National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

May 27, 2009

Employee Benefits Security Administration
United States Department of Labor
200 Constitution Avenue NW, Room N-5653
Washington, D.C. 20210

Re: Request for Information
Docket ID: EBSA-2009-0010

The National Business Group on Health appreciates the opportunity to respond to the request for information and the Department of Labor draft guidance and regulations to implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

The National Business Group on Health represents about 300 large employers providing health coverage to more than 55 million U.S. employees, retirees, and their families. We are the nation's only non-profit organization devoted exclusively to finding innovative and forward-thinking solutions to large employers' most important health care and related benefits issues. Business Group members are primarily Fortune 500 and large public sector employers with 59 members among the Fortune 100.

Substantially All Medical and Surgical Benefits

The guidance should define with concrete examples what the MHPAEA considers "substantially all medical and surgical benefits". The majority of expenses paid for benefits provided by most group health plans are for physician, hospital, and outpatient services including prescription drugs.

The intent of MHPAEA to provide mental health and / or substance abuse treatment benefits "as any other illness" and extend the same "duration and scope" of the majority of medical and surgical benefits provided by group health plans needs to be illustrated with specific examples.

We recommend defining substantially all medical and surgical benefits to be limited to outpatient care, inpatient hospitalization, and follow up care including prescription drugs.

Predominant Financial Requirements and Treatment Limitations

Consistent with defining what MHPAEA considers the majority of treatment and services provided by group health plans, specific examples should be provided in the agencies' guidance to illustrate how plans are to determine the level of annual deductibles, copayments, and coinsurance. The agencies should clarify whether plans can have separate annual deductibles applied only to mental health and / or substance abuse if they are more generous than the deductibles required for medical / surgical benefits.

Alignment with Primary or Specialty Care Treatment

The wide range of treatment services available for mental health and substance abuse and the extensive variety of providers creates uncertainty as to how group health plans should align benefits to provide parity in cost sharing and service limits. Outpatient mental health services, for example, are typically provided in "talk therapy" settings by licensed professional counselors at the master's degree level (e.g.; MSPsych, MSW, MEd, etc.). Hospitalization and more in-depth diagnostic and clinical evaluation and treatment is provided by specialists at the doctoral level (e.g.; MD, PhD, EdD, PsyD, etc.). The majority of mental health prescriptions in the country are still ordered through patients' primary care physicians.

The types of mental health and / or substance abuse treatment and services that are considered primary care or specialty services (as well as the types of providers classified as primary or specialty) for the purpose of aligning cost sharing and service limits to provide parity is an issue that plans will have to address under MHPAEA.

We recommend that the decision on classifying services and providers as primary or specialist can be left to the plans.

Out-of-Network Providers and Employee Assistance Programs

Many large employers provide assessment, referral, and brief counseling for family issues as well as other performance management resources through employee assistance programs (EAPs). These plans sometimes serve as the first contact for employees with mental health and / or substance abuse conditions.

The guidance should clarify that maintaining EAPs to identify employees' needs and link them with appropriate care and providers for mental health benefits (and substance abuse treatment benefits if provided) is acceptable and not considered a "treatment limitation" under MHPAEA since they are a way to identify mental health issues for referral.

We understand that this is allowed provided that:

- any reduction in benefits based on failure to pre-authorize treatment must be the same, or less than, any comparable reduction in benefits for failure to pre-authorize medical and surgical treatment for any other injury or illness; and

- If the group health plan provides medical and surgical benefits for out-of-network treatment, the EAP must provide participants an option to also seek treatment from out-of-network mental health providers (and out-of-network substance abuse providers if included).

Behavioral Health Organizations and Pervasive Developmental Disorders

Many large employers provide supplemental coverage for Pervasive Developmental Disorder (PDD) separate from mental health benefits through contracted third party behavioral health organizations. PDDs are also known as Autism Spectrum Disorders (ASD). These are neurobiological and genetic conditions that manifest early in life and are characterized by impairments in learning, social skills, sleep disorders, and problems communicating.

Treatment is typically rendered in, and coordinated through, the elementary and middle school environments and involves parental education, behavioral therapy, and work with audiologists, physical and occupational therapists, and speech pathologists. Treatments for these developmental disorders are highly dependent on the individual and no two approaches are the same.

Because they are considered developmental and learning disorders, they should not be subject to the mental health parity requirement. If parity were required, many employers would be forced to discontinue these very valuable benefits. Given the uniqueness of the treatment protocols and the intensity of early intervention required (25–35 hours per week for 2 to 3 years), providing parity would simply be too cost-prohibitive for employers to continue to sponsor these programs.

The guidance should specify that Pervasive Development Disorders are not considered mental health conditions and are exempt from the parity requirements of the MHPAEA – even if they are provided through behavioral health organizations with some benefits paid by group health plans. This will allow employers to continue these extremely valuable supplemental benefits for the dependents of their employees.

Thank you, again, for the opportunity to provide comments in response to the RFI.

Please do not hesitate to contact me or Steve Wojcik, Vice President of Public Policy, at 202.585.1812 if you have questions or would like to discuss this feedback in further detail.

Sincerely,

Helen Darling
President