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Submitted via Federal eRulemaking Portal: www.regulations.gov

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

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

CC:PA:LPD:RP (REG-120692-090)
Room 5205
Internal Revenue Service
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/Madam:

On behalf of WellPoint, Inc., thank you for extending the opportunity to comment on the Request for Information regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPA) of 2008.

WellPoint, Inc. is the largest health benefits company in terms of medical membership in the United States, with medical enrollment of almost 35 million members. Through its nationwide networks, the company delivers a number of leading health benefit plan solutions, along with a wide range of specialty insurance products and services including life and disability, pharmacy benefit management, dental, vision, behavioral health, long term care and flexible spending accounts. Headquartered in Indianapolis, Indiana, WellPoint is an independent licensee of the Blue Cross and Blue Shield Association and serves its members as the Blue Cross licensee in California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as Blue Cross Blue Shield in 10 New York City metropolitan and surrounding counties and as Blue Cross or Blue Cross Blue Shield in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.), and Wisconsin; and also serves members across the country through UniCare.

WellPoint is working with employers and government programs to finalize the design of health benefits that will be available after the October 3rd effective date of the MHPA. As a result, we believe it is important that the agencies resolve unclear issues in a timely manner in order to inform group health plans and health insurers of their compliance responsibilities. Attached as Appendix A are our comments on several issues we believe are critical to implementation of the MHPA.

We appreciate the opportunity to comment on these important issues, and we hope that our comments will assist the three agencies in evaluating the impact of the MHPA on the health care and health benefits marketplace. Please contact me by phone at (202) 628-7837 or by e-mail at Stephen.Northrup@wellpoint.com with any questions.

Sincerely,

Stephen J. Northrup
Vice President, Federal Affairs

Attachment

WellPoint, Inc.

Appendix A

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

Issue 1: Small employer exception

1. ***We request guidance permitting employers and health insurers to use a full time equivalence rule to determine the number of employees for purposes of the "small employer" exception to the MHPA***

WellPoint requests guidance regarding the calculation of employees for purposes of the "small employer" exemption in the Mental Health Parity and Addiction Equity Act (MHPA). The MHPA provides an exemption from the parity requirements for small employers. Under MHPA, the term "small employer" means, with respect to a calendar year and a plan year, an employer who employed an average of at least two (or one in certain states) but not more than fifty employees on business days during the preceding calendar year, subject to the controlled group rules under Section 414 of the Code and using rules under Section 4980D of the Code with regard to employers not in existence during the preceding year and predecessor employers. This definition creates difficulties because of the impact of state insurance laws governing small employers.

State insurance laws generally classify an employer group as a "small employer" based upon the number of "eligible employees" participating in the plan, in addition to the actual number of employees the employer employs.[1] Small employers governed by a state's small group insurance laws enjoy protections, such as rating restrictions, which larger employers do not. Accordingly, in these states, more employer groups will qualify as small groups than would otherwise qualify if the state used a "total number of employees" calculation.

However, this discrepancy between state small group laws and the MHPA will have an unfavorable result: some employer groups currently classified as small employers under state law will also be required to comply with MHPA, as they would not meet the MHPA "small employer" exemption. This result also creates a difficult and costly administrative challenge for health insurers who have set up their systems largely based upon market segments as defined by the specific state. Thus, both employer groups and health insurers are bound to experience confusion in complying with MHPA if this difference is allowed to stand. Otherwise, health insurers will have

[1] For the states that WellPoint serves, the differences in small employer definitions occur in the states of California, Colorado, Connecticut, Georgia, Indiana, Maine, Missouri, New York, Ohio and Texas. *See, e.g.*, IC 27-8-15-8.5 ("eligible employee" defined as an employee working at least 30 hours per week; the definition does not include temporary or seasonal employees).

to create distinct products that compensate for this discrepancy which will likely be more costly to the impacted employers' group health plans.

Under other federal laws such as COBRA, a full-time equivalence (FTE) rule has been established (See Treas. Reg. §54.4980B-2 Q&A-5(e)). Under the FTE method, the total number of employees may be determined by totaling all employment hours, not to exceed 40, for each part and full time employee who was not employed full-time during the previous year and dividing the total number by a figure that represents the annual full-time hours under the employer's general employment practices (not to exceed 40 hours) and adding the result to the average number of FTEs employed on business days during the preceding calendar year.

WellPoint believes that it is appropriate to implement a full-time equivalence rule for MHPA as well. Doing so will minimize the costly administrative impact and any confusion employers and insurers may have arising from the discrepancy in the definitions of "small employer" in state and federal laws.

Issue 2: Similar treatment or financial requirements

1. We request guidance clarifying the use of similar treatment limitations

WellPoint requests guidance clarifying the types of limitations that fall under the "predominant treatment limitations" requirement. Is the predominant treatment limitation requirement only applicable to limitations applying to all services under the policy? Or, may the predominant treatment limitation requirement also apply to limitations on a type of service that a member could receive for the treatment of numerous conditions? WellPoint believes that both types of limitations should be considered as predominant treatment limitations under the MHPA, and requests guidance accordingly.

One broad and general treatment limitation that applies to the benefits of most plans is the requirement that the treatment be medically necessary and not experimental or investigational. These requirements are applied by the plan to determine benefits regardless of the member's physical or mental condition. It is clear that this type of limitation should also apply to mental health-related services.

Additionally, particular types of services may also have limits, such as outpatient office visit or treatment limits, which apply regardless of the member's mental or physical condition. For example, a common benefit with visit limits is physical therapy. A health insurance policy may contain treatment limitations of 20 allowed physical therapy visits per year, without reference to the reason the therapy is being rendered. For purposes of benefit administration it makes no difference why the physical therapy is being provided; it could be for a stroke, broken leg, back injury, or some other condition. Accordingly, even if the physical therapy is being provided for a condition that is ostensibly mental health in nature, the physical therapy visit limitation should continue to apply.

Therefore, we request that the agencies confirm that the application of individual treatment limitations in these circumstances is appropriate and does not violate the MHPA.

2. We request guidance regarding the appropriateness of copay differences depending on the type of provider

WellPoint requests guidance confirming that health plans may design different levels of office visit copays for primary and specialty care, including mental health providers. It is appropriate to treat mental health providers as specialists; like other providers that are considered specialists, the educational focus of mental health providers is on the treatment of one area of the medical field – mental health. Additionally, primary care physicians, who oftentimes provide first-line basic mental health diagnosis and treatment, refer patients to mental health providers if more focused care on a particular mental health condition is necessary.

If all types of specialists – whether mental health or medical in nature -- are subject to the same level of copay and the copay level is not more restrictive for mental health providers, we believe that the requirements of the MHPA would be satisfied, and we request guidance accordingly.

Issue 3: State insurance benefit mandates

1. We request guidance that annual or lifetime benefit maximum dollar amounts in state insurance benefit mandates are not preempted by MHPA

In the last several years many states have enacted, or are in the process of enacting, benefit mandate laws to require benefits for treatment and services for autism spectrum disorder.[2] Those state mandate laws generally require health insurers to provide benefits for treatment and services for autism spectrum disorders up to a specific annual or lifetime dollar amount.[3]

The MHPA also permits a health plan to decide whether or not to offer mental health benefits, and, if benefits are offered, to define what mental health benefits are available under the plan or policy, subject to the requirements of other law. Thus, if a state insurance benefit mandate requires that benefits be provided up to an annual or lifetime benefit maximum, we believe that it is appropriate to take the position that such benefit maximums are permissible and not in violation of MHPA, as they require

[2] To date, such mandates have been enacted in the states of Arizona, Colorado, Connecticut, Florida, Illinois, Indiana, Kentucky, Louisiana, Montana, New Mexico, Pennsylvania, South Carolina, and Texas. Similar bills were introduced in the states of Georgia, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nevada, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Texas, Utah, Washington, and Wisconsin.

[3] For example, the Arizona autism benefit mandate, ARS 20-1402.03, provides for annual maximum benefits for "behavioral therapy" for the treatment of autism spectrum disorder of $50,000 for children between the ages of 0 – 8, and $25,000 for children between the ages of 9 and 16.

coverage for treatment and services that would otherwise not be available under the policy.

For example, Kentucky currently has a mandated benefit for autism[4] requiring a health insurer to provide benefits for up to $500 per month in "respite" care, among other types of services. A fact sheet developed by the Kentucky Department of Insurance[5] describes respite care as "short-term care and supervision in a child's home or another setting that allows temporary relief to the child's caregiver." The fact sheet further states that the insurer cannot require that the respite be provided from a licensed or certified health care provider, even though typically plans require health care services to be rendered by licensed health care providers. Absent this mandate, health insurers would not otherwise pay for respite care to provide the autistic child's parents with a break from their caregiving responsibilities, because respite care is not health care and need not be rendered by licensed medical providers. Because the Kentucky autism mandate requires coverage of services that a health plan would not typically cover, we believe that the $500 monthly maximum benefit in the Kentucky mandate is appropriate and does not violate MHPA.

Some state autism benefit mandate laws explicitly state that benefits required by the mandate are in addition to the benefits already available under the health insurance policy.[6] In the Illinois mandate, benefits for "habilitative care," applied behavior analysis, and therapeutic care for sensory processing are services not commonly offered by health insurers, but required to be provided by the policy under the mandate.

Therefore, we request guidance that the annual and lifetime benefit maximum amounts in state health insurance benefit mandates do not violate the MHPA.

Issue 4: Impact upon Medicaid and State Children's Health Insurance Programs (CHIP)

1. ***We request guidance that Medicaid managed care plans and CHIP managed care plans are not out of compliance with MHPA if a state Medicaid or CHIP agency has delayed compliance***

The MHPA applies to Medicaid managed care plans if a state chooses to cover mental health or substance use disorder benefits through the Medicaid health plan[7] All states provide behavioral health services for Medicaid beneficiaries, and most provide coverage for some substance use disorder benefits. States have taken a variety of approaches for such coverage -- the state Medicaid program may provide behavioral health benefits through a "carve-out" with a third-party vendor, contract with a managed

[4] KRS 304.17A-143.

[5] http://insurance.ky.gov/kentucky/Documents/pubs/Autism0608.pdf (last accessed 5/22/09). See also 806 KAR 17:460.

[6] *See, e.g.,* 215 ILCS 5/356z.14 (a) (coverage is required "to the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by the policy of accident and health insurance or managed care plan.")

[7] *See:* 42 U.S.C. §1396u-2 (b)(8) and BBA State Managed Care Letter, January 20, 1998, Health Care Financing Administration.

care plan to provide some or all of the services, or give beneficiaries access to services through community mental health centers.[8]

Similarly, the MHPA also applies to State Children's Health Insurance Program (CHIP) managed care plans. CHIP must comply with the law insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.[9]

Where the mental health or substance abuse benefit is carved-in to the Medicaid or CHIP managed care benefit, a managed care plan cannot independently implement any MHPA changes without specific direction from the Medicaid or CHIP agency. Medicaid managed care plans and CHIP managed care plans have contracts with individual state agencies that guide the benefits, operations, and processes in each state. Medicaid and CHIP plans cannot change or set benefits independently of their state partners, but must wait for individual state implementation guidance. In essence, a Medicaid or CHIP managed care plan's hands are tied until the state agency comes into compliance.

We believe that the managed care plan should not be penalized for this dependency. This is particularly important as some state Medicaid and CHIP agencies are out of parity, and states are moving at varying speeds to implement.

Therefore, we believe that Medicaid and CHIP managed care plans should be not penalized or be viewed as out of compliance if a state has not released implementation guidance in time for plans to come into full compliance by the federal implementation deadline.

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[8] For a good discussion of how some state Medicaid programs provide mental health benefits *see:* American Public Health Services Association and National Association of State Medicaid Directors, *Serving the Needs of Medicaid Enrollees with Integrated Behavioral Health Services in Safety net Primary Care Settings*, April 18, 2008.

[9] *See:* 42 U.S.C. §1397cc (f)(2) as amended by Section 502 of the "Children's Health Insurance Program Reauthorization Act of 2009".