May 28, 2009

Submitted via the Federal eRulemaking Portal: http://www.regulations.gov

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

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

U.S. Department of the Treasury
Internal Revenue Service
Attention: CC:PA:LPD:PR (REG – 120692-09)
Room 5205
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Dear Sir or Madame:

ValueOptions®, Inc. is writing to offer comments in response to the Request for Information (RFI) regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The RFI was issued in the *Federal Register* on April 28, 2009.

ValueOptions®, Inc., the nation's largest independent behavioral health and wellness company, provides services to more than 23 million individuals through a variety of contracts with state and county agencies and, additionally, with health plans and employers. ValueOptions® is a national behavioral health and wellness company that specializes in management for all behavioral health issues and promotes health and wellness through innovative programs. ValueOptions® mission is to improve the health and wellness for the people it serves.

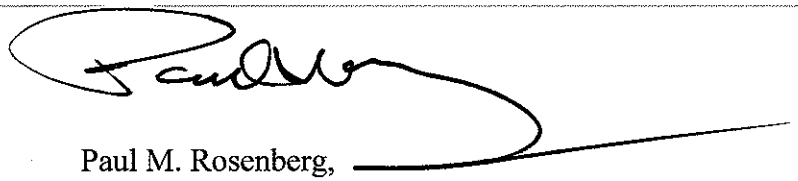
VALUEOPTIONS®
Improving Behavior to Improve Health

ValueOptions, Inc. would like to call your attention to the following comments and concerns that we address in our response to the RFI:

- Confirmation is needed that the intent of the law and the language in the law allows for either combined or separate deductibles and out-of-pocket maximums.
- Confirmation is needed that the benefit can be managed according to the terms and conditions of the plan.
- Clarification of the definitions of the terms "predominant" and "substantially all" is needed in order to ensure that financial requirements can vary based on the level of care. Such variation is needed so that valid comparisons can be made between outpatient medical and surgical and outpatient mental health and substance use disorders, as well as between inpatient medical and surgical and inpatient mental health and substance use disorders. Such comparisons would be made regardless of whether care was received in or out-of-network.
- Confirmation is needed that the law allows plans to define which diagnosis and which services (or treatments) they will cover.
- Allowances should be made for plans that have implemented the law in good faith prior to the issuance of the regulations.
- Confirmation is needed regarding the entities that the law does and does not apply to. In particular, ABHW is requesting confirmation that the law does not apply to Employee Assistance Programs.
- Use of existing ERISA law and accreditation standards related to the disclosure of medical necessity criteria.

ValueOptions, Inc. is pleased to have the opportunity to respond to the RFI. Our detailed comments on the questions in the RFI at attached to this letter. Thank you for the opportunity to comment. Please feel free to contact me at paul.rosenberg@valueoptions.com or (757) 459-5498 if you have any questions.

Sincerely,



Paul M. Rosenberg,
General Counsel

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Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Dear Sir or Madame:

ValueOptions, Inc. is a member of the Association for Behavioral Health and Wellness, one of nine members of the Coalition for Fairness in Mental Illness Coverage.

ValueOptions, Inc. strongly endorses the concerns raised in the letter from the Coalition for Fairness in Mental Illness Coverage regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Sincerely,

Paul Rosenberg
General Counsel

Coalition for Fairness in Mental Illness Coverage

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P.O. Box 7604
Ben Franklin Station
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Re: Interagency Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Dear Sir or Madame:

The Coalition for Fairness in Mental Illness Coverage was formed over thirteen years ago to win equitable mental health coverage. The Coalition members include: American Hospital Association, American Medical Association, American Psychiatric Association, and American Psychological Association, Association for Behavioral Health and Wellness, Federation of American Hospitals, Mental Health America, National Alliance on Mental Illness and National Association of Psychiatric Health Systems. The organizations represent consumers, family members, health professionals, and health care systems and administrators. The Coalition was extensively involved in the negotiating and drafting of both the Senate bill and the final law and vigorously supported its final passage.

We are responding to your request for information with a few specific comments that all of our nine organizations would like to call your attention to in the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Most, if not all, of our organizations are also submitting separate and more detailed comment letters to your agencies.

Issue 1: The Coalition seeks clarification on which group health plans and health insurance issuers are subject to comply with the MHPAEA. We feel that a review of the entities that the law applies to would be very helpful. There are two particular examples where we seek specific clarification – one is clarification that the law does not apply to Employee Assistance Programs and the other is clarification of whether or not it applies in a situation where there are three employers with twenty five employees each that join together to collectively purchase health coverage.

Issue 2: MHPAEA requires that the financial requirements and treatment limitations applied to mental health/substance use benefits are "no more restrictive than the predominant" financial requirements and treatment limitations "applied to substantially all" medical/surgical benefits covered by a health plan (or coverage).

We believe the parity standard of "no more restrictive than" means that the financial requirements or treatment limitations imposed on mental health or substance use benefits can be no greater than those applied to medical and surgical benefits. In other words, any financial requirement or treatment limitation imposed on the enrollee or participant for mental health or substance use benefits must be equal to or less than that applied to medical/surgical benefits.

With regard to the term "substantially all," the 1996 MHPA required that if a plan or coverage includes a lifetime or annual dollar limit on "substantially all" medical and surgical benefits, then it may impose either the same or a lesser limit on mental health benefits. The departments' implementing rule (62 Fed. Reg. 66932 et seq., December 22, 1997) essentially defined "substantially all" to mean that if a plan or coverage includes a lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it may either impose the same or a lesser limit on mental health benefits. However, if a plan or coverage applies a different lifetime or annual dollar limit on different benefit categories of more than one-third of all medical/surgical benefits, it may impose a limit on mental health benefits equal to the weighted average of these different categories.

As mentioned, the term "substantially all" is relatively easily applied to plan or coverage lifetime or annual dollar limits, where a plan or coverage generally has only one limit or a few limits. The term "predominant" has been included in the MHPAEA to address those financial requirements or treatment limitations for which there may be a number of limits or categories of coverage. The term "predominant" therefore has been included to indicate that the mental health or substance use benefit should be compared to the prevailing or most common financial requirement or treatment limitation imposed by the plan or coverage.

Therefore, under MHPAEA the financial requirement or treatment limitation that is applied to "substantially all" the medical/surgical benefit shall be that requirement or limitation that is applied to the mental health/substance use benefit. Of course, a plan or coverage may apply a lesser requirement or limit, since the MHPAEA provides that such requirement or limit shall be "no more restrictive than" the limit imposed on medical and surgical benefits.

The term "predominant" is an additional qualifier and meant to prevent mental health or substance use benefits financial requirements or treatment limitations from being compared to outliers in the medical/surgical benefit. For example, consider parity with regard to a limit on outpatient psychotherapy visits. To apply the MHPAEA standard, all outpatient medical/surgical visits of a plan should be considered. If there is no limit on substantially all outpatient medical/surgical visits, for example, then there shall be no limit on outpatient psychotherapy visits. However, if a plan has several types of outpatient medical/surgical visit limits (i.e. for primary physician, specialty, chiropractic, physical therapy, and various other services) so that no one (or a lack of a) limit represents substantially all of the limits on outpatient medical/surgical visits, then the predominant qualifier applies. This means that outpatient psychotherapy visits should be compared to the prevailing or most

common outpatient medical/surgical visit limit. For most plans we assume that this would be the primary physician office visit. Therefore, if the plan does not impose a limit on primary physician office visits, then the plan shall not impose a limit on outpatient psychotherapy visits.

In another example, consider parity with regard to a copayment requirement for outpatient psychotherapy visits. To apply the MHPAEA standard, all outpatient medical/surgical visits of a plan should be considered. If the copayment requirement for substantially all outpatient medical/surgical visits is $10, for example, then the copayment requirement for outpatient psychotherapy visits shall be $10. However, if a plan has several types of outpatient medical/surgical visit copayment requirements, so that no one copayment represents substantially all of the limit on outpatient medical/surgical visits, then the predominant qualifier applies. This means that outpatient psychotherapy visits should be compared to the prevailing or most common outpatient medical/surgical visit limit. For most plans, we assume that this would be the primary physician office visit. Therefore, if the plan imposes a $10 copayment for a primary physician office visit, then the plan shall impose a $10 copayment requirement for an outpatient psychotherapy visit.

It is acceptable to us to compare inpatient-to-inpatient and outpatient-to-outpatient medical/surgical benefits with mental health/substance use benefits for purposes of applying the MHPAEA parity standard to financial requirements and treatment limitations in a plan or coverage. Within the inpatient and outpatient benefits provided by a plan, the MHPAEA parity standard is meant to address the subtleties that may be involved in the various financial requirements and treatment limitations applied to various categories of coverage.

Issue 3: The language in the cost exemption section of MHPAEA requires that "determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries." Actuaries are not licensed by state or federal agencies. Actuaries are certified through education and experience requirements for membership in the American Academy of Actuaries. We request that the departments clarify that the term "qualified and licensed" actuary means a member in good standing of the American Academy of Actuaries, and therefore is an individual qualified to provide the cost exemption determinations required by the new law.

The Coalition also wants to reinforce that MHPAEA requires a group health plan seeking an exemption to have complied with the law for the first six months of the year involved and that an election of a cost exemption must be based on historical claims experience—retrospective data—and not on an analysis using only projections—prospective data. We also agree that model notices would be helpful to facilitate disclosure to federal and state agencies and to health plan beneficiaries and participants regarding a plan or issuer election to implement the cost exemption.

Issue 4: The Coalition worked hard to ensure that state mandate laws (where applicable) were not preempted by the MHPAEA and the upcoming regulations offer an important opportunity to provide guidance and clarity to the states regarding the preemption of and preservation of state laws that either mandate coverage of mental health and substance use disorders, set minimum standards for coverage of these disorders or require equitable coverage.

It is important to note that the MHPAEA does NOT articulate a new or different standard for preemption of state law. Instead, the MHPAEA incorporates the standards in ERISA and the Public Health Service Act set forth by Congress in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This preemption standard serves to protect state law, and allows for federal displacement of state law only in cases where a state law "prevents the application" of federal law, in this case the equitable coverage standards in the MHPAEA.

In the Coalition's view, this would allow states to continue to enforce, and in the future develop, state laws requiring equitable coverage for mental health and substance use disorders relative to medical-surgical coverage.

State laws that either require minimum coverage for mental health or substance abuse treatment, require coverage of specific mental health or substance use diagnoses or mandate inclusion of mental health and substance abuse disorders in group health plans, present a different set of issues.

1) State Mandated Benefits Laws: These state laws appear not to be preempted because the MHPAEA does not contain a mandate to cover either mental health or substance use disorders. Continued enforcement of state mandated benefits in no way prevents the application of the equitable coverage requirements in MHPAEA. This includes state laws that define mental health benefits by listing specific diagnoses in statute.
2) Minimum Benefit Requirements: These state laws will have to be reviewed on a case-by-case basis since some of them sanction specific numerical limits on inpatient days, outpatient visits or dollar coverage that apply mental health or substance abuse coverage, but not to medical-surgical coverage. This includes state laws that set a minimum standard for coverage, but do not obligate group health plans to offer any coverage above these minimum standards. In such cases, state laws are likely to "prevent the application" of the MHPAEA and would be preempted.

The Coalition would recommend careful review of existing state laws and guidance to states outside of the regulatory process to ensure that states are able to continue to enforce requirements for mandated mental health or substance sue benefits that are beyond the scope of the MHPAEA and are not permitted to enforce laws that authorize limitations on coverage that do not apply to medical-surgical coverage.

Thank you for the opportunity to respond to the RFI. If you have any questions about the Coalition's comment letter please contact the Coalition Chair, Pamela Greenberg, President and CEO, Association for Behavioral Health and Wellness, at greenberg@abhw.org or (202) 756-7726.

Sincerely,

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Attachment 1

A. (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?

The MHPAEA will impact a variety of policies, practices, and procedures for group health plans and health insurance issuers. Many of these impacts will also be felt both directly and indirectly by plan sponsors and participants. These impacts, and the associated costs and benefits, are best assessed in the course of reviewing what the MHPAEA does and does not address.

(1) The MHPAEA does not contain a coverage mandate. The MHPAEA does not require plans or health insurance issuers to provide coverage for mental health or substance use disorder benefits. The law reserves to plans and health insurance issuers the right to define mental health and substance use disorder benefits as they deem appropriate (subject to other applicable federal and state laws). The control of the scope of the benefits offered or provided by the plan or health insurance issuer has historically been a part of the plan design process, combined with the integration of state mandated benefits, where applicable. It is not anticipated that the MHPAEA will change this particular process and therefore there should be little cost impact to plans or health insurance issuers arising from this element of plan design. The impact on practices and the cost implications of the MHPAEA are driven by the changes required by the MHPAEA to treatment limitations and financial requirements.

(2) The MHPAEA does not affect existing plan terms and conditions. The MHPAEA clearly allows for the terms and conditions of the plan to be determined by the plan sponsors and health insurance issuers, provided that the defined boundaries of the MHPAEA with respect to treatment limitations and financial requirements are applied. Any interpretation that expands beyond the specific language of the MHPAEA to attempt to alter the plan and/or health insurance issuer's ability to define the terms and conditions of the plan would have a critical and negative effect on the affordability of mental health and substance use disorder benefits under this law.

(3) The MHPAEA does require plans to significantly alter the administration of financial requirements. The law requires that financial requirements for mental health or substance use disorder benefits be no more restrictive than the "predominant" financial requirements applied to "substantially all" medical and surgical benefits. However, traditionally within the two classes of benefits – medical and surgical benefits and mental health and substance use disorder benefits – the financial requirements, especially co-payments, are varied based on the level of care – inpatient or outpatient and whether or not the benefits are being obtained in-network or out-of-network. Absent clarification of the "predominant" and "substantially all" language, which we address in more detail below in our response to B.2., it is difficult to establish the impact of the new parity standard for financial requirements.

This issue is not limited solely to copayments but also effects the other "financial requirements" addressed under the MHPAEA, including coinsurance, deductibles and out-of-pocket expense. Due to some ambiguity in the language of the law we have seen contradictory interpretations of the statutory language which states that "there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits" (Public Law

110-343, Subtitle B, Section 512(a)(1)). We strongly believe that the language in the law is written to allow for plans and health insurance issuers to have the flexibility to apply either separate or shared (also called combined) financial requirements to mental health and substance use disorder benefits. In the event of a plan applying separate financial requirements for mental health or substance use disorder benefits those requirements must (a) not be applied only to mental health and substance use disorders – meaning the plan must have a similar financial requirement on the medical and surgical benefits and (b) the financial requirement must be no more restrictive for mental health or substance use disorder benefits than the similar financial requirement applied to the medical and surgical benefits. This will be discussed further in B.1. but we note it here because, as detailed below, a contrary interpretation engenders a very significant and negative cost impact to plans and plan participants.

An interpretation of the above statutory language that is contrary to the approach suggested in the previous paragraph would suggest that a plan must have combined cost-sharing requirements. This would have a wide-ranging impact, as many plans do not utilize this plan design. This is partly due to the fact that mental health and substance use disorder benefit administration and management is a highly specialized field and, as a result, many plans and health insurance issuers have chosen to directly contract with a specialized Managed Behavioral Healthcare Organization (MBHO) to administer the mental health and substance use disorder benefits under the plan (an arrangement commonly referred to as a "carve-out"). Thus, in cases where a carve-out arrangement is utilized there would be at least two organizations involved in the single financial requirement approach – the plan administrator for medical and surgical benefits and the plan administrator, or carve-out vendor, for mental health or substance use disorder benefits. In order to administer combined cost-sharing requirements these two organizations will have to develop program interfaces which would allow communication and sharing of accurate, real time data (such as deductible information) in order to ensure accurate application of the benefit. This is an intensive administrative process with significant costs connected with establishing and maintaining these interfaces. A shared deductible in this context would require that the plan and its administrators build the necessary system interfaces to share and coordinate this data, and our member plans have indicated that these interfaces and exchanges could have a cost ranging from $420,000 - $750,000 for each interface required. The number of interfaces required will depend on the plan and number of different medical and surgical and mental health and substance use disorder benefits vendors used by the plan. However, for a typical health insurance issuer who needs to interface with 40-50 other plan administrators on behalf of its plan customers, our member plans have indicated that the cost could be as much as $17 million to $30 million per plan administrator. These costs would typically be passed to the plan sponsors and plan participants.

In addition to the costs mentioned above, this issue can have other direct impacts on the individual plan participant. The general assumption is that shared deductibles are less costly for the member since the cost of mental health and substance use disorder care and medical and surgical care are both applied toward the same deductible and out-of-pocket expense maximum. Theoretically this is true. However, studies of participants in plans with shared deductibles of $\geq$ $ 1,000 (which is increasingly common) show that access to services is negatively impacted.[1] In the mental health and substance use disorders arena the barrier of high first dollar cost is even greater. In mental health and substance use disorder coverage the pattern of service use (utilization) is much higher – mental health and substance use disorder treatment episodes average eight (8) visits while medical and surgical treatment episodes average three (3) visits per episode of care – and more frequent – mental health and substance use disorder treatment

frequency averages one (1) to two (2) visits per week while medical and surgical treatment frequency averages one (1) visit per month. Thus, given the frequency and higher utilization for mental health and substance use disorder benefits, accumulation of costs is far quicker for participants accessing these benefits. Many studies have demonstrated the sensitivity of access and duration of treatment in mental health and substance use disorder treatment to alterations in the application of deductibles, copayments and out-of-pocket expense maximums.[2]

Having the ability to construct separate lower deductible and out-of-pocket expense maximums for plan participants faced with high medical and surgical expense deductibles and out-of-pocket expense maximums allows members to have less of a financial disincentive and barrier to accessing mental health and substance use disorder treatment which will ensure they receive necessary treatment when they need it. Plans have historically been unwilling to adjust the medical deductible to accommodate behavioral health needs since it is estimated that approximately 95% of plan participants only access the medical and surgical benefits. Absent the ability to have separate cost sharing requirements for mental health and substance use disorders that are no more restrictive than the similar requirements for medical and surgical benefits, purchasers are forced to utilize higher shared cost sharing with significant cost and treatment effects for those participants who need mental health and substance use disorder treatment. We believe that this issue is one of vital importance and one which can have far-reaching cost implications for all stakeholders.

(4) <u>The MHPAEA does require plans to significantly alter their administration of treatment limitations</u>. The MHPAEA will remove or minimize treatment limitations such as annual outpatient visit limits, yearly inpatient day limits, yearly and lifetime episode limits, and annual cost limits, which are typically based on state law requirements that will be preempted by the MHPAEA. For example, some plans limit outpatient visits to 20 or 30 visits per year, and inpatient benefits to 30 inpatient days per year. Some plans allow for a limited number of substance use disorder treatment episodes such as 2 per year or per lifetime, and some have annual cost limits (such as $10,000 per year) for some or all services. The removal of these limits – which currently function as cost controls – will have significant impact on plans and the cost to plan participants. While not all benefit plans utilize such limits, and their removal may be an improvement for members currently subject to them, overall the removal of limits will increase the costs of the plan and benefit coverage for all plan participants. The magnitude of the cost impact related to the removal of benefit limits will vary from plan to plan and is not easily quantified. Several studies have been performed following the implementation of in-network parity at the state level and for federal employee health benefit plans that have previously implemented parity. These studies have demonstrated that the cost impact ranges from 0% increase to a trend increase that exceeds 4% of total cost.[3] The studies also clearly delineate that, with appropriate utilization and care management cost was consistently contained to less than a 2% increase in total plan cost.

(5) <u>The MHPAEA does impact the Out of Network (OON) benefits which plans and health insurance issuers offer</u>. The requirement that plans must provide OON mental health and substance use disorder benefits if they provide OON medical and surgical benefits will now require plans and health insurance issuers to provide OON mental health and substance use disorder health benefits to some participants who did not previously have such a benefit. OON services are challenging to administer for plans and health insurance issuers because of the difficulties in controlling the quality of the services and in coordinating care. Unlike in-network providers who have a contractual relationship with the plan or health insurance issuer, OON

providers have no incentive to cooperate with plans or health insurance issuers as far as quality assurance activities, outcomes improvement measures, case management initiatives, or care coordination efforts. Because OON services are more costly and harder to manage, it is expected that this provision of the MHPAEA will result in significantly higher costs for plans, health insurance issuers, plan administrators and plan participants.

(6) Summary. The MHPAEA will impact plans and plan participants in a variety of areas including issues of cost sharing, benefit plan design, and plan management. Direct costs include expected higher costs for mental health and substance use disorder services due to the required changes in benefit design and to likely increased use of OON services. Indirect costs result from changes that arise from the MHPAEA such as the increased administrative burden to manage changes in financial requirements and likely increased utilization – without the counterweight of controls historically imposed as disincentives to inappropriate utilization of benefits, which will result in increases to plan costs and premiums for plan participants.

Direct benefits of the MHPAEA will be: (1) to arguably give members increased access to services and (2) additional choice, in some cases for plans which now must offer an OON option, for individual plan participants seeking services and treatment. Indirect benefits include the potential for enhanced function for an individual plan participant with mental health and substance use disorder problems, both at work and at home. These changes will positively impact all stakeholders (plan sponsors, plan administrators, health insurance issuers, plan participants and consumers) in terms of health benefits and costs.

A. (ii) Are there unique costs and benefits for small entities subject to MHPAEA (that is, employers with greater than 50 employees that maintain plans with fewer than 100 participants)? What special consideration, if any, is needed for these employers or plans? What costs and benefits have issuers and small employers experienced in implementing parity under State insurance laws or otherwise?

Small group benefit plans, as defined in this question, will be subject to all of the issues outlined in our comments in section A.(i) above. While these costs are not unique these small groups are particularly vulnerable to the impact of "catastrophic cases" – meaning that one or two seriously ill members can have dramatic impact on the costs of the overall plan given its small size. This is as true for mental health and substance use disorders as it is for medical and surgical cases. The impact of the changes discussed above in A.(i) creates an enormous pressure on these small groups with respect to the temptation to exclude some mental health and substance use disorder benefits which are not limited by treatment limitations and financial requirements by simply providing no coverage for these conditions at all in an effort to control overall plan costs.

Parity implementation costs in states where there are existing specific parity requirements mandated by state law vary depending on the extent of the particular state law's parity requirements. However, increases of up to 15% in annual mental health and substance use disorder benefits costs are not unusual. Experience has shown that in these circumstances, in order to keep costs down, small groups have tended to choose more restrictive policies – policies which have more treatment limitations and financial requirements for mental health and substance use disorders benefits such as annual outpatient visit limits, a 30-day annual inpatient benefit, or a lifetime episode cap for substance use disorder treatment. The ability of small groups to utilize such plan designs will be virtually eliminated under the MHPAEA since these

plans typically do not have restrictions of the same type on substantially all of their medical and surgical benefits. The MHPAEA will also put increased pressure on costs for these small groups if they have members who need specialized mental health and substance use disorder needs.

A. (iii) Are there additional paperwork burdens related to MHPAEA compared to those related to MHPA 1996, and, if so, what estimated hours and costs are associated with those additional burdens?

The MHPAEA is a much more extensive piece of legislation in terms of its impact on the parity of mental health and substance use disorder benefits than the MHPA of 1996. The MHPAEA will significantly increase the paperwork required for plan and health insurance issuers with respect to recordkeeping, reporting to governmental agencies and third-party disclosures.

Typical steps that are necessary for plans to become MHPAEA compliant will generate a significant level of paperwork for recordkeeping purposes. For example, in order to do the document review and assessment of plan designs to ensure compliance with the MHPAEA, plan administrators must compare their medical and surgical benefit plan offerings against their mental health and substance use disorder health plan offerings. In most groups, this involves multiple medical and surgical benefit plans having to be compared against multiple mental health and substance use disorder benefit plans. The comparison process very often results in plan design changes and the creation of additional benefit plan offerings, all of which must be documented and communicated to stakeholders - the plan participants, the plan administrators, applicable regulatory agencies etc. It is not possible to accurately estimate the specific impact in terms of hours or costs at this time but it must be noted that each plan must be reviewed and changes made that generate significant record-keeping paperwork, third-party disclosures and filings with governmental agencies.

B. 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?

With respect to financial requirements, the MHPAEA very precisely defines “financial requirements” to include “deductibles, copayments, coinsurance, and out of pocket expenses.” The MHPAEA does not address or otherwise set forth any language with respect to “other financial requirements.” The definition of “financial requirements” does include reference to aggregate lifetime and annual limits which are addressed under the Mental Health Parity Act of 1996. Outside of these defined “financial requirements” and aggregate lifetime and annual financial limits, there are no other financial requirements applied by plans that are addressed under the language of the MHPAEA.

With respect to “treatment limitations,” it should be noted that plans and health insurance issuers do, in some cases, apply other types of similar treatment limitations -- as that term is defined

currently by the MHPAEA. The definition of "treatment limitation" in the MHPAEA includes "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." Currently plans and health insurance issuers do frequently apply the types of treatment limitations specifically listed (e.g. number of visits or days of coverage) and will in some cases also apply "other similar limits on the scope or duration of treatment." In answering this question, and considering proposed regulations, the "other" treatment limitations to be considered must be SIMILAR limits on the scope or duration of treatment in order for the provisions of the MHPAEA to apply. The similarity of a treatment limitation for the purpose of the MHPAEA must have some temporal or durational aspect similar to the treatment limitations which the MHPAEA specifically lists such as number of visits or days of coverage.

The only additional limit we would consider falling within this definition but not specifically listed currently by the MHPAEA is a limit on the number of episodes of treatment. For example, some plans and health insurance issuers limit the number of episodes of inpatient detoxification treatment available to a plan participant or insured to a certain number of episodes per lifetime.

How do plans currently apply financial requirements or treatment limitations to (1) medical and surgical benefits and (2) mental health and substance abuse disorder benefits?

Plans and health insurance issuers utilize financial requirements and treatment limitations both in medical and surgical benefits and mental health and substance use disorder benefits. There is wide variety in the use and application of financial requirements and treatment limitations applied by plans and health insurance issuers due to the demands of the marketplace and wide variety in plan designs utilized by plan sponsors and insurance purchasers in meeting their varied objectives in offering, promoting, sponsoring and providing benefit plans.

Are these requirements or limitations applied differently to both classes of benefits?

In many cases yes but in other cases no. Currently most plans and health insurance issuers apply some form of financial requirements and treatment limitations (as those terms are defined by the MHPAEA) to both classes of benefits – medical and surgical benefits on the one hand and mental health and substance use disorder benefits on the other. In some cases plans and health insurance issuers vary the application of financial requirements and treatment limitations between the two classes of benefits. In other cases, plans are already designed such that there is no disparity between the application of financial requirements and treatment limitations between the two classes of benefits.

However, it typically has been more common to see greater restrictions placed on the mental health and substance use disorder benefit in terms of financial requirements and treatment limitations and it is for this reason that ABHW supported passage of the MHPAEA. We have also come across examples of plans where parts of the mental health and substance use disorder benefit were more generous than the medical and surgical benefit because the employer wanted to encourage use of the mental health and substance use disorder benefit.

Do plans currently vary coverage levels within each class of benefits?

Yes. It is extremely common for plans and health insurance issuers to apply varied financial requirements and treatment limitations within a class of benefits – meaning medical and surgical

benefits as one "class of benefits" and mental health and substance use disorder benefits as a second "class of benefits". Frequently plans and health insurance issuers will apply variances in benefit levels and in the application of financial requirements and treatment limitations on the basis of the level of care involved. Level of care refers to the "setting" of treatment. The most notable and predominant levels of care are inpatient care and outpatient care.

In addition, in many cases plans and health insurance issuers often delineate a separation within each class of benefits between in-network benefits and out-of-network benefits and apply differing levels of financial requirements and treatment limitations to those sub-divisions within the class of benefits.

For example, a plan may provide in-network benefits for inpatient coverage of 80% coverage with 20% coinsurance for the plan participant but for in-network outpatient visits the coverage may be 100% after payment by the plan participant of a $20 copayment. That same plan for out-of-network benefits might only provide for out-of-network inpatient coverage of 60% with 40% coinsurance for the plan participant and for out-of-network outpatient coverage might only be 50% after payment by a plan participant of the 50% coinsurance. Thus, plans typically vary coverage within a class of benefits based on in-network and out-of-network coverage and inpatient and outpatient levels of care.

In assessing compliance with the MPHAEA, plans and health insurance issuers presume that the requirements of the MHPAEA will assess the "predominant" financial requirements and treatment limitations applicable to "substantially all medical and surgical benefits covered by the plan (or coverage)" <u>with respect to similar coverage.</u> In other words, the plan or health insurance issuer will ensure that in-network inpatient coverage financial requirements and treatment limitations for mental health and substance use disorder benefits are aligned with the predominant financial requirements and treatment limitations on in-network inpatient treatment for medical and surgical benefits and likewise for in-network outpatient coverage financial requirements and treatment limitations, etc. This presumption should be clearly articulated in the regulations with respect to the terms "predominant" and "substantially all" contained in the MHPAEA. We discuss the need for this clarification in detail in B.2. below.

B. 2. What terms or provisions require additional clarification to facilitate compliance?

Overall, the MHPAEA provides clear, defined application of rules to ensure the objective of equitable treatment of mental health and substance use disorder benefits with those benefits provided for medical and surgical treatment. However, there are a number of areas where further clarity regarding the application of parity within the bounds of the legislative language would be of assistance to all stakeholders. We believe clarification of the following items specifically discussed below is vital for all stakeholders.

What specific clarifications would be helpful?

(a) **<u>Flexibility on Design of Financial Requirements:</u>**

The application of parity to plan financial requirements, including deductibles and out of pocket expense maximums is a critical component of the MHPAEA. It is essential that, in implementing this key element of parity, plan sponsors have the flexibility to design plans with

either combined (also referred to as "shared") or separate deductibles and out-of-pocket expense maximums. A combined deductible or out-of-pocket expense limit would involve a single deductible or out-of-pocket expense maximum applicable to both the medical and surgical benefits and to the mental health and substance use disorder benefits. A separate deductible or out-of-pocket expense maximum would involve two parallel deductibles or out-of-pocket expense maximums, with one applicable to the medical and surgical benefits and one applicable to the mental health and substance use disorder benefits. Separate deductibles and out-of-pocket expense maximums would be designed to meet the parity standard established by the MHPAEA – namely that the financial requirements applicable to mental health and substance use disorder benefits be no more restrictive than those applicable to comparable medical and surgical benefits.

The MHPAEA states that plans must ensure that "there are no separate cost sharing requirements that are applicable **only** with respect to mental health or substance use disorder benefits" (emphasis added). The interpretation of this language is that a plan cannot have a financial requirement (deductible, copayment, coinsurance and out-of-pocket expense) for mental health and substance use disorders that it does not also have for medical and surgical benefits. That is, the plan cannot have a separate financial requirement that is applicable ONLY to mental health and substance use disorders if the plan does not also have a comparable financial requirement applicable to medical and surgical benefits. However, this provision of the MHPAEA does allow for separate and no more restrictive deductibles and out-of-pocket expense maximums.

It is necessary to read this language in context of the language of the whole paragraph. The language specifically states that financial requirements applicable to such mental health and substance use disorder benefits may be "no more restrictive than the predominant financial requirements" applied to the medical and surgical benefits. This language would be meaningless unless the law allowed for financial requirements that were separately applied to mental health and substance use disorder benefits because if separate requirements are not permitted then there is no basis or need to make requirements "no more restrictive".

If the intent of the law was to prohibit separate cost sharing provisions, the use of the word "only" in the language would be meaningless – the language of the MHPAEA would simply prohibit any separate cost-sharing requirements. In addition, we note that the Federal Employee Health Benefit Plan (FEHBP) Carrier Letter dated April 20, 2009 directs health insurance issuers (also known as "carriers") to implement the requirements of the MHPAEA and it states "expenses incurred for mental health or substance use disorders may be applied to the same medical and surgical deductibles and catastrophic limits or to separate deductibles and catastrophic limits so long as they are for the equivalent amounts." In addition, this interpretation would be consistent with the existing parity law requirements under the MHPA of 1996 which allows plans to apply annual and lifetime limits either by means of a combined aggregate limit for medical and surgical and mental health and substance use disorder benefits or through separate limits that are equivalent between medical and surgical benefits and mental health and substance use disorder benefits.

For these reasons, ABHW strongly recommends that the regulations allow plan sponsors the flexibility to design or select plans (or coverage) which provide valuable mental health and substance use disorder benefits, in parity with medical and surgical benefits, using either combined or separate, but no more restrictive, financial requirements. This range of design

options within the framework of the MHPAEA is essential to encouraging mental health and substance use disorder coverage and keeping such coverage affordable for all stakeholders.

Lastly, we strongly believe that where plans choose to implement combined financial requirements, it would support health care reform goals of simplification and cost-control if the necessary data exchange interfaces (discussed above in our response to A(i)) were subject to standard industry wide formats and coding.

(b) **Management of the Benefit:**

The law clearly was intended to allow for the management by plans of the mental health and substance use disorder benefit, as is currently done. The MHPAEA amends the construction clause in Section 712(b) of ERISA which contains language which states "Nothing in this section shall be construed…" so that, after amendment, Section 712(b)(2) now reads as follows: "Nothing in this section shall be construed in the case of a group health plan (or heath insurance coverage offered in connection with such a plan) that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a)" (emphasis added). This means that the only terms and conditions that the MHPAEA applies to are financial requirements, treatment limitations, out-of-network availability, and availability of plan information. The location of this provision in the law was purposeful and was specifically placed where it was so that the ability to manage the benefit falls outside of the scope of the parity requirement. This interpretation allows plans and health insurance issuers to continue managing mental health and substance use disorder benefits to keep costs down and ensure quality of care. Further, in recognition of the very real differences between the two classes of benefits, plans and health insurance issuers need not necessarily manage mental health and substance use disorder benefits in the same way as the medical and surgical benefits are managed.

Management of the benefit is critical in keeping down the cost of the parity requirement, and the Congressional Budget Office (CBO) took into account the use of managed care arrangements in their analysis of the MHPAEA. Utilization management and utilization review are hallmarks of the managed care approach to health benefit plans. Without the ability to uniquely manage the mental health and substance use disorder benefit costs using other plan terms and conditions that are not addressed by the MHPAEA, costs will increase substantially over the estimates done by the CBO. (See our response to A(i) above for additional discussion on this issue).

In addition, mental health and substance use disorder diagnoses and courses of treatment are not as clear and objectively defined as most medical and surgical diagnoses. Whereas medical and surgical services have numerous tests and lab analyses to diagnose an illness or condition and then determine the subsequent appropriate course of treatment and the successful resolution of the illness/condition, mental health and substance use disorder care does not always have similar concrete biological markers to illuminate the diagnosis and treatment planning process in such an objective fashion. Also, most medical and surgical episodes of care are short and treatment end points are specific. Treatment for a broken arm or an ear infection is clearly defined and both the patient and the provider know if the treatment worked. In contrast, mental health and substance use disorder treatment can continue for much longer periods of time and there aren't always bright-line indicators for the termination of therapy. Unlike the predominant cases of substantially all medical and surgical treatment, there are no specific end points to some mental

health and substance use disorder treatments and furthermore these treatments are variably defined by patient self-reporting of functionality or observable, though subjective, elimination of symptoms. As a result, mental health and substance use disorder treatment requires a different management strategy that is extremely case- and provider-specific and that infuses reviews against practice standards, outcomes management, concurrent and retrospective reviews/consultations during the course of the treatment and/or treatment record reviews to ensure the quality and efficacy of the treatment, most of which are not widely employed with respect to medical and surgical treatment.

The federal government, in its provision and administration of mental health and substance use disorder benefits (including coverage purchasing decisions), has recognized the need for different management strategies for medical and surgical benefits as opposed to mental health and substance use disorder benefits. For example, the Department of Defense Tricare program requires pre-certification and concurrent review for non-emergency admissions to psychiatric and residential treatment facilities and for outpatient visits that go beyond a pre-determined number. Tricare does not uniformly apply the same requirements across medical and surgical services. Additionally the Office of Personnel Management (OPM) has recognized, in FEHBP's implementation of the MHPAEA (FEHBP Program Carrier Letter No. 2009-08; April 20, 2009; page 5), that "plans may manage care through referrals, prior authorization, treatment plans, pre-certification of inpatient services, concurrent review, discharge planning, case management, retrospective review, and disease management programs."

Accordingly, we believe the regulations should clarify and reinforce that the MHPAEA does not require parity in all aspects of plan terms and conditions, just those elements specifically addressed in MHPAEA – namely financial requirements, treatment limitations, out-of-network coverage and availability of plan information.

(c) **Definition Clarification: "Predominant" & "Substantially All":**

The MHPAEA requires that the financial requirements applicable to any mental health or substance use disorder benefits provided by the plan must be no more restrictive than the "predominant" financial requirements applied to "substantially all" medical and surgical benefits covered by the plan. The MHPAEA goes on to state that the "predominant" financial requirement means "the most common or frequent of such type" of financial requirement. Therefore, the MHPAEA could be interpreted to require that each type of financial requirement (i.e., deductible, copayment, and coinsurance) for mental health or substance use disorder benefits can only be a single amount across the board, regardless of the mental health specialty or level of care involved.

Additionally, that single financial requirement amount must be compared for parity purposes to the most common financial requirement (i.e., deductible, copayment, and coinsurance) from the entire scope of medical and surgical benefits of the plan combined, due to the use of the term "substantially all." This single "across-the-board" method is not how financial requirements are currently applied to mental health or substance use disorder benefits (as discussed above in our response to B.1.) , and would necessitate a significant change to the current practices of plans. This approach fails to take into account the fact that plans apply varying dollar amounts within each type of financial requirement (i.e., deductible, copayment, and coinsurance) for medical and surgical benefits in order to reflect the medical specialty, level of care, and cost of care involved. The MHPAEA could be interpreted to prohibit the health plan from doing likewise for mental

health or substance use disorder benefits, which is a radical departure from accepted plan design and administration practice and would create a striking and vast negative impact on health care costs for plans and plan participants.

To illustrate this point using one type of financial requirement: medical and surgical benefits utilize a range of copayment amounts depending on the type of service and/or level of care. For example, an office visit to the primary care physician (PCP) has a $15 copayment, a visit to a cardiologist has a specialty copayment of $35, a $100 copayment is applied to an emergency room visit, and a $250 copayment is assessed per admission for inpatient hospital care. Higher levels of care also typically have a coinsurance component to them. Similarly, health plans currently apply varying copayment amounts for mental health or substance use disorder benefits as well, depending on the type of service or level of care. However, the MHPAEA could be interpreted to require that there be only one single financial requirement applied to all mental health or substance use disorder benefits, regardless of the type of service or level of care involved. Further, the language of the MHPAEA requires that the financial requirement amount must be compared to the "predominant" financial requirement for "substantially all" medical and surgical benefits. Without further guidance and clarification from the regulations, this could result in the plan being left to collect an inpatient psychiatric admission copayment of only $15 and no co-insurance, since PCP visits are arguably the most "predominant" service utilized under medical and surgical benefits and therefore the copayment for PCP visits will be the "predominant" financial requirement. This result would increase health plan costs substantially and create significant disparity between medical and surgical benefits and mental health and substance use disorder benefits.

As a result of this ambiguity, the definition of "predominant" needs further clarification, as we do not believe that the intent of the MHPAEA was to eliminate the plan's ability to impose varying copayment and coinsurance and deductible amounts based on the level of care provided. Similarly, the term "substantially all" requires clarification.

We believe that the intent of the MHPAEA was for financial requirements applicable to mental health or substance use disorder benefits provided by the health plan to be no more restrictive than the "predominant" financial requirements applied to similar levels of care for the medical and surgical benefits covered by the plan. This interpretation permits each type of mental health or substance use disorder benefit to be compared to its medical and surgical benefit counterpart for purposes of determining the applicable financial requirement and ensuring compliance with the MHPAEA.

Outpatient mental health or substance use disorder benefits would have a copayment and coinsurance that is no more restrictive than the "predominant" copayment and coinsurance for similar outpatient medical and surgical benefits. Inpatient mental health or substance use disorder benefits would have a copayment and coinsurance that is no more restrictive than the "predominant" copayment and coinsurance for similar inpatient medical and surgical benefits. This same methodology would apply to other levels of care as appropriate. Accordingly we urge you to clarify this matter in the final regulations in a manner that supports this intended interpretation and states that for purposes of parity compliance the "predominant" requirement be the most common or frequent type of such requirement with respect to the similar coverage within the class of benefits, e.g. comparing inpatient mental health and substance use disorder requirements to similar or comparable inpatient medical and surgical requirements. The term

"substantially all" should likewise be defined with respect to similar coverage within the class of benefits.

(d) **Definition Clarification: "Financial Requirements" & "Cost-Sharing Requirements":**

The MHPAEA requires, in Section 512(a) (1) that the "…financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and that there are not separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits…."

We note that the MHPAEA defines "financial requirement" as including "deductibles, copayments, coinsurance and out-of-pocket expenses" but the MHPAEA contains no definition of "cost sharing requirements." The language of the section, as currently written, cannot be fully and clearly interpreted and applied absent clarifying regulations specifically defining "cost-sharing requirements."

The defined term "financial requirements" already subsumes those elements which are considered within the industry to constitute cost sharing mechanisms – namely deductibles, copayments, coinsurance and out-of-pocket expense requirements. We believe the term "cost sharing requirements" is complimentary to the existing defined term "financial requirements" since there does not appear to be anything identified as a cost sharing requirement that is not already listed in the definition of "financial requirement" provided in the MHPAEA.

Accordingly, the regulations should clarify that the term "cost sharing requirements" should be defined in a manner complimentary to the definition of "financial requirements", that is as follows: "The term 'cost sharing requirement' includes deductibles, copayments, coinsurance and out-of-pocket expense requirements."

(e) **Definition Clarification: "Treatment Limitation":**

The definition of the term "treatment limitation" contains unduly open-ended and ambiguous language. In contrast to the definition of "financial requirement" which lists those specific plan design elements which constitute "financial requirements" without any undefined terms, the definition of "treatment limitation" contains the vague and unclear phrase "or other similar limits on the scope or duration of treatment."

We believe that examination of the already enumerated types of limitations included in the definition of treatment limitations coupled with the language "or other similar limits on the scope or duration of treatment" provides a framework upon which the regulations can, and should, build in terms of providing a clear unambiguous definition of those plan design elements which constitute "treatment limitations" which must comply with the parity requirements of the MHPAEA. As previously discussed above, in our response to item B.1., the treatment limitations to be considered must be SIMILAR limits on the scope or duration of treatment in order for the provisions of the MHPAEA to apply. The "similarity" of a treatment limitation for the purpose of the MHPAEA must have some temporal or durational aspect similar to the specific enumerated treatment limitations which the MHPAEA specifically lists in the definition of "treatment limitation," such as number of visits or days of treatment.

The regulations should clarify that the term “other similar limits on the scope or duration of treatment” includes only those elements of a plan design which limit the treatment in terms of time, frequency or duration. As previously stated, the only addition we can think of that would be a “similar limit on the scope or duration of treatment" is episodes of treatment and we suggest that this category be added to the list of treatment limitations.

We do not believe it was the intent of the legislation to include, nor does the actual language support inclusion of, items such as evidence based treatments as being a “similar limit on the scope or duration of treatment”. Limitations on treatment types are not “similar” to limitations on the number of visits or days of coverage. Also, plans and health insurance issuers do not require coverage of all evidence-based treatments for medical and surgical benefits. This is another provision that could result in increased costs if the language of the MHPAEA is interpreted to go against the clear intent of the law and require coverage of all evidence-based treatments.

Accordingly, the regulations should clarify that the term “other similar limits on the scope or duration of treatment” includes only those elements of a plan design which limit the treatment in terms of time, frequency or duration. As previously stated, the only addition we acknowledge that would be a “similar limit on the scope or duration of treatment" is episodes of treatment.

(f) **Implementation & Enforcement:**

MHPAEA stipulates that regulations will be promulgated by October 3, 2009; however, the guidance contained within such regulations will not be timely enough for many plans with an implementation date of January 1, 2010. Most plans and health insurance issuers make plan design decisions and changes well prior to January 1 to ensure that communication of changes, as well as the enrollment and implementation processes can occur efficiently and seamlessly. For example, it is common for plans to finalize plan decisions as early as 6 to 8 months prior to the beginning of the plan year. Realistically, regulations promulgated even now, let alone by October 3, 2009, will be too late to provide guidance for plans (particularly those with a January 1, 2010 compliance effective date) to incorporate into plan designs and plan disclosure materials necessary for plan participants to make informed plan enrollment choices.

Accordingly, we request that if a plan implements a plan design based on a good faith interpretation of the provisions of the MHPAEA as set forth in the statute without the benefit of being able to review and implement the upcoming regulations at the time of filing the benefit plan, then the plan should be exempt from any enforcement action and monetary penalties if it is later determined that the plan is not fully compliant with the parity law based on the regulations. Furthermore, any changes that are required to make the benefit plan compliant with the MHPAEA should not be required to be implemented in mid-year but should be deferred until the next plan year. Otherwise, changes to the plan would be onerous, costly, and confusing for plan participants; furthermore, state regulatory agencies responsible for review and approval of health insurance coverage do not have the capacity to rapidly re-review and approve plans in mid-year. This would be similar to allowances made in the effective date, implementation and enforcement of other federal regulations such as the privacy regulations promulgated under the Health Insurance Portability & Accountability Act (HIPAA).

(g) **Guidance on Preemption of State Laws:**

We would request that the regulations provide clarification with respect to the relationship between state and federal laws with regard to parity. There are state-specific mandates regarding the treatment of mental health and substance use disorder problems (e.g., state mandates regarding length of stay and dollar caps) and it is not clear how these mandates relate to the federal parity law and whether such provisions may or may not be preempted by the MHPAEA. We do know that the intent of the parity law was to not preempt state coverage mandates.

Specifically we would request: (1) further clarification and definition of the pre-emption language of the MHPAEA and (2) clarification on how a plan or health insurance issuer may obtain an advisory opinion or guidance in some other form with respect to particular state law interactions with the MHPAEA.

(h) **Application of the MHPAEA to Particular Types of Plans:**

We request clarification with respect to which entities are subject to the MHPAEA. It is our understanding that the law applies to Medicaid Managed Care plans; however, we have received questions regarding this interpretation so we are seeking clarification that the law does indeed apply to Medicaid Managed Care plans.

In addition, we would request clarification with respect to the application of MHPAEA to Medicare plans, including both Medicare Advantage and Medicare Supplement plans and coverage.

(i) **Application of the MHPAEA to Employee Assistance Programs (EAP):**

It is also our understanding that the MHPAEA does not apply to Employee Assistance Programs (EAPs) and we request confirmation of this. The MHPAEA applies to group health plans (or health insurance coverage offered in connection with such plans) that provide both medical and surgical benefits and mental health or substance use disorder benefits. EAPs do not provide medical and surgical benefits and therefore we do not believe that the law applies to them. Furthermore, EAPs are most often sold as separate plans and are intended to provide short-term mental health and substance use disorder benefits for assessment and evaluation leading to appropriate referrals for treatment when necessary.

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?

Criteria for medical necessity determinations are currently made available to plan participants, beneficiaries and contracting providers upon request and, in some cases, as a matter of routine disclosure without the need for a request by the participant, beneficiary and contracting provider. The information disclosed may range, depending on the circumstances, from the specific criteria relevant to a plan participant or beneficiary's particular specific request for benefits to a broad disclosure to a contracted provider of a plan of the complete set of medical necessity criteria for all benefits under the plan (in order to facilitate communication and understanding of plan and

health insurance carrier protocols with respect to utilization review and care management processes).

This practice of disclosure is a result of market-driven demand by health care consumers and providers for transparency in the elements which define benefits available to plan participants, beneficiaries, and contracted providers. In addition, there are existing legal and regulatory disclosure requirements for plan and health issuer benefit plan information including medical necessity criteria information. This transparency and the prior development of federal and state law disclosure requirements as well as accreditation standards have driven plans and health insurance issuers to make the disclosure of medical necessity criteria utilized by plans and health insurance coverage purchased by such plans as a routine function of the business of administering plan benefits. We fully support the need for such transparency and disclosures.

The MHPAEA codifies in plain language the already existing best practices for disclosure of this information in accordance with existing law and current best practices and operating procedures prevalent in the health care industry as noted above. For example, existing federal regulations under ERISA require that a plan (including insurance coverage purchased in connection with a plan) provide the plan's medical necessity criteria in the event that such criteria are utilized in the review and determination of a claim for benefits under the plan by a claimant – who can be a participant, beneficiary or contracted provider among others. The relevant provisions are included in the Department of Labor's claims procedure regulations at 29 CFR 2560.503-1 et seq. Specifically, the regulations require that a plan provide a participant, beneficiary or representative (often the provider) with both the specific provision of a plan relied upon in a benefit determination (see 29 CFR 2560.503-1(g)(1)(ii)) as well as requiring disclosure of any internal rule, guideline, protocol or similar criterion (see 29 CFR 2560.503-1(g)(1)(v)(A)). Thus plans and issuers have routinely provided to participants, beneficiaries and contracted providers the criteria utilized in making benefit determinations under the plan or insurance coverage.

In addition there are state insurance laws which require disclosure of medical necessity criteria in both the narrow context of a utilization review denial of a request for benefits (similar to the federal ERISA requirement noted above) or in a broader context related to disclosure of plan benefit information. For example, in a more narrow context, Texas law requires disclosure of medical necessity criteria used in making a specific determination by a plan or health insurance issuer directly or through their utilization review agent (see 28 TAC 10.102(c)(3)). With respect to broad disclosure, California law, for example, requires disclosure of medical necessity criteria utilized by an insurer to the public upon request (see Calif. Ins. Code 10123.135(f)(2)(E)).

Currently health insurance carriers (including both insurers and managed care entities such as health maintenance organizations) who are accredited by organizations such as the National Committee on Quality Assurance (NCQA) or URAC (which is also known as the American Accreditation HealthCare Commission, Inc.) are also subject to this requirement as a matter of accrediting standards. Specifically, NCQA standards UM 2 and UM 7A require the disclosure of medical necessity criteria to participants and beneficiaries (UM 7A) and practitioners (UM 2). URAC standard HUM 4 also addresses a disclosure requirement for utilization management requirements and procedures including medical necessity criteria.

To whom is this information currently made available and how is it made available?

As discussed both below and in the response to the first part of Question 3, above, this information is currently provided to those individual specified in federal and state law as well as by accreditation requirements.

The MHPAEA requirement clarifies, in very succinct fashion, that the criteria for medical necessity under the plan (or coverage) with respect to mental health and substance use disorder benefits, be made available by the plan administrator (or health insurance issuer). Specifically the MHPAEA requires that the criteria be disclosed "in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request." (29 U.S.C. 1185a as amended by the MHPAEA).

As noted above, Congress specifically noted in the plain language of this section that such disclosures be made in "accordance with regulations." The language of the MHPAEA does not specify which regulations but as noted above, there are both federal and state disclosure requirements codified in existing regulations under ERISA and state law which are already in force and in practice by plans and health insurance issuers.

We presume Congress did not intend to disrupt or disturb existing specific disclosure requirements already in place under federal regulations and state law but rather sought in clear, concise language to codify what and to whom such disclosures must be made. This establishes a consistent "floor" of disclosure requirements that has already developed in practice due to existing state and federal regulations.

These existing regulations specify plan administrators and health insurance issuers must make disclosure of medical necessity criteria to a claimant – which is defined to include any plan participant or beneficiary as well as any party authorized to act on behalf of a claimant and specifically noting that providers can be authorized representatives of claimants. (See 29 CFR 2560.503 (a) and (b)(4)). State law requirements vary with respect to the definition of parties to whom plans and health issuers must provide disclosure of medical criteria – from the narrower requirement to notify and disclose to the beneficiary and the provider in Texas law to the broader member of the "public" requirement of California law (both of which are noted above). The MHPAEA requirement in this regard is clear – the disclosure must be provided to any current or potential participants, beneficiaries and contracted providers.

Are there industry standards or best practices with respect to this information and communication of this information?

Yes. The industry standards and best practices are an outgrowth of the combined market-driven need for transparency and existing federal, state and accreditation requirements for disclosure.

However, plans and health insurance issuers do face one constraint in the disclosure of medical necessity criteria. This constraint arises in the context of instances where a plan or health insurance issuer has licensed, from a third-party, medical necessity criteria which are not the property of the plan or health insurance issuer. In the ordinary course of business, a plan or health insurance issuer may not further disclose or distribute such criteria without potentially infringing upon the intellectual property rights of the third-party who owns the criteria and/or

violating the terms or provisions of a licensing agreement for the medical necessity criteria obtained from the third-party.

In order to comply with existing federal and state disclosure requirements currently plans and health insurance issuers provide disclosure of a summary of the criteria as well as the source of the criteria without providing the actual medical necessity criteria so that they can comply with disclosure requirements but not be placed in violation of intellectual property rights or licensing agreement restrictions. This practice is necessary to meet disclosure requirements without violation of other legal requirements with respect to the content and ownership of these criteria. We believe this practice satisfies the MHPAEA requirement that a plan administrator or health insurance issuer "make available" the information and any regulations promulgated with respect to this requirement of the MHPAEA should reflect this practice as meeting the disclosure requirements for the medical necessity criteria under the MHPAEA language.

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?

Currently, pursuant to federal and state laws as well as accreditation standards, plans and health insurance issuers MUST provide the specific reason for any denial of a claim for benefits under the plan – including a denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits.

The provisions of the MHPAEA require that: "The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, upon request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations." Plans and health insurance issuers currently comply with this and other, broader disclosure requirements under the existing federal ERISA claims regulations and state laws and accreditation standards which in many cases apply more broadly to any claim for benefits as opposed to simply requests for reimbursement or payment for services as specified in the MHPAEA.

To whom is this information currently made available and how is it made available?

The information is typically made available to the individual, or their authorized representative, as well as the provider involved in the claim for benefits or payment. For example, the ERISA claims regulations require that the notification to a claimant – which may include a plan participant or beneficiary – be a written notice of a claim determination and must include the specific reason or reasons for an adverse determination. (See 29 CFR 2560.503-1(g)(1)(i)).

In addition, there are state laws related to claims and utilization management which contain similar requirements. For example, Alabama law requires the issuance of a written notice issued to a provider for a retroactive denial of a claim, including the specific reason for the denial. (See Code of Ala. Sec. 27-1-17 (g)). This is one example among several different state laws which apply to claim and benefit denial notices to patients, beneficiaries and providers.

In addition, both NCQA and URAC accreditation standards explicitly require disclosure of the specific reason for a denial of benefits in writing to the patient and provider. NCQA utilization management standard UM 7 C with respect to notices of denials requires that the accredited organization provide to members and members' treating provider a written notice of denial which contains the "specific reasons for the denial, in easily understandable language." (See NCQA 2008 Utilization Management Standards). URAC also requires that the written notification of a non-certification decision include the principal reasons for the determination and requires that the principal reason must not be non-specific and be provided to the patient and attending physician or other ordering provider or facility rendering the services at issue. (See URAC Health Utilization Management Standards Version 6.0 – Standard HUM – 22).

Are there industry standards or best practices with respect to this information and communication of this information?

As noted above, the current industry standards and best practices are defined by federal and state law requirements as well as accreditation standards. The MHPAEA merely clarifies that these general practices and standards MUST be applied to any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits.

Again, as with the medical necessity criteria disclosure requirements discussed in question B3 above, we presume Congress did not intend to disrupt or disturb existing specific disclosure requirements already in place under federal regulations and state law but rather sought in clear, concise language to codify what and to whom such disclosures must be made. This establishes a consistent "floor" of disclosure requirements that has already developed in practice due to existing state and federal regulations. We believe these practices satisfy the MHPAEA requirement that a plan administrator or health insurance issuer "make available" the specific reason for a denial of reimbursement or payment for services and any regulations promulgated with respect to this requirement of the MHPAEA should reflect that these practices meet the disclosure requirements under the MHPAEA for the specific rationale for denial of any reimbursement or payment of services.

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 and surgical benefits?***

Plans and health insurance issuers currently vary in the offering of out-of-network benefits for treatment of mental health and substance use disorders. Typically, the coverage for out-of-network benefits varies between the two classes of benefits – medical and surgical benefits on one hand and mental health and substance use disorder benefits on the other.

Plans and health insurance issuers classify and apply financial requirements and treatment limitations which are applicable to mental health and substance use disorder benefits in the same fashion as they do for in-network benefits. That is, plans vary coverage within the context of out-of-network benefits based on the type of coverage in terms of dividing inpatient and outpatient benefits.

Again, in assessing compliance with MPHAEA, plans and health insurers presume that the requirements of the MHPAEA will focus on the "predominant" financial requirements and treatment limitations applicable to "substantially all medical and surgical benefits covered by the plan (or coverage)" with respect to similar coverage (see discussion in response to B.1 and B.2. above) meaning the plan or health insurance issuer will ensure that for out-of-network benefits, just as with in-network benefits, inpatient coverage financial requirements and treatment limitations for mental health and substance use disorder would be aligned with the predominant financial requirements and treatment limitations on inpatient treatment for medical and surgical benefits and likewise for outpatient coverage financial requirements and treatment limitations.

6. Which aspects of the increased cost exemption, if any, require additional guidance?

In the case that a plan chooses to seek a cost exemption there needs to be additional guidance on: what the process is for filing an exemption, what forms and data are needed, what actuarial certification and other information must be documented and filed, and what the standards are for the review and response to such filings.

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?

Yes, we believe that model notices provided by the agencies would be helpful.

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[1] LoSasso, A.T., & Lyons, J.S. (2002). The effects of copayments on substance abuse treatment expenditures and treatment reoccurrence. *Psychiatric Services*, 53(12), 1605-1611.

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