Kaiser Foundation Health Plan, Inc.
Program Offices

May 28, 2009

Submitted electronically *via* http://www.regulations.gov

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

Office of Health Plan Standards & Compliance Assistance
Employee Benefits Security Administration
Room N–5653,
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

CC:PA:LPD:PR (REG–120692–09)
Room 5205, Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044.

Re: Request for Information regarding the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (Division C of Pub. L. No. 110-343)
Department of Labor, Employee Benefits Security Administration, RIN 1210–AB30
Department of Health and Human Services, Centers for Medicare & Medicaid Services [CMS–4140–NC]

Dear Sir or Madam:

Kaiser Permanente offers the following comments in response to the Request for Information ("RFI") regarding the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* ("MHPAEA") issued on April 28, 2009 in the *Federal Register.* The RFI is a collective request from the Departments of Labor, Health and Human Services and Treasury ("Departments") to solicit public comments in advance of future rulemaking regarding issues raised by MHPAEA.

The Kaiser Permanente Medical Care Program (which offers services to the public under the Program's trade name "Kaiser Permanente") is America's largest private integrated healthcare delivery system, comprising Kaiser Foundation Health Plan, Inc. (and its local subsidiaries, collectively "Health Plan"), the nation's largest nonprofit health plan; the nonprofit Kaiser

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Foundation Hospitals ("Hospitals"); and the Permanente Medical Groups ("Medical Group"), eight independent physician group practices that contract exclusively with Health Plan to meet the health needs of Kaiser Permanente's 8.7 million members in nine states and the District of Columbia.

We support the objectives of MHPAEA to achieve consistent minimum parity for mental health and substance use disorder benefits. As an integrated health care delivery system, we also recognize the many challenges in meeting the extensive parity requirements under MHPAEA. We appreciate the opportunity to respond to this RFI. Our comments and recommendations follow:

We recommend that the Departments provide clear and concise guidance as soon as possible

MHPAEA will impact benefit design and bidding for health plans that include mental health or substance use disorder benefits for large groups of over 50 employees. Health Plan will need to determine what constitutes comparable benefits or "predominant" financial restrictions or treatments limitations for medical and surgical benefits in order to apply the correct deductibles, copayments, limits on days of coverage, or other similar restrictions on mental health and substance use disorder benefits.

There are additional challenges for state-regulated products, such as Health Plan's HMO plans that fall under various applicable state parity/benefits mandate laws. For these products, substantial contract revisions may apply to large group plan contracts. Contract negotiations regarding benefits and premiums are well underway for plan years beginning in 2010. Thus, it is critical that all health plans and health insurers receive this information as soon as possible, so that they can make any necessary benefit modifications, fix any incorrect assumptions and communicate accurately to customers seeking information about the impact of MHPAEA.

Moreover, as a provider of health care services, Kaiser Permanente may have to modify health care delivery and operations to address anticipated higher utilization of mental health and substance use disorder resources by its members. Therefore it is imperative that guidance be issued as soon as possible to ensure continued access to care.

We recommend that the Departments allow plans reasonable flexibility in meeting the parity requirements of MHPAEA

Within Kaiser Permanente, copayments or coinsurance limits apply for many medical and surgical services as well as for mental health and substance use disorder benefits. Copayment and coinsurance amounts may vary among benefits for in-network versus out-of-network coverage. Treatment limitations may be determined by medical necessity. For example, coverage may be discontinued for a treatment that fails to deliver improved or expected outcomes. Current limitations on mental health and substance use disorder benefits conform, as required, to applicable state and federal law, and may include frequency of treatment, number of visits and days of coverage.

Meeting the parity requirements of MHPAEA may be relatively straightforward for categories of mental health or substance use disorder benefits with comparable services or classes of service for medical and surgical benefits. Similar or reasonably equivalent benefits (e.g., inpatient stays, outpatient visits) can be re-designed to achieve parity for financial limits (e.g., per stay/visit copayment or coinsurance) or for treatment restrictions (number of days or visits) when compared on a service-by-service basis.

However, certain other mental health services have no obvious corollary services on the medical/surgical side, such as residential treatment for substance use disorders. In addition, numerous states have adopted mental health parity laws, so plans may be subject to different tests or standards imposed by various state regulatory schemes for determining compliance. Some state statutes formulate how certain services may be exchanged or converted.[1] Other states require that certain financial limitations on mental health services be "actuarially equivalent."[2] Adding to the complexity are state laws that mandate certain benefits be covered. MHPAEA leaves these state requirements in place but requires a broad level of parity –

Because health plans and insurers are required to meet the complex requirements under state parity laws and mandates, we urge the Departments to permit broad flexibility in meeting federal parity requirements that still support the intent of MHPAEA. In particular, we strongly urge the Departments to issue clear guidance on how MHPAEA interacts with state law. Variations in state law make the Departments' views on the MHPAEA's preemption scheme especially important as we move towards implementation of both federal and state requirements, as applicable.

We encourage the Departments to expressly address how health plans and insurers can satisfy the federal parity requirements for benefits that cover treatment of mental health, behavioral and substance abuse disorders, which are particular to that field and for which there are no clear comparisons to medical or surgical benefits offered under the same benefit plan. However, we also recommend that the Departments avoid developing a rigid scheme for meeting parity requirements that will create potential conflicts with existing state parity laws.

We recommend that the Departments clarify that MHPAEA does not apply to "retiree-only" group health plans.

ERISA, the IRC and the PHSA include provisions that exempt the application of MHPAEA in the case of "any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than

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[1] *See e.g.,* Haw.Rev.Stat.§431M-4 "Each day of in-hospital services may be exchanged for two days of nonhospital residential services, two days of partial hospitalization services, or two days of day treatment services….Each day of in-hospital services may also be exchanged for two outpatient visits under this chapter; provided that the patient's condition is such that the outpatient services would reasonably preclude hospitalization." *See also* Va.Code § 38.2-3412.1. Coverage for mental health and substance abuse services.

[2] *See* for example Md.Ins.Code 15-802.

2 participants who are current employees…."[3] Therefore, implementing regulations should clarify that those separate group health plans (and any health insurance offered by such plans) that provide benefits for retirees and their family members and have fewer than 2 participants who are current employees should not be subject to MHPAEA.

We recommend that guidance be given regarding how MHPAEA affects the currently required 190-day limit for inpatient psychiatric hospital services during a Medicare beneficiary's lifetime.

According to CMS regulations and policy manual provisions, payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. The limitation applies only to services furnished in a psychiatric hospital.[4] Given this limitation, and the apparent conflict between the two federal laws, we are requesting that the Departments provide guidance on whether or how MHPAEA applies to the 190-day limits for large group health plans that do not impose similar day limits on inpatient hospital stays.

Conclusion

Implementation of MHPAEA is a huge undertaking and benefits design for 2010 is already underway. We need clarification in how parity will be determined and urge the Departments to be flexible in their approach. Finally, we ask the Departments to confirm that MHPAEA does not apply to retiree-only plans and to provide guidance regarding the impact of MHPAEA on Medicare's 190-day limit for inpatient psychiatric services.

We appreciate the opportunity to provide you with information. We would welcome the opportunity to discuss these matters with you further. If you have questions or concerns, please contact me at 510-271-6621 (email: lori.potter@kp.org).

Sincerely,

Lori Potter
Counsel, Legal & Government Relations
Kaiser Foundation Health Plan, Inc.

[3] S*ee* 26 U.S.C. §9831(a)(2), 29 U.S.C. §1191a(a) and 42 U.S.C. §300gg-21(a)).

[4] *See e.g*., 42 CFR 409.62 and Medicare Benefit Policy Manual, CMS Pub. 100-02 , Ch. 4, Section 50.

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