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:

Aetna[1] welcomes the opportunity to submit this response to the request for information regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The request was published by the Departments of Labor, Health and Human Services and the Treasury (the Departments) in the Federal Register on April 28, 2009.

It is understood that MHPAEA requires group health plans of 50 or more employees that provide both medical and surgical benefits and mental health or substance abuse benefits to ensure that financial requirements and treatment limitations are the same for both physical and mental illness. Specifically, if the employer offers mental health and

[1] Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits coverage include: Aetna Health Inc., Aetna Health of California, Inc., Aetna Health of the Carolinas, Inc., Aetna Health of Illinois, Inc., Aetna Health Insurance Company of Connecticut, Aetna Health Insurance Company of New York, Corporate Health Insurance Company and or Aetna Life Insurance Company.

substance use benefits, MHPAEA prohibits imposing more restrictive financial requirement (such as co-pays, deductibles, out of pocket limits) or treatment limitations (such as day or visit limits) on mental health or substance use benefits than those applied to medical or surgical benefits. MHPAEA does not dictate whether parity is achieved by reducing medical benefits or increasing mental health benefits. In addition, if a plan offers out-of-network coverage for medical or surgical benefits, it must provide comparable out of network coverage for mental health and substance use disorder benefits.

Aetna's Background in the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").

Aetna is one of the nation's leading diversified health care benefits companies, serving members with information and resources to help them make better informed decisions about their health care. Our programs and services strive to improve the quality of health care while controlling rising employee benefits costs. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life, long-term care and disability plans and medical management capabilities.

Aetna provides benefits through employers in all 50 states. Our membership includes 19.066 million medical members, 14.536 million dental members and 11.240 million pharmacy members. Aetna customers include employer groups, individuals, college students, part-time and hourly workers, health plans and government-sponsored plans. Because MHPAEA and the regulations interpreting the statute will have a broad and significant impact on our constituents, we look forward to working constructively and collaboratively with the Departments in contributing to the development of regulations that can be both afforded and administered.

Aetna's Role in the Enactment of the Statute

Aetna has been at the forefront of the enactment of MHPAEA. Our organization was a leader in supporting Senate Bill 558 in 2004. We then actively endorsed the Senate-House compromise agreed to in June of 2008. Between June and October of last year we were fully and consistently engaged in the enactment of the final legislation.

Aetna's General Response to the MHPAEA as it is Understood

Our support of MHPAEA is rooted in our basic belief that it affords the long overdue right to non discriminatory mental health and substance use disorder coverage. The law is the socially responsible response to an overwhelming body of scientific evidence demonstrating that mental illnesses represent legitimate diseases of the brain. The passage of MHPAEA is an acknowledgement that illness of the brain should be treated like any other illness.

We believe that this law will promote timely and appropriate care for mental health, essential to the overall health of our members. There is widespread recognition and

research that supports the fact that untreated mental health conditions are key drivers of medical cost. When employees and their dependents can receive timely, appropriate, and evidenced- based behavioral healthcare, patient outcomes including overall health and productivity are shown to improve, and are also shown to lead lower overall plan sponsor costs.[2]

Aetna is also embracing MHPEA because our commitment to innovation, quality of care and our demonstrated integration capabilities are notable differentiators that will enable our constituents to optimize MHPAEA's opportunities. The recognition that mental health benefits should be the same as physical benefits coupled with the fact that mental illness has an impact on physical health and vice versa strongly supports Aetna's approach to the value of integration of care and our holistic approach to patient management. We believe that MHPAEA is likely to improve health outcomes through integrated medical and behavioral benefits and services. Such health improvements can lead not only to lower healthcare costs but to improved productivity among employees.

Finally, we applaud MHPAEA as a landmark decision also because "By bringing together all stakeholders, by encouraging the exchange of ideas, by pushing those involved to understand real-world consequences of legislative action, and by finally reaching compromise, this effort provides an excellent roadmap of how well meaning individuals and groups can accomplish meaningful healthcare reform." [3]

Because we have been so invested in the enactment of this law for the reasons noted, it follows that we would be equally invested in how it is implemented. One in five Americans will suffer from a mental illness this year. The impact of the current economic climate will result in increases in depressive and anxiety disorders and the growing need for behavioral healthcare services may be unprecedented. MHPAEA was enacted to provide better access to quality care for mental health and substance use conditions. With limited resources and costs continuing to be a major concern for purchasers, it is important that the requirements associated with MHPAEA are not administratively cumbersome or costly to the extent that the intent of the statute is defeated or undermined in its implementation.

Clarification of Terms and Provisions

The Departments have asked whether terms or provisions of the MHPAEA require clarification in order to facilitate compliance. *II B 2. What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?* Aetna has identified the terms and provisions delineated below as those critically in need of clarification.

1. Flexibility on Design of Financial Requirements

[2] Kovach PhD Judith "The Impact of Inadequate Mental Health Care in Michigan" CSG. 24 June 2008. Council of State Governments

[3] Williams, Ronald and Un, Hyong, MD; *The Hill, September 28, 2008*

The application of parity to plan financial requirements, including deductibles and out of pocket maximums is a critical component of MHPAEA. It is essential that, in implementing this key element of full parity, plan sponsors have the flexibility to design plans with either integrated or separate deductibles, maximums and limits. An integrated deductible or limit would involve a single deductible, maximum or limit applicable to both the medical/surgical benefit and to the mental health substance abuse benefit. A separate deductible, maximum or limit would involve two parallel deductible or limits for the medical surgical benefit and the behavioral/substance abuse benefit. Separate deductibles, maximums or limits would be designed to meet the parity standard, meaning that mental health/substance abuse financial requirements would be either equal to or more generous than those applicable to comparable medical/surgical benefits.

A requirement that a single integrated deductible be used would have a very serious impact on implementation costs. A large number of plan sponsors carve out their behavioral health/substance abuse benefit from their medical plan and utilize separate carriers or administrators for the two benefits. Plan sponsors taking this approach will, of course, need to ensure that parity is met across these benefits. An integrated deductible in this context would require, however, that the carriers or administrators have the necessary system interfaces to share and coordinate the deductible accumulator, which could cost as much as $750,000 for each interface. The number of interfaces required will depend on the customer base of a given carrier, but for a typical carrier who needs to interface with 40-50 other carriers or TPAs in the market, the cost could be $30 million.

A requirement for separate, as opposed to integrated, limits would also have a significant impact on benefits costs and could impact the ability and willingness of many plan sponsors to offer mental health/substance abuse benefits.

For this reason, Aetna proposes that the regulations allow plan sponsors to design or select plans which provide valuable mental health and substance abuse benefits, in parity with medical surgical benefits, using either integrated or separate deductibles and limits. This range of design options within the framework of parity is essential to encouraging mental health and substance abuse coverage and keeping such coverage affordable.

Finally, while we think that requiring integrated accumulators would be unnecessary, costly and problematic; if that approach is taken it will be <u>critical</u> that a single industry file layout (format and coding) be implemented.

2. Management of the Benefit- The regulations should confirm that MHPAEA does not require parity in the management of the benefits.

A close examination of the language of the law confirms that it intended to allow for plans to manage the mental health and substance use disorder benefits. The law amends the construction clause in Section 712 of ERISA which contains language which states "Nothing in this section shall be construed …." The amendment made by MHPAEA adds "in the case of a group health plan (or health 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)". The reasonable interpretation of this is that the only terms and conditions to which the law applies are the financial requirements and treatment limitations and out of network parity requirements defined by MHPAEA.

We believe that the location of this provision in the law was deliberate and specifically intended to fall outside of the scope of the parity requirement. The law was worded so that the benefits would not be required, with respect to other terms and conditions of the plan other than financial requirements, treatment limitations and out of network coverage requirements, to be managed in the same way as the medical and surgical benefits. This recognizes the fact that there are significant clinical differences between 1) mental health and substance use disorders and 2) medical conditions that would make parity in the practical clinical management of these benefits extraordinarily challenging and significantly cost prohibitive.

These differences include but are not limited to the practical reality that mental health and substance use disorder diagnoses and courses of treatment are not as clear and objectively defined as most medical surgical diagnoses and treatments. Also, treatment outcomes in mental health and substance use disorders often rely on patient self reporting at times promoting services beyond those that are medically necessary and requiring a different type of clinical management.

The MHPAEA has been applauded by diverse and multiple stakeholders to date because it does not limit plans' ability to use care coordination and management tools that are advancing high-quality, evidence based mental health and substance use disorder care. Utilization review, concurrent review, case management, application of medical necessity criteria, clinical practice guidelines and discharge planning are among the tools needed to ensure quality and to control costs. These tools have proven successful in controlling excessive behavioral healthcare spending that existed many years ago. The utilization management practices developed by managed behavioral healthcare organizations have helped establish a set of working guidelines that continue to evolve. "These practices show how behavioral disorders can be covered without runaway costs and limitless treatment horizons".[4] These are, incidentally some of the tools currently used in the Federal Employees Health Benefit Plan used by Congress. Management of the benefit is crucial in cost containment. It is important to note that the Congressional Budget Office (CBO) took into account the use of managed care arrangements in the analysis of MHPAEA. Without the ability to manage care the costs will increase significantly over the estimates done by the CBO.

The federal government has recognized the need for different management strategies for medical and surgical benefits than those for mental health and substance use disorder benefits. 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. It is our

[4] Melek, S; Milliman White Paper, May 2009

understanding that TRICARE does not uniformly apply the same requirements across medical and surgical services. Also, the Office of Personnel Management (OPM) has recognized in FEHBP's implementation of the MHPAEA 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"

Management of benefit delivery is not a financial term or a treatment limitation and therefore should not be within the scope of the parity requirement. Because of the critical cost and administration implications inherent in compromising or complicating current medical management of mental health substance use disorders, the regulations should make clear that MHPAEA does allow for clinical management of mental health and substance use disorder benefits and does not require parity in the medical management of the benefits.

3. The regulations should confirm that group health plans may continue to determine plan design specific to covered diagnoses and treatment.

of the MHPAEA does not limit the employer's ability to determine which mental health or substance use disorder conditions the plan will cover and we believe this was the specific intent of the drafters of the law. This interpretation is grounded in Aetna's significant involvement in discussions with the drafters regarding this issue during the evolution of the final bill. MHPAEA defines mental health benefits and substance used disorder benefits as the benefits "defined under the terms of the plan". Plans need to retain the ability to determine which mental health and substance use disorders will be covered in the same way that plans determine which physical health conditions will be covered. The regulations should clarify that in administering MHPAEA, an employer may define coverage with respect to particular diagnoses or groups of diagnoses.

In the same way, we believe that MHPAEA does not mandate that a group health plan cover all possible treatment for a given mental health substance use diagnosis, any more than a group health plan is required to cover all possible treatments for a specific physical diagnosis. Group health plans can currently exclude certain treatments for medical conditions. MHPAEA prohibits group health plans from applying treatment limitations to mental/substance use benefits that are more restrictive than the treatment limitations that apply to medical surgical benefits. The law defines treatment limitations to include limits on the frequency of treatment, number of visits, days of coverage "or other similar limits on the scope or duration of treatment". We do not believe that the intent of MHPAEA was for type of actual treatment type to fall within "scope or duration of treatment" in the same manner as frequency of treatment, number of visits, days of coverage or to compare similarly with frequency of treatment, number of visits and days of coverage.

If plans are required to cover all possible treatment for a particular diagnosis, employers may simply exclude that diagnosis from coverage entirely. Because of significant cost and administration implications, a requirement to include all diagnoses and or treatments

could force employers to drop mental health and substance use disorder coverage entirely. These outcomes are in direct opposition to the purpose and spirit of MHPAEA which we believe was to increase access to quality mental health and substance use treatment. The regulations should confirm that determination of plan design specific to covered diagnoses and treatment will continue to be a purchaser decision.

MHPAEA now, in addition to state laws, NCQA and other regulatory bodies all require transparency regarding disclosure of medical necessity and denial reasons for protection and accountability related to sound clinical decisions on coverage. The regulations should specify that MHPAEA does not prohibit a group health plan from excluding certain types of treatment for a particular mental health condition or substance use disorder just as the group health plan may exclude certain treatments for medical conditions.

4. **The regulations should clarify the application of MHPAEA to Employee Assistance Programs and confirm that the law does not apply. If the law does apply to EAP as gatekeeper prior to accessing mental health substance use disorder benefits, this provision should be clarified.**

MHPAEA applies to group health plans that provide both medical and surgical benefits and mental health or substance use disorder benefits. EAPs do not provide medical surgical benefits. Also, EAPs are 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 further treatment when necessary.

EAPs can play a significant role in achieving healthier outcomes while containing costs and interrupting that role would counter the purpose of the law. An EAP which serves not as a "gatekeeper" but as a 24/7 "welcoming front door" to the BH continuum enhances member engagement and enables its clinicians to assess and address issues early, before they become more serious. The EAP can be instrumental in helping members make optimal use of their mental health benefits. While not a substitute for mental health benefits, EAPs may help ease members into the BH benefits continuum and resolve member issues before they become more extensive.

5. **Effective Date**

It is our understanding that the regulations for MHPAEA are required to be promulgated by October 3, 2009. It is important for the Departments to understand that an extensive window of time is required by most employers, especially large employers to implement any plan designs or plan design changes. Most employers finalize benefit designs mid year for the next calendar year. The multitude of essential administrative tasks include analysis and pricing, customer and other business partner discussion and negotiations, communication and planning with third party administrators, system programming, creation and modification of enrollment materials, and the development and implementation of communication and education programs for enrollees including

Internet based programs. As such, the timing for the publication of the regulations will not meet the preparation timing needs of most plan sponsors and will jeopardize effective and timely communication to members needed for them to make informed plan enrollment choices.

Therefore, we are requesting that if a plan implements a benefit design based on good faith interpretation of MHPAEA, without the benefit of the regulations at the time of filing of the plan, the plan should be exempt from any enforcement action and monetary penalties if it is later determined that the plan is not in full compliance with the law as clarified in the regulations. Also- any further changes required should be deferred until the following year as further plan modifications during the same plan year will be cost prohibitive, inefficient and confusing to members. We would recommend that regulations promulgated under the MHPAEA not be effective earlier than 12 months after they are published in final form.

Aetna is pleased to have the opportunity to respond to this Request for Information. Thank you for considering our comments. Should you have any questions, please feel free to contact Flora Vivaldo at vivaldof@aetna.com (310) 827-0515.

Sincerely,

Louise Murphy
Head of Behavioral Health
On behalf of the Aetna MHPAEA Task Force