May 28, 2009

VIA ELECTRONIC MAIL: http://www.regulations.gov

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

Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. 74 Fed. Reg. 19155 (April 28, 2009). RIN 1210 – AB30.

The Society for Human Resource Management (SHRM) is pleased to submit the following comments in response to the Request for Information (RFI) issued by the U.S. Departments of the Treasury, Labor and Health and Human Services (Departments or agencies) published April 28, 2009, for comments regarding issues under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). As one of the key employer groups that helped secure passage of the MHPAEA, SHRM looks forward to working with the Departments to craft workable implementing regulations.

SHRM is the world's largest association devoted to human resource management. Representing more than 250,000 members in over 140 countries, the Society serves the needs of HR professionals and advances the interests of the HR profession. Founded in 1948, SHRM has more than 575 affiliated chapters within the United States and subsidiary offices in China and India.

SHRM respectfully submits these comments in an effort to increase the Departments' understanding of the practical circumstances faced by SHRM members who administer both insured and self-insured health care plans. These comments are intended to assist the Departments in crafting guidance which promotes the MHPAEA goal of achieving parity in mental health and substance use disorder (MHSA) benefits while taking into account the real world difficulties and expense of applying MHPAEA to a variety of plan designs within the rapidly approaching effective

date for regulatory guidance. Our comments follow the Departments' request, and then provide some additional comments to aid the Departments.

1. Financial requirements and treatment limits

The RFI asks for specific information on how treatment limitations and financial requirements are currently applied to both medical and surgical benefits as well as mental health and substance use disorder benefits. As a threshold matter, most plans apply different financial requirements or treatment limits based on treatment setting (e.g., outpatient or inpatient services), provider type (e.g., primary care, specialist, or ancillary provider), and type of service (e.g., medical, surgical, ancillary, or mental health).

A. *Treatment settings* - One common variable in financial requirements or treatment limits is the treatment setting, for example, whether the individual receives outpatient or inpatient treatment. This distinction is further complicated in the MHSA context by frequent use of intermediate treatment settings, such as intensive outpatient, as further discussed below. Medical/surgical benefits apply different financial requirements and treatment limits to outpatient and inpatient services; they rarely apply outpatient financial requirements or limitations on visits to inpatient services. SHRM believes a similar approach should be permitted in the MHSA context. Just as it is appropriate to apply different requirements and limits to outpatient and inpatient medical and surgical benefits due to differences in providers and best medical practice, it is appropriate to apply different requirements and limits to outpatient and inpatient MHSA benefits. The regulations should reflect that this is an acceptable approach.

Another challenge in this area is that intermediate levels of care, such as intensive outpatient, may be used to deliver MHSA services. Such intermediate levels are not typical in medical and surgical benefits. SHRM recommends that the regulations deal with intermediate levels of care by allowing employers to compare them to the most similar care provided for medical and surgical benefits such as outpatient surgery or chemotherapy, as determined by the employer, and apply the parity rules to the financial requirements and treatment limitations.

B. *Provider or service type* - Within the medical plan context, different financial requirements and treatment limits apply based on the type of provider, or the type of services. For example, plans often apply different co-pays to benefits provided by primary care physicians, physician specialists and non-physician specialists. The different co-pays are applied in order to impact consumer behavior; encouraging individuals to seek less "costly" care sooner. Similarly, deductibles are commonly used to encourage consumer engagement in health care spending, and many employers offer several health plan options with different deductibles. Because primary care physicians, psychiatrists, psychologists and masters-degree prepared clinicians deliver various mental health services, the application of different co-pays can shape appropriate consumer use of these professionals.

Plans also apply different treatment limits to different types of services. Such limits may be based on clinical guidelines, medical necessity criteria, or simply cost management approaches. For example, preventive care may be limited to two visits per year, chiropractic visits may be limited to ten visits per year, and no limits may be applied to primary acute care or specialty acute care services.

The sound reasoning behind the different financial requirements and treatment limits applied to medical/surgical and mental health/substance abuse addresses the nature of MHSA benefits and treatments, which often differ tremendously from medical and surgical benefits and treatments.

SHRM believes the best approach would permit flexibility to encourage consumer engagement and acknowledge the differences in providers and services by allowing employers to apply a "similar services" test to the financial requirements and treatment limit parity rules. For example, outpatient psychotherapy should be subject to no more restrictive financial requirements or treatment limitations than are imposed on outpatient non-physician specialist services for medical, such as services provided by nurse practitioners and physician assistants. Ancillary services, like applied behavior analysis, that are delivered by certified individuals who are not primary care or mental health specialists, would be treated similar to services ancillary to medical care, such as speech therapy.

2. <u>What terms or provisions require additional clarification to facilitate compliance?</u>

The RFI seeks input on any terms or provisions within the statute that require additional explanation in order to facilitate compliance.

A. *"Predominant" and "Substantially all"* - Two of the most important terms in the statute--"predominant" and "substantially all"--are not clearly defined and could lead to significant problems in trying to apply the statutory provisions. For example, financial requirements applicable to MHSA benefits are to be no more restrictive than the *predominant* financial requirements appli*ed to substantially all* medical and surgical b*enefits covered by* the plan.

"Predominant" - "A financial requirement… is considered to be predominant if it is the most common or frequent of such type of limit or requirement." (See ERISA 712(a)(3)(B)(ii)). Many group health plans include both deductibles and co-pays or co-insurance for both medical/surgical benefits and for MHSA benefits. Consequently, it is difficult or impossible to say which cost-sharing approach is most common or frequent with respect to an entire plan. Even if it were possible to determine, the underlying reasons for having different types of financial requirements would be thwarted if a very literal reading were given to this provision.

"Substantially all medical and surgical benefits" – This phrase is not defined in MHPAEA. Group health plans may apply different co-pays to primary care, specialist, and ancillary service provider visits. For example, a plan may have a $250 per person deductible, and in addition apply $10 co-pays to primary care visits, $30 co-pays to specialist visits and $50 co-pays to ancillary service provider visits, like chiropractic visits. All participants would be subject to the deductible, and all visits would be subject to co-pays (until any out-of-pocket maximum is reached). Arguably, the predominant financial requirement is deductibles, because all services– whether rendered by a provider subject to the co-payment rules, or a hospital, outpatient facility or other treatment venue– are subject to the deductible. But since the "predominant financial requirement" is what is applied to "substantially all medical and surgical benefits" it could also include the co-payments applied to these services. One interpretation would be for plans to determine where the majority of participant visits are – to primary care, specialists or ancillary service providers and use that statistical information to establish the predominant financial requirement.

By adopting a "similar services" approach or permitting distinctions between different categories of treatment, some of the challenges posed by these terms would be addressed.

B. *"Separate" or" shared" deductibles* - Another concept in MHPAEA that requires additional clarification is "there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits" and the corollary "there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits" (ERISA section 712 (a)(3)(i) and (ii)). The question is whether "separate" means that there can be no cost sharing or treatment limitations that apply *only* with respect to MHSA benefits, or whether it means that any cost sharing or treatment limitations for MHSA benefits must be shared with such provisions for medical or surgical benefits. The latter approach (which we call a "shared" deductible) would apply any expenses for any type of service or from any provider to a single deductible amount.

A shared deductible would create significant administrative and practical issues, and could well detract from the goals of promoting employee health, including mental health. The many employers that have carved-out mental health benefits for specialty management to a different vendor than their medical benefits may be administratively unable to apply mental health services to the deductible maintained by the medical plan vendor on a "real-time" basis, resulting in claims payment delays and errors. The lack of connectivity among different claims paying systems underlies the Administration's significant investment efforts around health information technology and underscores the challenges of imposing a shared deductible. Developing the connectivity frequently requires cooperation between competing vendors requires at least daily information exchange of personal health information and is expensive to automate. Because of concern over whether a shared deductible might be required, some employers have moved to eliminate carve-out arrangements, which often have better expertise and focus

on MHSA treatment when compared to medical vendors. So, by requiring an actual shared deductible, participants needing MHSA treatment may actually receive less appropriate care and overall costs may increase as these benefits are managed by non-specialty vendors. For these reasons, SHRM believes the regulations should permit separate deductibles that are equal for medical and MHSA benefits.

3. Disclosure of medical necessity criteria and reasons for denial

The RFI requests input on what information is currently made available regarding the criteria for determinations of medical necessity of mental health or substance use disorder benefits under the plan. The MHPAEA includes provisions requiring disclosure of medical necessity criteria and reasons for denial of reimbursement or payment for services. SHRM believes, however, that with respect to group health plans subject to ERISA, the current ERISA disclosure rules (e.g., 29 CFR 2620.104(b)-1 and 2) and claims and appeal rules (29 CFR 2560.503-1) more than adequately address these requirements. As a result, SHRM recommends that the current ERISA disclosure rules be applied to MHPAEA.

4. Increased cost exemption

The RFI asks for information on which aspects of the increased cost exemption require additional guidance. The cost exemption included in the MHPAEA is more complicated and onerous than the increased cost exemption contained in the Mental Health Parity Act of 1996 (MHPA 1996). At the outset, clarification is needed regarding the timing of when the plan's two- percent cost increase must occur. One way to interpret this provision would require the two-percent increase in the first plan year when the MHPAEA requirements apply (generally, plan years beginning on or after October 3, 2009). A second interpretation would require the two-percent increase in the first plan year involved in an initial exemption request. In order to ensure availability of the cost exemption to employers whose circumstances, plan design, or demographics may change in the future, SHRM believes that the proper interpretation is to require the two-percent cost increase in the first plan year involved in an initial exemption request.

A second aspect of the increased cost exemption that the Departments should clarify relates to how long the exemption lasts. One way to interpret MHPAEA's provision would exempt a plan from the parity requirements only for the next plan year. To qualify for another exemption, a plan would, under this interpretation, need to comply with the parity requirements again. In other words, the exemption is only available in alternate years. This scenario could require constant plan design changes to come into compliance with the parity requirements, and because the cost exemption is only valid for one year, many employers may elect to forego the cost exemption. The risk of this interpretation is that employers who are unwilling to undergo seemingly constant plan design changes, and the expense (including retaining an actuary) of the cost exemption, may simply decide to eliminate or restrict mental health and substance abuse coverage. Consequently, SHRM urges the Departments to pursue flexibility in the regulations to support the goal of continuing MHSA coverage by relaxing the alternate year standard and instead allowing an

employer to substitute normative claims data (as if the plan had complied with the parity requirements) rather than actual claims data.

5. Additional Comments

A. *Effective date* - No guidance is required to be issued prior to October 3, 2009. For SHRM members and others who are responsible for implementing the regulations for an effective date of plan years beginning on or after October 3, 2009, it will be vitally important to provide for a delayed effective date. Employers and their vendors spend many months in advance of a new plan year discussing plan design and administration changes, and typically provide employees with information about plan design well in advance of the start of a new plan year. With final details for 2010 plan years now fixed or nearing that point, employers and their vendors will soon have virtually no ability to change plan design or administration for their 2010 plan years. Employers, vendors, and employees should be provided a full annual cycle to implement any required changes.

In order to accommodate the time necessary to implement plan design changes, SHRM urges the Departments to adopt a delayed effective date of no earlier than the first plan year beginning at least 12 months after final regulations are issued. Prior to such effective date, the Departments should require employers to comply with a reasonable, good faith interpretation of the law. Reliance on proposed or interim guidance would be one alternative, but not the sole method, of demonstrating such good faith compliance.

B. *Employee Assistance Programs* - Employee Assistance Programs (EAPs) are a diverse umbrella of programs which emphasize services that enhance employee work performance. While many EAPs are considered group health plans, most do not provide medical or surgical benefits in the traditional sense but instead provide free or low-cost short-term counseling and, if appropriate, referrals to an outside provider. As such, EAPs should not require changes under the MHPAEA parity rules. The Departments should explicitly acknowledge that some EAPs are considered group health plans, but that if considered a separate group health plan, with no medical benefits, parity would require no changes to EAPs. Furthermore, the agencies should not require that the EAP must be considered together with the group health plan and subject to parity requirements, as this would have the likely effect of curtailing EAPs which are designed to provide a distinct, short-term benefit to prevent the development of a more serious mental health condition. We would encourage the agencies to develop regulations that acknowledge the special role EAPs play in employer benefit packages, spanning not just mental health and substance abuse, but other employee issues.

Many employers use the EAP as a gatekeeper to other MHSA benefits. The EAP gatekeeper role is similar to a medical management technique; for example, the EAP may complete a telephonic assessment and direct employees to the benefit type (EAP or MHSA benefit, or financial, family or other employee assistance resource) and provider type best suited to their needs. EAPs are well positioned to assist employees with

personal problems and stress resulting from relationships, work and finances. The MHSA benefit is focused on *treatment* of mental health or substance abuse *condition*s. The determination that an employee is best served by the EAP would not be based on *medical* necessity, but whether the problem presented could be effectively addressed in the EAP's short term counseling benefit. Even though the determination is not a "medical" one, EAPs should be able to continue to provide this important gatekeeper function which improves employee productivity, treatment outcomes, and reduce costs.

C. *ERISA plan vs. benefit option* - From a design perspective, it is very difficult to try to apply parity to a single ERISA plan. For example, one benefit option may have co-pays where another has co-insurance, and it would be difficult if not impossible to apply parity overall to such a design. Another example is a PPO, which offers out-of-network benefits, and an EPO, which does not. Again, applying parity overall would not make sense, because the EPO, by definition, does not offer out-of-network benefits. Another example is an employer with a single ERISA plan providing high and low deductible options, with different plan features. Each such option should be regarded distinctly for purposes of the parity rules. Applying parity on a benefit option basis would better parallel common plan designs and is consistent with both past guidance on MHPA and the legislative purpose of ensuring that employees accessing mental health benefits are treated the same as those accessing medical/surgical benefits.

   Alternatively, but less effective in practical and conceptual terms, employers should be able to apply the most generous medical/surgical design to all MHSA benefits – regardless of which medical/surgical design option the employee is enrolled in – to better accommodate certain forms of MHSA administration and management. For example, an employer with three medical/surgical options with deductibles of $500/$750/$1000 could apply the $500 deductible to MHSA benefits for an employee enrolled in any of the medical options. However, administration may be challenging depending on the position taken by the agencies with respect to shared, rather than separate, deductibles.

D. *Medical management* - While SHRM believes that MHSA benefits must involve medical management techniques, we do not believe that medical necessity should be the sole standard applied in the mental health context. Because the evidence-base for treatment of MHSA conditions is more recent and less well-developed than much medical research and focused on the more common MHSA conditions, it is often difficult to provide clinically-based evidence for certain protocols. Rather, the protocols and plan design may also be influenced by employment-related legal concerns, like complying with Department of Transportation or OSHA rules. We urge the Departments to adopt a flexible and broad interpretation of "medical management" that would permit this type of consideration to enter into techniques such as pre-authorization, case management, directing members to preferred providers or centers of excellence.

We also would recommend that financial consequences or penalties associated with medical management be considered as part of the permitted medical management activities, even if not applied to services in similar levels of care for the medical benefit.

E. *The law permits the plan to define "benefits with respect to services for mental health conditions"* - We encourage the Departments to adopt a broad interpretation of this provision, allowing plans to define both the benefits provided for particular services and the conditions covered. For example, a plan should be permitted to exclude services, such as applied behavior therapy, just as medical plans may exclude certain services, such as chiropractic therapy. We also encourage the Departments to clarify that this provision would permit a plan to exclude benefits for services performed in certain settings, such as excluding services provided in a non-medical setting.

F. *Diagnostic codes* - We would recommend that even if a DSM diagnostic code is applicable to an individual's condition, some services and treatments may be treated as medical benefits, such as medical treatments for autism or eating disorders.

Conclusion

SHRM and its members support the goals of MHPAEA. Yet we encourage the Departments to recognize the practical implications of implementation, and not to create requirements that could result in diminished coverage for behavioral health conditions. Accordingly, SHRM respectfully urges the Departments to adopt a good faith compliance standard for MHPAEA for at least the first plan year it is effective for group health plans.

We welcome the opportunity to assist the Departments as they continue to develop guidance on MHPAEA.

Respectfully submitted,

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