BEHAVIORAL HEALTH SYSTEMS
Behavioral Healthcare Programs for Business & Industry Since 1989

May 26, 2009

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4137-NC
P.O. Box 8017
Baltimore, MD 21244-8010

Re: Request for Information
Mental Health Parity and Addiction Equity Act of 2008

Dear Sirs:

Behavioral Health Systems (BHS) was formed in 1989 as a privately held Alabama corporation. We created and administer a preferred provider organization (PPO) of mental health-related hospitals, physicians and professionals. BHS markets this PPO to large, private employers under a "carve-out" arrangement, through which BHS administers their employees' mental health/substance abuse benefits. BHS staff oversees the care provided through this network, and process all claims between the employer client and BHS providers.

BHS is an open-model PPO which contracts with a broad network of specialty providers on a negotiated fee-for-service basis. This ensures maximum freedom of choice, and the ability of BHS to handle any size member volume.

BHS offers the lowest cost structure possible for mental health and substance abuse benefits on a fee-for-service rate basis, with no risk borne by BHS. This ensures maximum cost savings accrue directly to the client, that they have full knowledge of cost and utilization, and that client preference regarding plan design/coverage limits are easily accommodated.

Employers currently participating in the BHS managed care/EAP programs have realized a savings in the 25 – 50% range, while at the same time increasing benefits to their employees.

BHS has the sole endorsement of the Employers Coalition for Healthcare Options (Alabama) and the Louisiana Business Group on Health as the endorsed mental/nervous provider on behalf of their memberships, and maintained a similar endorsement from the Alabama Healthcare Council during its existence.

BHS represents 500 clients, 502,000+ covered lives, and 10,800+ providers across the nation. The opinions expressed below are not only BHS' opinion. We have thoroughly discussed MHPAEA with all BHS clients, and this represents the opinion of the BHS client base.

II, A. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

(i) What policies, procedures, or practices of group health plans and health insurance issuers may be impacted by MHPAEA? What direct or indirect costs would result? What direct or indirect benefits would result? Which stakeholders will be impacted by such benefits and costs?

BHS clients' plans include the following policies that would be adversely impacted by MHPAEA:

1. Discouraging recidivism. It is a BHS goal to ensure the effectiveness of benefit dollars spent by discouraging recidivism. BHS recognizes several factors associated with recidivism. Non-compliance with the prescribed post-discharge aftercare treatment plan is the most common and prevalent factor. Individuals diagnosed with substance abuse or a serious mental illness are likely to be the least compliant with the treatment regimen. BHS has implemented several methods of reducing recidivism, including:
    - Required participation in an aftercare program of up to two years duration following active treatment.
    - Frequent contact with the patient and family to provide support and promote the patient's participation in the prescribed aftercare program.
    - A benefit penalty to discourage patient non-compliance, including decreased benefit levels for subsequent treatment episodes or loss of benefits for a particular level of care.

    MHPAEA prohibits the benefit penalty by requiring mental health benefits consistent with the "predominant" benefit levels that apply to "substantially all" benefits. **MHPAEA, by requiring continued coverage of substance abuse treatment following successive relapses, actually empowers the user and promotes recidivism.** By not allowing the plan to limit the number of treatment episodes, MHPAEA forces the employer to terminate a non-compliant employee in order to contain plan costs, and requires the plan to pay multiple episodes of treatment for non-compliant dependents whose coverage cannot be terminated.
2. Precertification and concurrent review. BHS network providers are contractually required to adhere to BHS precertification/concurrent review procedures, and are prohibited from billing the patient for any services not precertified. Although MHPAEA allows the plan to apply utilization review protocols to out-of-network providers, these providers are not contractually bound to BHS procedures. Plans will be limited to retrospective review for services by out-of-network providers. Neither the member nor the out-of-network provider will be aware the services

are not covered until the claim is denied. The member will be liable for any out-of-network services denied for lack of medical necessity.

3. Exclusive provider network. One major advantage BHS offers is its "open network" philosophy. All current clients of BHS retain BHS as their exclusive provider choice (EPO model) given BHS' flexibility to add providers as requested. Requested providers affiliated on a patient-specific basis are reimbursed as any network provider. Under MHPAEA, out-of-network providers have no incentive to affiliate with the BHS provider network, even on a patient-specific basis, resulting in increased costs to the patient (higher deductible and copay), loss of BHS control over the utilization review process, and a potentially lower quality of care for the patient from providers not reviewed according to network affiliation criteria.
4. Limited services. BHS has never used day or visit limits to manage plan costs, yet we have been able to reduce every client's plan costs while offering members better benefits. MHPAEA will drive the employer to reduce covered services and diagnoses, while the member will forego necessary treatment due to higher out-of-pocket costs.
5. Separate deductibles and out-of-pocket maximums. These are difficult for a behavioral health carve-out plan to coordinate with the medical and surgical plan. If the employer rolls mental health and substance use disorder benefits back into the medical and surgical plan to avoid the difficulty of coordinating deductibles and out-of-pocket maximums, the employer doesn't obtain the utilization review expertise and cost benefit of the behavioral health carve-out.

With respect to financial impact on the plan sponsor, BHS has completed cost analyses on clients as large as 250,000 lives and has discovered the cost impact of parity will exceed the expected overall .5% increase. **This will cause many employers to drop mental nervous and substance use disorder benefits in the state of this economy and have opposite the intended effect.** Plan members will be forced to pay for services now excluded from coverage.

II, B. Comments Regarding Regulatory Guidance

1. The statute provides that the term "financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit. The statute further provides that 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. Do plans currently impose other types of financial requirements or treatment limitations on benefits? How do plans currently apply financial requirements or treatment limitations to (1) medical and surgical benefits and (2) mental health and substance use disorder benefits? Are these requirements or limitations applied differently to both classes of benefits? Do plans currently vary coverage levels within each class of benefits?

As a behavioral health carve-out plan, BHS is uniquely qualified to respond regarding mental health and substance use disorder benefits. In every case with our clients, the end result has been that BHS has offered plan members increased services while reducing the plan sponsor's costs.

BHS recognizes several factors associated with recidivism. Non-compliance with the prescribed post-discharge aftercare treatment plan is the most common and prevalent factor. Individuals diagnosed with substance abuse or a serious mental illness are likely to be the least compliant with the treatment regimen. Among BHS methods of reducing recidivism, is a benefit penalty to discourage patient non-compliance. This includes decreased benefit levels (higher deductible and copay for the patient) for subsequent treatment episodes or loss of benefits for a particular level of care.

MHPAEA prohibits the benefit penalty by requiring mental health benefits consistent with the "predominant" benefit levels that apply to "substantially all" benefits. **MHPAEA, by requiring continued coverage of substance abuse treatment following successive relapses, actually empowers the user and promotes recidivism.** By not allowing the plan to limit the number of treatment episodes, MHPAEA forces the employer to terminate a non-compliant employee in order to contain plan costs, and requires the plan to pay multiple episodes of treatment for non-compliant dependents whose coverage cannot be terminated.

Furthermore, plan requirements and limitations are historically applied differently to the two classes of benefits because the services and treatments involved are not comparable. Medical and surgical services have nothing comparable to partial hospitalization, intensive outpatient programs, psychological testing or outpatient ECT. Medical and surgical treatment plans for a non-catastrophic illness typically include one or two office visits whereas a non-managed recommended outpatient treatment plan for depression might include weekly therapy with a counselor for a year or more, hours of psychological testing, and medication management by a psychiatrist.

2. What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?

Additional clarification is needed for the following:

- How should the plan calculate the "predominant" benefit level?
- How should the plan determine what constitutes "substantially all" benefits (i.e., need to ensure comparison is made between like coverages)?
- Are separate but equal deductibles and out-of-pocket maximums allowed?
- Confirm that MHPAEA does not include EAP plans, even those that provide a limited number of counseling sessions.
- Where is the line between defining terms of the "benefits", "covered diagnoses/conditions" and setting "treatment limits"? How can the plan differentiate limits and exclusions? Can the plan:
    - Exclude court-ordered or chronic services?

  - Exclude a level of care (residential) for certain conditions (autism) while allowing it for others (substance abuse)?
  - Exclude type of treatment (long-term psychoanalysis)?
  - Define coverage as short-term for certain conditions (EAP, marital counseling) not otherwise covered?
  - Exclude an episode of inpatient care provided when a stay results in early, voluntary AMA discharge (when patient has been informed in advance of this repercussion)?
  - Exclude substance abuse coverage for dependents while providing it for employees?
  - Not cover all evidence-based treatment?
  - Exclude services for a condition (autism) but cover services for a secondary condition (depression)?
- Could a benefit plan with a requirement for precertification via an EAP or a gatekeeper (like BHS) still allow for denial of any coverage (in-network or out-of-network) if not complied with? What about a requirement for concurrent case management through BHS?
- Can an employer exclude substance abuse services beyond one treatment episode? Can an employer require completion of 2-year aftercare program between substance abuse treatment episodes? How does requiring parity impact the employer's ability to offer a drug-free work place? What is the employer's recourse against employees with multiple positive drug screens and treatment episodes? Must the employer cover all treatment episodes for dependents?
- If an employer offers employees a choice of three medical and surgical benefit levels (i.e., 90/10, 80/20, or 70/30), is this considered one plan or three plans? If all three medical and surgical benefit options have the identical mental health and substance use disorder benefit level (i.e., 80/20), under parity do the mental health and substance use disorder benefits have to be consistent with the predominant benefit level selected by the majority of the employees? Or, do the mental health and substance use disorder benefits for an employee have to be consistent with the medical and surgical benefit level selected by that employee?

3. What information, if any, regarding the criteria for medical necessity determinations made under the plan (or coverage) with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

BHS currently makes its medical necessity criteria available to providers, client companies, and members upon request. We do not perceive the MHPAEA requirement to make available medical necessity criteria as a change to current practices.

URAC, an independent, nonprofit organization, is well known as a leader in promoting health care quality through its accreditation and certification programs. Their accreditation standards are considered industry best practice. BHS is accredited by

URAC for Health Utilization Management. These standards require accredited organizations to issue notification of non-certification decisions to the patient and provider. The notification must include the principal reasons for the determination not to certify, and a statement that the clinical rationale used in making the non-certification decision will be provided, in writing, upon request.

ERISA claims regulations (29 CFR 2560.503-1) require that the notification of any adverse benefit determination by a group health plan that is based on a medical necessity exclusion or limit, include an explanation of the clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

4. What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?

BHS currently includes the specific plan limitation or exclusion in its notification of adverse benefit determination. Notification is given to the patient and provider. We do not perceive the MHPAEA requirement to make available the reason for any denial under the plan as a change to current practices.

ERISA claims regulations (29 CFR 2560.503-1) require that the notification of any adverse benefit determination by a group health plan that is based on an internal rule, guideline, protocol, or other similar criterion, include the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other criterion will be provided to the claimant free of charge upon request.

5. To gather more information on the scope of out-of-network coverage, the Departments are interested in finding out whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. If so, how is such coverage the same as or different than out-of-network coverage provided for medical surgical benefits?

One major advantage BHS offers is its "open network" philosophy. All current clients of BHS retain BHS as their exclusive provider choice (EPO model) given BHS' flexibility to add providers as requested. Requested providers affiliated on a patient-specific basis are reimbursed as any network provider. All BHS network providers meet strict credentialing criteria.

BHS has many concerns over the MHPAEA requirement to provide out-of-network coverage if provided for medical and surgical benefits, and hopes the Departments will address whether a plan can exclude from coverage an out-of-network provider on the following basis:

- "Quality" (i.e., for having filed fraudulent claims)
- "Criteria" (i.e., physician in aftercare)
- "Specialty" (i.e., non-psychiatrist billing for psychiatric services)

Additional concerns arise from the fact that out-of-network providers are not contractually bound to plan utilization review procedures. Plans will be limited to retrospective review for services by out-of-network providers. Neither the member nor the out-of-network provider will be aware the services are not covered until the claim is denied. The member will be liable for any out-of-network services denied for lack of medical necessity.

Please clarify:

- Can the plan apply a penalty to out-of-network providers for failure to obtain precertification if the penalty applies to in-network providers?
- Can this penalty apply if there is no precertification requirement for medical and surgical?
- Will companies who offer only a standard Blue Cross medical plan (with "participating providers") be considered to have an in-network-only plan if the mental/nervous is carved out, or is the Blue network of participating providers so expansive that it could be called an in-network/out-of-network plan with no penalty?

6. Which aspects of the increased cost exemption, if any, require additional guidance? Would model notices be helpful to facilitate disclosure to Federal agencies, State agencies, and participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption?

BHS strongly encourages the Department to develop such model notices. Clarification is also needed as to the entire process for filing a cost exemption.

BHS appreciates the opportunity to comment on this important regulatory guidance.

Sincerely,

Patricia L. Friedley
Executive Vice President & Chief Quality Officer