WELLPOINT

655 15th Street, NW
Suite 425
Washington, DC 20005

Elizabeth P. Hall
Vice President
Public Policy

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Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8010

ATTENTION: CMS-4140-IFC

Re: WellPoint, Inc. Comments on the Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 26 CFR Part 54, 29 CFR Part 2590, and 45 CFR Part 146 (75 Fed. Reg. 5411, February 2, 2010)

Dear Ms. Tavenner:

On behalf of WellPoint, Inc., thank you for extending the opportunity to comment on Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 (75 Fed. Reg. 5411, February 2, 2010).

WellPoint is the nation's largest health benefits company, with more than 33 million members in its affiliated health plans. As an independent licensee of the Blue Cross and Blue Shield Association, WellPoint serves members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as the Blue Cross Blue Shield licensee in 10 New York City metropolitan and surrounding counties and as the Blue Cross or Blue Cross Blue Shield licensee in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin. In a majority of these service areas, WellPoint does business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield or Empire Blue Cross Blue Shield (in the New York service areas). WellPoint also serves customers throughout the country as UniCare.

WellPoint has completed testing of its standard plans under the requirements of the MHPAEA regulations, and in the course of analyzing the regulations and performing testing, a number of issues have arisen that we believe need to be clarified and resolved. As a result, we would urge the Department and the Administration that it is important that the agencies resolve unclear issues in a timely manner (we suggest 90 days from the date in which comments are due to the Department) in order to inform group health plans and health insurers of their compliance responsibilities. Attached as Appendix A are our comments on several issues we believe are critical to implementation of the MHPAEA regulations.

We appreciate the opportunity to comment on these important issues, and we hope that our comments will assist the agency in evaluating the impact of the MHPAEA on the health care and health benefits marketplace. Please contact Jennifer Boyer by phone at (202) 628-7831 or by e-mail at Jennifer.Boyer@WellPoint.com with any questions.

Sincerely,

Elizabeth P. Hall
Vice President for Public Policy

Attachments

Appendix A

Issue 1: A Short Compliance Due Date Requires Reasonable Enforcement Rules, or an Extension of the Compliance Date

First and foremost, WellPoint is concerned with what we believe is an extremely short compliance deadline required by the regulation, particularly because the regulation requires substantial compliance work in addition to the compliance work that had already been done to comply with the Act. The Department is perhaps unaware of all of the preparation that an employer with a self-funded health plan must take in arranging an open enrollment period and materials. Many plans with a July 1 renewal date have been extremely concerned with their ability to comply with the timeline, because they are in the process of preparing open enrollment materials at the same time that they are required to test (and perhaps amend) their plans.

For insured plans, WellPoint has a similar concern: we are concerned that there is insufficient time before the compliance date to perform compliance testing, adjust benefits where necessary, amend insurance policies and certificates, and file and obtain state insurance regulator approvals of the policy and certificate amendments.

Because of the too-short compliance date and the complexity of the regulation, and based upon the Departments' verbal assertions in teleconferences that they will take a reasonable approach to enforcement, we suggest that the Department develop a special enforcement rule similar to HHS' enforcement rule for HIPAA Privacy.[1] Guiding compliance principles in the HIPAA enforcement rule require the HHS Secretary to seek, to the extent practicable, the cooperation of affected companies in obtaining compliance, and give the Secretary the option to provide technical assistance to help affected companies voluntarily comply. Further, the HIPAA enforcement rule states that the HHS Secretary will attempt to resolve noncompliance issues by informal means. The HIPAA enforcement rule codified a regulatory commitment to promoting and encouraging voluntary compliance with the HIPAA Rules, and was designed to provide the HHS Secretary with reasonable discretion "to avoid being overly prescriptive in areas where it would be helpful to gain experience with the practical impact of the HIPAA rules, to avoid unintended adverse effects."[2]

We also recommend that the compliance date be moved to October 1, 2010, which will give us sufficient time to test all of our plans, update our plan designs, receive approval from the various state Departments of Insurance and update our claim systems to implement these approved plan changes. In addition, this will coincide with other plan changes required by federal health care reform, and will only require us to make policy changes once instead of repeatedly.

Issue 2: Actual Compliance Testing Results in Imparity for Mental Health/Substance Abuse Benefits

WellPoint has some significant concerns related to the implementation of the cost-sharing provisions and requirements in the regulation and the unintended consequences that we believe have the potential to result from them. Since the regulation was issued on February 2 of this year, WellPoint has been analyzing the regulations and conducting compliance testing of its plans to adjust them to meet the new requirements of the regulations. Our compliance testing has revealed a commonly occurring scenario: Because cost-sharing on a particular classification of medical/surgical benefits does not meet either the "substantially all" or "predominant tests," no cost-sharing can be imposed upon mental health/substance abuse benefits. Thus, this situation means that the mental health/substance abuse benefits must be modified to eliminate the cost-sharing, making the mental health/substance abuse benefits richer than the medical/surgical benefits, resulting in an imparity in benefits. Our testing has shown that this result is the rule, rather than the exception.

We have pulled data for plans in New York that were tested with the pass/fail status and have determined that 75% of plans would fail in the outpatient benefit category. Notably, plans that are offered in conjunction with health savings accounts or health reimbursement accounts do not require any benefit modification. This is because only preventive health care services are subject to anything other than deductible or coinsurance. However, all of our other plan designs, are failing the test in the outpatient benefit category. This is because our plans generally apply cost-shares (e.g., $20 copay) to services provided in a physician's office, but deductible and coinsurance apply to services

[1] The HIPAA Enforcement Rule is codified at 45 CFR Part 160, Subparts C, D, and E (71 Fed. Reg. 8390)(Feb. 16, 2006). See, in particular, 45 CFR sec. 160.304, 160.312, 160.410, and 160.412.
[2] 71 Fed. Reg. at 8391

provided in a facility setting (e.g., MRIs, outpatient surgery, etc.). Under this plan design, which is very common in all of WellPoint's plans and those of the self-funded plans we administer for employers, in most cases we are faced with having to remove the cost-share entirely. In other cases, our members will see coinsurance applying when they visit their mental health professional instead of the copay that would apply if they saw any other physician in their office, which is where the majority of care is provided. This discrepancy will cause significant confusion for our members receiving mental health/substance abuse services.

As we understand the intent of the MHPAEA was to ensure that mental health and substance abuse benefits were provided at parity -- that is, financial and treatment provisions applicable to mental health and substance abuse benefits are to be, to the extent practicable, the same as benefits on the medical/surgical side. We believe that a regulation which could result in a scenario that legally requires much richer mental health/substance abuse benefits and that this would deviate from the legislative intent of the MHPAEA as well as provide a counterintuitive result that could result in unintended consequences for our members, including increased costs. We respectfully request that the Department revisit the definitions of "substantially all" and "predominant" so as to ensure that compliance testing under the regulation will ensure mental health/substance abuse benefits are at parity with, and not richer than, medical/surgical benefits.

We believe that if the Department does not revisit the parity test, plan sponsors could be forced into a difficult Hobson's choice: either increase the cost of the plan to accommodate no cost-sharing on mental health/substance abuse benefits (potentially making the plan unaffordable for employer and/or employee), or modify the plan's medical/surgical benefits such that increased cost sharing in the various benefit classifications will permit cost-sharing on the mental health/substance abuse side. We believe that neither result would be beneficial to either plan sponsors or plan beneficiaries. Alternatively, the plan could apply for a cost exemption or decide to discontinue offering mental health/substance abuse benefits altogether, which will also have undesired effects contrary to the purpose and intent of the MHPAEA.

In order to minimize consumer confusion, we recommend that outpatient mental health and substance abuse benefits be mapped to the most similar type of outpatient services provided on the medical side. Instead of combining all medical/surgical outpatient services, which include services that we believe will never apply to the treatment of mental health or substance abuse conditions, outpatient office visits on the mental health and substance abuse side should be mapped to outpatient office visit services on the medical side. Inpatient and emergency room services are specific enough that combining medical and mental health and substance abuse into those separate categories is appropriate.

Issue 3: The increased costs, administrative expenses, and compliance difficulty for plan sponsors and health insurers to establish procedure and IT coordination between health plans and behavioral health carve-out vendors could greatly outweigh any potential benefit of the regulation

The regulation takes a conflicting view of behavioral health carve-outs, companies that manage and process mental health and substance abuse benefits, primarily for employers with self-funded health plans. Many employers with self-funded health plans choose to have their medical/surgical benefits administered by a third-party administrator and their behavioral health benefits managed by a "carve-out" entity. In fact, a very large employer may retain several behavioral health carve-out companies to manage behavioral health benefits for its many plans and plan options.

In the Preamble to the regulation, the Department asserts that behavioral health carve-outs are a good way for plans to save on behavioral health costs by providing targeted management of behavioral health benefits. However, we believe that the real world application of the regulation will serve to discourage the use of carve-outs.[3] Compliance with the regulation will require expensive and time-consuming coordination between medical plans and behavioral health carve-out companies, both in procedure and information technology interfaces, and the cost of this coordination is proving to be much more than the $35,000 per interface that the Department estimated.

In addition to the expense of the technical interface and process involved in "sharing" deductibles between the medical plan and carve-out entity, we believe an employer that uses a carve-out will be required to test its mental health/substance abuse benefits against every single medical plan option. This will greatly complicate the compliance analysis and may force changes to medical plans that are unfavorable to individuals covered under the plans.

[3] We note that this is essentially the argument of the Coalition for Parity, Inc. in the litigation currently pending in the U.S. District Court for the District of Columbia (Coalition for Parity, Inc. v. Sebelius, case no. 1:10-cv-00527-CKK).

Issue 4: The Department should clarify that a plan may permissibly determine what type of mental health or substance abuse facilities are eligible for benefits

The MHPAEA is intended to provide parity with respect to financial requirements and treatment limits. The new regulation does not mandate that plans provide coverage for any specific types of mental health conditions or substance use disorders, types of services or treatments, or settings of care. However, the language of the regulation does not clarify that a plan may permissibly determine what type of mental health or substance abuse facilities are eligible for benefits, and WellPoint respectfully requests this clarification to be included within the final rule.

Treatment limits are defined as including "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) as amended by Pub. Law No. 110-343, *emphasis added*). In this context, the term "treatment limits" applies to limits on the number of days of treatment or number of office visits that are covered (or similar limits), and does not explicitly and is not intended to require the plan to cover all treatments or settings of care for a particular mental health condition or substance use disorder covered under the terms or conditions of the plan.

Additionally, the MHPAEA makes clear that, except for the parity requirements, nothing in the Act is intended to affect "the terms and conditions of the plan or coverage relating to such benefits . . . ." (29 U.S.C. §1185a(b) and 42 U.S.C. §300gg-5(b) as amended by Pub. Law No. 110-343). The MHPAEA provisions indicate a clear understanding that plans have the discretion to determine what conditions, treatments, services, or settings of care are covered under the terms and conditions of the plan.

This position is supported by the legislative history of the MHPAEA. The Senate Committee Report includes the following statement with respect to the application of the parity requirements:

> 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. [Emphasis supplied.]

(Sen. Rep. No. 110-53, 110th Cong., 1st Session (2007) at p. 7). The House Energy and Commerce Committee Report includes similar language:

> In addition, this requirement does not change the current ability of an insurer or provider to determine medically necessary and appropriate care and treatment for their patients. It merely ensures that patients are not denied mental health coverage based on the specific disorder they have. For example, a person cannot be denied coverage by their health plan merely because they have autism. A plan may determine, however, whether a treatment is medically necessary or appropriate for a given person at a given time based on their individual situation.

(H. Rep. 110-374, Part 3, 110th Cong., 2nd Session (2008)).[4]

Thus, we believe the MHPAEA is not intended for plans to cover any specific services or treatments, or settings of care, however we would appreciate the Department clarifying this intent within in the regulation.

Issue 5: The Department may have underestimated the compliance burden and expense to plans

The Department requested public comments on their compliance cost estimates, which 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 to make the needed changes to the plan and related documents. This results in a total cost estimate of $27.8 million in the first year. This estimate also assumes that each issuer has an average of just 1,000

[4] The version of 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.

plans.[5] We believe that the Department may have significantly underestimated the compliance burden and expense to plans.

The cost and burden of complying with the regulation is very significant and this should be taken into consideration by the Department. Plans have already spent considerable time, effort and cost in complying with the black letter provisions of the MHPAEA statute prior to October 3, 2009. While we understand the tremendous strain that the Department is under to meet the deadlines required by Congress for various initiatives which has only been increased by the passage of health care reform legislation, the Department did not supply any interim guidance for plans as they were performing their MHPAEA compliance activities, and so plans were left to interpret the statute on their own. Because plans requested guidance from the Department, plans feel that they are now being penalize with additional compliance burden for relying upon their reasonable interpretation of the statute, even though it conflicts with the regulation, absent any additional guidance from the Departments.

Additionally, we are concerned that these significant additional costs of complying with this regulation will only serve to drive up the costs of health insurance and self-insured health plan benefits, at a time when the nation seems to have the utmost sensitivity to costs, especially those that have the potential to further burden plans with additional administrative costs. Compounding the issue is the fact that we believe plans, in many instances, will have to undo benefit changes they had already made in their best efforts to comply with the MHPAEA statute in 2008-2009. Moreover, plans will very likely experience increased inquiries and confusion from plan beneficiaries over their benefits being modified yet again to comply with a law that they believed their employer had already complied with. Responding to these inquiries has the potential to even further drive up plan administrative costs.

Interpretation of this regulation has been far more burdensome than expected, given the legislative language of the final bill. The regulation establishes extremely complex standards for comparisons of mental health and substance abuse benefits with medical/surgical benefits. The complexity of modern benefit designs – including various types of cost sharing (e.g., deductibles, copayments and coinsurance), different levels of coverage (e.g., employee only, employee plus one, employee plus two, etc.) and treatment/benefits limitations – and the fact that the regulation requires each of these to be tested separately within each of the six classifications, means that such comparisons will necessarily be numerous as well as complex.

WellPoint has now engaged in three months of compliance activity relative to the regulation, and based upon our experience, we believe that the Department has the potential to have seriously underestimated the projected true costs of complying with the regulation. For example, the time spent by our legal professionals to read, analyze, interpret, provide legal guidance and answer numerous compliance questions on this regulation has far exceeded the one half-hour estimated by the Departments. In fact, our legal professionals have alone spent several hours attending teleconferences at which the Department provided verbal guidance and interpretation of the regulation.

More importantly, however, attorneys lack the professional qualifications and experience necessary to compliance test a plan under this regulation. Compliance testing necessarily includes analyzing and categorizing a plan's claims data, a task for which an attorney is not at all suited. In order to accurately perform plan compliance testing, the services of actuaries and underwriters are required. We estimate that our actuaries and underwriters have spent, or will spend before the compliance date, between 30 to 45 minutes on each one of our 46,000 plans in force, or roughly between 23,000 and 34,500 hours. Additional time will be spent running the data through our testing tool. While the Department has assumed that there are about 460 health insurance issuers in the group market, no estimate was given as to the number of self-funded group health plans subject to the regulation. Even if WellPoint is more efficient at plan compliance testing than other entities, we believe that the estimated compliance burden for the industry is many multiples of the $27.8 million in the first year that the Department estimated.

Further, we are concerned with the cost and burden of compliance with expected additional upcoming MHPAEA regulations that may again require plans to alter benefits. The Department verbally promised to issue in the near future new regulations interpreting the cost exemption and scope of services/treatment settings portions of the MHPAEA. If these new regulations deviate from plans' reasonable interpretations in the current compliance process, plans will again need to re-test their benefits and potentially modify them once more . We are concerned that such frequent benefit changes has the potential to confuse employers as well as their employee plan beneficiaries, who will in turn believe that they are not able to rely upon plan benefits (and/or cost-sharing amounts) that change so frequently. In fact, plan beneficiaries may find themselves in a situation where their plan benefits change unexpectedly

[5] 75 Fed. Reg. sec. 5410, 5426.

during a course of treatment due to necessary plan compliance with a multitude of new and sometimes inconsistent rules. This type of uncertainty will further cause concern among individuals who rely upon the security and stability of their health benefits to finance their health care needs, and it will cause employers and other plans sponsors to frequently revise their financial projections and cost estimates for sponsoring their plans, leading to uncertainty in the business world.

Finally, the required annual benefit testing will be costly and will dissuade plans from innovating plan benefits in an attempt to hold down spiraling health care costs. We respectfully suggest that the Department should encourage plan innovation, rather than hamper it.

We therefore at a minimum believe that the accurate cost and burden of complying with the rules should be taken into strong consideration and respectfully request that the Department consider additional detailed analysis of the costs involved relative to the potential benefit of the regulation. We would be happy to provide additional data to assist the Department in their cost/benefit analysis. Should the Department choose to reissue the regulation, we respectfully request that the reissued regulation address all essential issues at the same time and with the same compliance date.

Issue 6: Interactions with Health Care Reform

Compliance with the regulation will probably require most health plans to modify their mental health/substance abuse benefits in some benefit classifications. We are finding that in some cases the compliance testing results prohibit us from applying cost-sharing to MH/SA benefits in some classifications (e.g., outpatient mental health). If a plan wanted to apply some sort of cost-sharing to its mental health/substance abuse benefits in order to maintain the financial stability of the plan, it would have to adjust the medical/surgical benefits such that they met the "substantially all" and "predominant" tests. The unanswered question of whether that adjustment of medical/surgical benefits, which is essentially a business decision not directly driven by compliance with the regulation, could eliminate the grandfather status of the plan under the PPACA. Plans may inadvertently eliminate their grandfather status because they, in good faith, adjusted their benefits to comply with mental health parity regulations and later regulations could indicate that the adjustment would eliminate the grandfather status. Alternatively, if the plan felt that the adjustment of the medical/surgical benefits would run a large risk of eliminating the plan's grandfather status and refrained from that adjustment, it is possible that the plan benefits could become too expensive and contribute to employers eliminating coverage (or severely cutting it back) prior to 2014. Because of this we recommend that at a minimum the Department revise the effective date of this regulation to match the effective dates of health care reform rules to avoid unintended consequences. Alternatively, we respectfully request that the Department retract this regulation and reissue it to address all essential interactions with the recently passed health care reform legislation.

Issue 7: Applicability of regulations to Medicaid and CHIP

Finally, we believe that it would be inappropriate for the Department to use the regulation as a model to apply to the Medicaid and CHIP programs. Instead, CMS should take into account the unique structure of Medicaid and CHIP in each state when formulating guidance.