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May 28, 2009

Submitted via email to: E-OHPSCA.EBSA@dol.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

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

Dear Sir or Madame:

Magellan Health Services, Inc. (Magellan) is writing to furnish comments in response to the Request for Information (RFI) issued by the Departments of Labor, Health and Human Services, and the Treasury on April 28, 2009 related to the MHPAEA. It is our understanding that these comments submitted to the Department of Labor will be shared with the other Departments.

Magellan is a leading specialty health care management organization with over 30 years of behavioral health expertise. We currently manage the behavioral health benefits of approximately 40 million people on behalf of our customers, and these customers include health plans, corporations and government agencies. The attached document contains our detailed comments in response to the questions posed in the RFI. Thank you for the opportunity to offer input and feedback into the rulemaking process. If you have any questions, or would like any additional information, please do not hesitate to contact me.

Sincerely,

M. Steckel

Madeleine D. Steckel
Associate Regulatory Counsel

Encl.

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Response to Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Submitted by Magellan Health Services, Inc.

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?

Group health plans and health insurance issuers will be impacted in the areas targeted by the MHPAEA - - financial requirements, treatment limitations, and out-of-network coverage. Policies, procedures, and practices in these targeted areas will have to be changed, and many of these changes will be felt both directly and indirectly by plan sponsors and participants.

Out of Network (OON) Benefits. Many group health plans and health insurance issuers do not currently provide OON benefits for mental health or substance use disorder benefits. Because of the OON requirement in the MHPAEA, group health plans and health insurance issuers will now be required to provide OON mental health and substance use disorder benefits to a large number of plan participants who did not previously have such a benefit. (The other option, of course, would be to no longer provide OON coverage for medical and surgical benefits, and then the MHPAEA OON requirement would not apply.) OON services are very challenging to administer for plans and health insurance issuers because of the great 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. In addition, group health plans and health insurance issuers often encounter the situation where a provider refuses to join the network and chooses to remain OON, which is more expensive for the plan as well as the participants. 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.

Financial Requirements. Traditionally within the two classes of benefits (medical and surgical benefits, and mental health or substance use disorder benefits) the financial requirements are varied based on two factors: the level of care (inpatient or outpatient) and whether the benefits are being obtained in-network or out-of-network. Absent clarification of the "predominant" and "substantially all" language contained within the MHPAEA's financial requirements section, 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 because it is not clear whether the traditional practice of varied financial requirements for mental health or substance use disorder benefits can still be continued.

In addition, ambiguity in the MHPAEA's financial requirements section that states "no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits," makes it unclear how group health plans and health insurance issuers must implement this requirement. Does this language mean that if a group health plan has a deductible for mental health or substance use disorder benefits, then it must also have a deductible for medical and surgical benefits (so long as the deductible for mental health or substance use disorder benefits is no more restrictive)? Or does this language mean that a group health plan cannot have any separate cost sharing requirements at all, such that all cost sharing requirements must be a single, combined

amount for all benefits under the plan? Contradictory interpretations of the language in question are possible, but we strongly believe that the language in the MHPAEA is written to allow for group health plans and health insurance issuers to have the flexibility to apply either separate cost sharing requirements to mental health and substance use disorder benefits (as long as similar cost sharing requirements are applied to medical and surgical benefits as well) or combined cost sharing requirements for both mental health or substance use disorder benefits and medical and surgical benefits. Separate cost sharing requirements for mental health or substance use disorder benefits as compared to medical and surgical benefits are acceptable under the MHPAEA so long as those requirements (a) are not applied only to mental health and substance use disorders – meaning the plan must have a similar cost sharing requirement on the medical and surgical benefits, and (b) the cost sharing requirements are no more restrictive for the mental health or substance use disorder benefits than similar cost sharing requirements applied to the medical and surgical benefits. This will be discussed further in B1; we note it here because, as detailed below, a contrary interpretation engenders a very significant and negative cost impact to plans and plan participants.

The contrary interpretation - - that a plan must only have combined cost-sharing requirements - - would have a wide-ranging impact as most plans do not currently utilize this kind of plan design. Mental health and substance use disorder benefit administration and management is a highly specialized field; as a result, many group health plans and health insurance issuers have chosen to contract with a specialized managed behavioral healthcare organization to administer such behavioral health services (this is commonly referred to as a "carve-out" arrangement). In cases where a carve-out arrangement is utilized, there would be at least two organizations involved in administering the single, combined cost sharing amount approach: the entity administering the medical and surgical benefits and the entity, or carve-out vendor, administering the mental health or substance use disorder benefits. In order to ensure accurate application of the participants' benefits under a combined cost-sharing design, these two separate organizations would have to develop program interfaces which would allow communication and sharing of accurate, real time data (such as deductible information). This would be an intensive administrative process with significant costs connected with establishing and maintaining these interfaces. A combined deductible in this context would require that the plan and its administrative services vendors build the necessary system interfaces to share and coordinate these various data feeds and exchanges, which would be exceedingly costly. These costs are typically passed on to the plan sponsors and plan participants.

Furthermore, there can be a direct impact on the individual plan participant connected to this particular issue as well. For example, the general assumption is that a combined deductible is less costly for the plan participant since the costs for mental health or substance use disorder care and the costs for medical and surgical care are both applied toward one single deductible amount. However, approximately 95% of plan participants only access the medical and surgical benefits of their plan. As a result, the vast majority of plan participants would be negatively impacted in trying to meet a single $1,000 deductible for their physical health care needs rather than a separate $500 deductible for each class of benefits (mental health/substance use disorders and medical/surgical). Similarly, the 5% of plan participants who do utilize the mental health or substance use disorder benefits of their plan could be at a serious disadvantage if they do not have significant physical health concerns to help contribute to meeting their deductible. This higher hurdle due to a combined deductible rather than a separate but equal (or even lower, since a lower amount would still be "no more restrictive") deductible may be enough to discourage those plan participants from seeking the mental health or substance use disorder care they need.

Treatment Limitations. The MHPAEA will remove or minimize treatment limitations such as annual outpatient visit limits, yearly inpatient day limits, and yearly or lifetime episode limits, which

are typically based on state law requirements. For example, some plans limit outpatient visits to 20 or 30 visits per year, and inpatient benefits to 30 days per year. Some plans allow for a limited number of substance abuse treatment episodes such as 2 per year or per lifetime. The removal of these limits – which function as cost controls – will have a significant impact on group health plans and health insurance issuers, who may need to pass along the cost to plan participants. While not all plans utilize such limits, and their removal may be an improvement for some plan participants, the removal of limits will increase the overall costs of the plan and the benefit coverage for all plan participants. Removal of benefit limits is also likely to exacerbate the difficulty in working with out-of-network providers, who as discussed previously are more likely to take advantage of plans and health insurance issuers (as well as plan participants) by extending treatment beyond patient needs.

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 implemented parity previously. These studies have demonstrated the range of cost impact from 0% increase to a trend increase that exceeds 4% of total cost[1-5]. 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.

1. Branstrom, R.B., & Sturm, R. (2002). An early case study of the effects of California's mental health parity legislation. Psychiatric Services, 53(10), 1215
2. Barry, C.L., Frank, R.G., & McGuire, T.G. (2006). The costs of mental health parity: Still an impediment? *Health Affairs*, 25(3), 623-634.
3. Goldman, H.H., Frank, R.G., Burnam, A., et al (2006). Behavioral health insurance parity for federal employees. *New England Journal of Medicine*, 354(13), 1378-1386.
4. Melek, S.P., Pyenson, B.S., & Fitch, K.V. An actuarial analysis of the impact of HR 1424: "The Paul Wellstone Mental Health and Addiction Equity Act of 2007." Milliman, Inc. July 5, 2007
5. Rosenbach, M., Lake, T., Young, C., et al (2003). Effects of the Vermont Mental Health and Substance Abuse Parity Law. U.S. Department of Health and Human Services.

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. These small groups are particularly vulnerable to the impact of "catastrophic cases" – meaning that one or two seriously ill members can have a dramatic impact on the costs of the overall plan given its small size. This is as true for mental health and substance abuse 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 to exclude mental health and substance use disorder benefits in an effort to control overall plan costs and the unpredictable, and potentially catastrophic, effect for the plan and its participants posed by the risk of unpredictable high cost cases.

Special considerations within the discretion of the agencies are needed for small groups. At minimum, small groups should be shown greater latitude in demonstrating the cost impact of implementing parity, e.g., by permitting small groups to utilize actuarial statements that apply broadly to plans their size as opposed to actuarial statements that are specific to their plans. For many small plans, even the cost of obtaining an actuarial statement and pursuing a cost exemption will be prohibitive. The agencies might also consider creating a separate administrative track for processing small groups exemption requests, in order to expedite their relief from potentially devastating costs that could be incurred in connection with one or two cases.

Parity implementation costs in states where there are existing specific parity requirements vary depending on the extent of the parity requirements. Increases of up to 15% in annual mental health and substance use disorder benefits costs are not unusual. To keep benefit costs affordable, small groups have tended to choose more restrictive policies. 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 put significant increased cost pressure on these small groups if they have members who need specialized mental health and substance use disorder needs. There is the potential for small, self-funded plans to drop mental health or substance use disorder benefits entirely for all these reasons.

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 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 document review and assessment of plan designs to ensure compliance with 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 comparing multiple medical and surgical benefit plans against multiple mental health and substance use disorder benefit plans. The comparison process very often results in significant plan design changes and creation of additional benefit plan offerings, all of which must be documented, submitted for legal review, 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 reviews and changes for each plan generates 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?

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." Therefore, there are no "other types of financial requirements" applied by plans as addressed under the language of 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." In addition to the types of treatment limitations specifically listed (e.g., number of visits or days of coverage), group health plans and health insurance issuers will, in some cases, also apply other <u>similar</u> limits on the scope or duration of treatment. In answering this question, and considering the regulations to be proposed, the emphasis must be on the word <u>SIMILAR.</u> Any limits

on the scope or duration of treatment must be similar to the concepts of frequency or number 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 by the MHPAEA is a limit on the number of episodes of treatment. For example, some group health plans and health insurance issuers limit the number of episodes of inpatient substance abuse detoxification treatment available to a plan participant 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? Are these requirements or limitations applied differently to both classes of benefits?

Group health plans and health insurance issuers currently utilize financial requirements and treatment limitations both in medical and surgical benefits and mental health and substance use disorder benefits. In some cases plans and health insurance issuers vary the application of financial requirements and treatment limitations between the two classes of benefits and in some cases plans and health insurance issuers plan designs are already designed such that there is no disparity between the application of financial requirements and treatment limitations between the two classes of benefits. There are some plans where parts of the mental health and substance use disorder benefit were more generous than the medical and surgical benefit because the plan sponsor wanted to encourage use of the mental health and substance use disorder benefit. 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.

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

Yes. It is extremely common for group health 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 offerings 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 for both classes of benefits.

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. So 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% coverage with 40% coinsurance and for out-of-network outpatient visits coverage might only be 50% with a 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 plans for compliance with the MPHAEA, plans and health insurance issuers presume that the requirements of the MHPAEA will apply 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 levels of coverage. 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, and no more restrictive than, 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, and so on. This interpretation 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.

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

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.

Flexibility on Design of Financial Requirements:

As discussed previously in A(i), it is essential that group health plans, plan sponsors, and health insurance issuers have the flexibility to design benefit plans with either combined 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 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). We interpret this language to mean 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 disorder benefits. This provision of MHPAEA does plainly allow for separate but no more restrictive deductibles and out-of-pocket expense maximums. The "no more restrictive" language would be meaningless unless the MHPAEA allowed for financial requirements that were separately applied to mental health and substance use disorder benefits; if separate requirements are not permitted at all, then there is no basis or need to make them "no more restrictive."

Furthermore, if the intent of the law was to prohibit separate but equal (or lower) cost sharing provisions for mental health or substance use disorder benefits, the use of the word "only" in the language would be meaningless. If Congress had intended to eliminate the ability of a plan to have

separate but equal (or lower) cost sharing elements, the language of the MHPAEA would simply prohibit any separate cost-sharing requirements.

In addition, the interpretation permitting separate but equal (or lower) cost sharing requirements would be consistent with the existing 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 benefits, or through separate limits for medical and surgical benefits and mental health benefits so long as the limit for mental health is no more restrictive.

Management of the Benefit:

The MHPAEA clearly was drafted with the intention to allow plans and health insurance issuers to manage mental health and substance use disorder benefits, as is currently done. The law amends the construction clause in Section 712(b) of ERISA which contains language which states "Nothing in this section shall be construed…" and the amendment made by MHPAEA adds "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 of the plan or coverage that the MHPAEA applies to are financial requirements, treatment limitations, out-of-network availability, and plan information as set forth in the MHPAEA. The specific placement of this provision into this particular section of the law was purposeful and was done 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, 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, in recognition of the very real differences between the two classes of benefits.

Management of the benefit is critical in keeping down the costs of the MHPAEA's parity requirements, 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 not addressed under 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 through observable, 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 not only the quality and efficacy of the treatment, but also that coverage for services does not continue beyond the point of medical necessity.

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

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 MHPAEA requires that financial requirement amount to 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 or health insurance issuer 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 which must be applied to all mental health or substance use disorder benefits. This lopsided result would increase health plan costs substantially and create significant disparity between medical and surgical benefits and behavioral health 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 analogous inpatient medical and surgical requirements. The term "substantially all" should likewise be defined with respect to similar coverage within the class of benefits.

Definition Clarification: "Financial Requirements" & "Cost-Sharing Requirements":

The MHPAEA requires 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" but 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 redundant to the existing defined term "financial requirements" since there is nothing identified as a cost sharing requirement that is not already listed in the definition of "financial requirement" provided in the MHPAEA. In addition, we note that in examining the language of the similarly worded provision with respect to "treatment limitations," the language

there is consistent in using the single defined term "treatment limitation" throughout the section. Accordingly, the regulations should clarify that the term "cost sharing requirements" should be defined the same way as "financial requirements," such as something like the following: "The term 'cost sharing requirement' includes those requirements which are 'financial requirements' as defined above."

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 catch-all 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.

Therefore, 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. We do not believe it was the intent of the legislation to include, nor does the actual language support inclusion of, non-numerical or non-quantifiable limits like type of treatment as 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. Interpretation of this provision to require coverage of all evidence-based treatments for mental health or substance use disorder benefits goes against the clear intent of the law, is not supported by the statutory language, and would result in significant increased costs not considered in the cost studies referenced above.

Implementation & Enforcement:

The 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 a roll-out 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, and 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 and/or rolling out 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).

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 coverage of mental health and substance use disorder problems which contain specific numbers of days or visits which must be covered as well as dollar caps for expenses, 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 MHPAEA was to not preempt the coverage mandate portion of state laws, but the remaining language of these various state laws are still of concern. 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.

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

It is our understanding that the MHPAEA does not apply to Employee Assistance Programs (EAPs) and we request confirmation of this position. 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 supplement group health plans and are most often sold as separate plans to provide short-term mental health and substance use disorder benefits for assessment and evaluation leading to appropriate referrals for treatment when necessary. Moreover, EAPs by definition provide short-term assistance focused on enabling employees to resolve personal issues before they become health problems. Requiring EAPs to furnish a potentially unlimited number of sessions in order to match the availability of outpatient medical sessions would destroy the very nature of EAPs and cause employers to abandon them.

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 or contracting provider.

The information disclosed may range, depending on the circumstances, from the specific criteria relevant to a plan participant's particular specific request for benefits to a broad disclosure of the complete set of medical necessity criteria for all benefits under the plan to a contracted provider of a 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, and contracted providers. In addition, there are existing legal and regulatory disclosure requirements contained in ERISA and/or state laws 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 national 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 a routine function of administering plan benefits. Thus, plans and issuers have routinely provided to participants and contracted providers the criteria utilized in making benefit determinations under the plan or insurance coverage. We fully support the need for such transparency and disclosures.

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

The MHPAEA requires that the disclosure of medical necessity criteria 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 which are codified in existing regulations under ERISA and state law which are already in force and used in practice by plans and health insurance issuers. These existing regulations specify that medical necessity criteria must be disclosed to plan participants or beneficiaries as well as any party authorized to act on their behalf, 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 whom plans and health issuers must provide disclosure of medical criteria.

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 MHPAEA.

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

The information is typically made available to the individual plan participant, or their authorized representative, as well as the provider involved in the claim for benefits or payment, pursuant to applicable federal and state law as well as accreditation requirements.

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, although as also noted this already occurs right now.

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 (OON) benefits for treatment of mental health and substance use disorders. Some plans limit coverage to in-network providers only. Typically, when plans do cover OON benefits for mental health or substance use disorders, the coverage is different from the OON benefits for medical and surgical care. Plans and health insurance issuers classify and apply financial requirements and treatment limitations which are applicable to OON 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 OON benefits based on the type of coverage in terms of inpatient vs. outpatient level of care. It is

also worth noting that some state laws provide for the limitation of mental health or substance use disorder benefits to in-network coverage only.

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? 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?

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, actuarial certification and other information must be documented and filed; and, what the standards are for the review and response to such filings. Model notices provided by the agencies would be helpful.