year involved in an initial exemption request.

Further, it appears that if a plan qualifies for and elects a cost exemption; it will be exempt from the parity requirements only for the next plan year. To qualify for another exemption, a plan would, under this interpretation, need to comply with the parity requirements again. This scenario could require constant plan design changes to come into compliance with the parity requirements causing employers to forego the cost exemption. The risk of this interpretation is that employers who are unwilling to undergo seemingly constant plan design changes that will anger and confuse members and the expense (including retaining an actuary) of the cost exemption, may simply decide to eliminate or restrict MHSA coverage.

Consequently, SHRM urges the Departments to offer a cost exemption that is feasible and serves to protect plans from rapid increases in MHSA costs. The cost exemption should be designed to permit plans to provide cost increase estimates in advance of complying with the Rules and to maintain that exemption until projected estimates are below threshold.

III. CONCLUSION

SHRM and its members support the goals of MHPAEA yet we encourage the Departments to recognize the practical implications of implementation, the unintended consequences of some of the provisions, and the cost and administrative burden of some of the requirements. SHRM members will be the individuals who implement the Rules beginning July 1, 2010. We urge the Departments to adopt at least a one plan year period of good faith compliance to give employers and their vendors a full annual cycle to implement these sweeping, unanticipated, and at times, unclear regulations.

We appreciate the opportunity to assist the Departments as they continue to develop guidance on MHPAEA.

Respectfully submitted,

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