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May 28, 2009

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

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

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

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

Dear Sirs and Mesdames:

We are writing on behalf of our firm, Towers Perrin, to submit comments in response to your request at Volume 74, *Federal Register*, 19155, dated April 28, 2009, regarding future rulemaking under the MHPAEA. Our comments are set forth below.

Towers Perrin is a global professional services firm that helps organizations improve performance through effective people, risk and financial management. The firm provides innovative solutions in the areas of human capital strategy, program design and management, and in the areas of risk and capital management, insurance and reinsurance intermediary services, and actuarial consulting. Towers Perrin has offices and alliance partners in the world's major markets.

The Human Capital business of Towers Perrin provides global human resource

consulting and related services that help organizations effectively manage their investment in people. We offer clients actuarial and related consulting services in areas such as employment benefits, compensation, communication, change management, employee research and the delivery of HR services.

We appreciate this opportunity to comment.

INTRODUCTION

Our comments are informed by our experience with large employers that sponsor group health plans providing mental health (MH) and substance use disorder (SUD) benefits. In most instances, these MH/SUD benefits are administered by third party vendors which are either different companies than those administering the medical/surgical benefits under the plan, or the medical/surgical and MH/SUD benefits are administered by different divisions within the same company, using different claims systems.

Towers Perrin's comments on the MHPAEA pertain, in particular, to situations where MH/SUD benefits have been "carved out" of the group health plan and are administered by a separate entity. These entities are known as Managed Behavioral Healthcare Organizations or MBHOs. The six largest MBHOs administer MH/SUD benefits for approximately 45 million participants in self-funded group health plans. [1]

BACKGROUND

A few background comments on the state of carved out MH/SUD benefits are necessary before we address the questions in the Request for Information regarding the differences between medical/surgical and MH/SUD benefits, and the clarifications that we suggest be included in upcoming regulations.

- In 2008, 6.2% of the enrolled population received MH/SUD treatment. This figure is based on cost and utilization data we gathered in 2009 for the 2008 plan year from the six largest MBHOs on the self-funded group health plans they administer. This figure has grown steadily in recent years from 4.3% in 2002. [2]

[1] Enrollment data requested by Towers Perrin for the 2009 plan year.

[2] Towers Perrin requests book-of-business, self-funded MH/SUD cost and utilization data from the largest MBHOs each year and creates MBHO norms from this data. Unless otherwise noted, the cost and utilization statistics presented below are derived from this annual data.

- Approximately three out of four people complete their MH/SUD treatment in 10 outpatient visits or less. About .4% of the population is admitted to a psychiatric hospital. [3]

- MH/SUD plans cover MH/SUD diagnoses treated by MH/SUD clinicians. Physicians – other than psychiatrists – also treat MH/SUD conditions. For example, most children with Attention Deficit Disorder – a psychiatric diagnosis – are treated exclusively by pediatricians. Depression, the most common psychiatric diagnosis, is more likely to be treated by a physician (other than a psychiatrist) than an MH/SUD clinician. According to a recent study, 85% of new prescriptions for SSRI (selective serotonin reuptake inhibitors) antidepressants were written by physicians other than psychiatrists. [4]

MH/SUD costs in carved out plans, as expressed in claims expense per employee per year, have decreased sharply over the last 20 years. In 1988, MH/SUD claims accounted for 10.9% of medical plan costs. By 2008, this figure had dropped to 1.5%. [5]

Some of the methods now used to control MH/SUD costs will not be available after the MHPAEA becomes effective (generally, for plan years beginning after October 3, 2009); the continued acceptability of certain other cost management mechanisms are uncertain, pending regulatory guidance. These methods are discussed below.

- With respect to both medical/surgical and MH/SUD benefits, group health plans often encourage participants to use network providers through incentives such as lower out-of-pocket costs and, in most cases, the absence of treatment limitations. MH/SUD network arrangements differ from medical/surgical in several ways:

    - The primary care versus specialty care distinction commonly present for medical/surgical treatments does not typically apply to MH/SUD. Most MH/SUD outpatient visits (67%) are with clinicians other than psychiatrists, who are medical doctors (MDs). [6] Some patients are in treatment with both a non-MD clinician for "talk therapy" and a psychiatrist, who prescribes and monitors medications.

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[3] In 2002, Towers Perrin obtained outpatient visit data from three leading MBHOs. The data showed that 73% received 10 visits or less. Since 2001, several MBHOs have stated that the percentage completing treatment in 10 or fewer visits has remained stable.

[4] http://psychservices.psychiatryonline.org/cgi/reprint/55/5/494.pdf

[5] The denominator for MH/SUD claims was obtained through Towers Perrin's annual MH/SUD cost and utilization data referenced above. Medical plan costs were obtained from nationally available employer surveys. Towers Perrin calculated the percentage of medical plan costs attributable to MH/SUD.

[6] Towers Perrin periodically asks the MBHOs to report the distribution of outpatient visits by provider type in connection with a market study. In 2003, four of the largest MBHOs reported – on average – that 33% of outpatient visits were with psychiatrists.

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- A large oversupply of non-MD MH/SUD clinicians has existed for at least two decades. Because of the competition for patients, the MBHOs have used the same fee schedules for the past 15 years. The majority of non-MD MH/SUD clinicians have not seen an increase in network fees since the early 1990s. In contrast, psychiatrists are in short supply, due, in part, to the growing percentage of the treatment population taking psychotropic medications, which can be prescribed only by MDs. Medical students specializing in psychiatry have also declined.

- Billed charges from clinicians unaffiliated with networks have risen over time, as expected. Even though network providers are typically reimbursed at approximately 80% of billed charges versus 50% for out-of-network providers, the latter group's reimbursement per visit now averages 28% higher.

The bullet points immediately above pertain to professional services rendered by clinicians other than psychiatrists. Another distinction between MH/SUD and medical/surgical provider networks is the use of alternatives to acute inpatient care in the MH/SUD environment. Alternative care (sometimes called intermediate care) facilities and programs are less intensive than inpatient treatment but more intensive than outpatient office visits. The most common examples are listed below.

Alternative Level of Care	Description
Residential Treatment Centers (RTCs)	Facility offering 24/7 care, most often used for the treatment of troubled youth, eating disorders and SUD
Partial Hospitalization	Therapeutic sessions rendered five days per week in an inpatient facility. Patient returns home at night.
Structured Outpatient Programs	Similar to partial hospitalization only primarily for those with SUD diagnoses.

About .3% of plan participants receive treatment in alternative care settings each year, half of whom are being treated for SUD disorders. About 20% of claim expenses are incurred in these facilities and programs, most of which (85%) is delivered in network facilities and programs.

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CURRENT MEDICAL/SURGICAL AND MH/SUD BENEFIT DESIGNS

Among the questions identified in the Request for Information are the following.

- What policies, procedures, or practices of group health plans and health insurance issuers may be affected by MHPAEA?
- Do plans currently impose financial requirements or treatment limitations on benefits other than those specifically identified in the MHPAEA?
- How do plans currently apply financial requirements or treatment limitations to (i) medical and surgical benefits and (ii) mental health and substance use disorder benefits?
- Are these requirements or limitations applied differently to both classes of benefits?

The practices of group health plans with respect to medical/surgical and MH/SUD benefits that will be affected by the MHPAEA fall into two categories. The first category includes practices where there is widespread agreement among behavioral healthcare industry experts regarding the changes required by the MHPAEA. The second category includes practices that may be affected by the MHPAEA, depending on the regulatory guidance issued.

MH/SUD BENEFIT CHANGES REQUIRED BY THE MHPAEA

The MHPAEA will result in three major changes to MH/SUD benefit administration in carved out MH/SUD plans:

- Commonly used annual limitations will, for the most part, need to be eliminated.
- Coinsurance levels paid by plan participants will generally need to be decreased for MH/SUD benefits with respect to out-of-network coverage, as MH/SUD out-of-network benefits are almost always lower than provided for medical/surgical.
- Where applicable, single MH/SUD benefit designs will be replaced with multiple MH/SUD benefit designs to bring those benefits into parity with medical/surgical benefits provided under each group health plan.

Elimination of out-of-network annual limitations: Virtually all group health plans with carved out MH/SUD benefits limit out-of-network (OON) treatment, both inpatient and outpatient. The plan provision we see most often limits OON inpatient days to 20 per year, which also applies to treatment rendered in alternative care settings. A similar cap (e.g., 20

visits) is applied to OON office visits. In contrast, these plans typically do not impose any visit limits on OON medical/surgical treatments.

Although precertification and medical necessity reviews are routinely performed with OON inpatient facilities, this practice is much less likely to be applied to outpatient visits. Essentially, OON MH/SUD visits are "managed" by the annual visit limit.

The elimination of the annual visit limits for MH/SUD benefits to bring the plans into compliance with the MHPAEA will require new approaches to the application of medical necessity on OON outpatient treatment. Because of the fee schedule history with MH/SUD providers described in the background section, a good deal of animosity between MH/SUD clinicians and the MBHOs has arisen. Over time, treatment limitations came into widespread use as a solution to OON providers' refusal to cooperate with medical necessity reviews, and the complaints and appeals filed by participants when claims were denied.

The development of new procedures for managing OON outpatient treatment is influenced by the absence of objective clinical data such as laboratory or radiology results to document medical necessity. Because of the nature of psychiatric conditions, the establishment of medical necessity is a more labor-intensive endeavor on the part of both the plan administrator and the health care provider. The MBHOs will need to develop new methods for engaging in medical necessity reviews for OON outpatient treatment and additional clinical management resources may also be required.

Alignment of MH/SUD out-of-network coinsurance with that for medical: As noted above, out-of-network coinsurance that must be paid by plan participants for MH/SUD services is usually higher than that imposed for medical/surgical. A fairly common difference is 70% benefit reimbursement levels for OON medical/surgical and 50% for MH/SUD. Based on the 70%/50% benefit level difference commonly found today, bringing the plan into compliance with the MHPAEA will result in the cost of an average OON visit increasing by 40% or, based on 2008 MBHO norms, $25/visit.

If the current plan payment for the average network visit is compared to the projected payment for an average OON visit in 2010 (after the MHPAEA takes effect and assuming that the MH/SUD coinsurance for plan participants decreases from 50% to 30%), OON providers will receive a plan payment of about $40 more for an OON visit than for a network visit. In addition, OON providers will no longer be confronted with the problem of collecting the full amount of billed charges from the member after the maximum visits per year which are covered by the plan have been exhausted.

The sharp increase in benefit reimbursements for OON visits, combined with the removal of treatment limitations (i.e., visit limitations), may impact the size and/or availability of network MH/SUD providers. Network providers may terminate their contracts with the

MBHOs in the hope that they can increase their private pay practices enough to compensate for the loss of network referrals.

Single to multiple MH/SUD benefit plans: Most plan sponsors with carve out MH/SUD benefits adopt one MH/SUD schedule of benefits for several group health plans. And these group health plans often have varying financial requirements and treatment limitations for medical/surgical benefits. Under the MHPAEA, a single MH/SUD benefit schedule will generally need to be replaced with separate MH/SUD benefit schedules, each aligned with the medical/surgical financial requirements and treatment limitations under each group health plan.

MH/SUD BENEFIT CHANGES THAT MAY OR MAY NOT BE REQUIRED BY THE MHPAEA, DEPENDING UPON REGULATORY GUIDANCE

Common versus separate-but-no-greater-than out-of-pocket maximums: Behavioral health experts differ in their interpretations of the permissibility of separate out-of-pocket maximums for medical/surgical and MH/SUD under the MHPAEA. The uncertainty stems from the following provision in the MHPAEA: ". . . and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits" [ERISA § 712(a)(3)(A)(i); IRC § 9812(a)(3)(A)(i)] A "common" out-of-pocket maximum is one that applies to both medical/surgical and MH/SUD claims. A "separate-but-no-greater-than" out-of-pocket maximum applies one out-of-pocket maximum to medical/surgical covered expenses and a separate, but not larger, out-of-pocket maximum to MH/SUD covered expenses. One of the clarifications requested below pertains to the MHPAEA requirements regarding annual out-of-pocket maximums.

In group health plans, there are often two separate out-of-pocket maximums, applicable to medical/surgical benefits: one for covered expenses for network services and the other for out-of-network covered expenses. In contrast, carved out MH/SUD benefits rarely include out-of-pocket maximums, for either network or out-of-network treatment. However, network MH/SUD coverage is usually designed in other ways to minimize out-of-pocket costs. For example, for network MH/SUD services, out-of-pocket expenses are minimized by capping expenses for higher levels of care (e.g., $250/year) and often use a $15 copay for office visits.

If "separate-but-no-greater-than" out-of-pocket maximums are not permitted under the MHPAEA, then medical/surgical and MH/SUD plan administrators will need to create a mechanism for exchanging claim data in order to adjudicate a shared out-of-pocket maximum. Claims administration experts have reservations about the ability of two entities, which often are marketplace competitors, to ensure that the interface will function properly, especially absent a clear point of accountability.

Another factor that bears consideration is that participants are reluctant to enlist their employer in helping to resolve claims problems in connection with MH/SUD claims, due to the stigma that continues to surround these conditions.

Finally, according to an MBHO with extensive experience with cross-platform claim adjudication, the creation and testing of such an arrangement requires at least 90 days to establish the data exchange procedures, complete the required programming and verify that the interface functions as intended. If the group health plans involved have limited experience with such arrangements, more time will be required.

CLARIFICATIONS REQUESTED

Towers Perrin recommends that clarifications to the MHPAEA be provided in the following areas:

- The acceptability of separate-but-no-greater-than deductibles and out-of-pocket maximums for medical/surgical versus MH/SUD benefits
- The use of primary care versus specialty care physician copays as the "predominant" financial requirement for purposes of determining the applicable copay for MH/SUD office visits
- Coverage of out-of-network alternative care
- The use of different financial penalties for failure to precertify MH/SUD versus medical/surgical treatment
- The degree to which "reasonable and customary" reductions for out-of-network MH/SUD services must be comparable with medical/surgical services

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

1.

Separate cost sharing:	" ... there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits" [ERISA § 712(a)(3)(A)(i); IRC § 9812(a)(3)(A)(i)]

Question: Does the MHPAEA provision above mean that a separate-but-not-greater-than out-of-pocket maximum can be applied to MH/SUD benefits as that applied to medical/surgical? Or does this provision mean that any out-of-pocket maximum that applies to medical/surgical must also be applied to MH/SUD on a

TOWERS PERRIN

combined basis? Do deductibles have to be treated the same as out-of-pocket maximums for this purpose?

For example, under the first interpretation, a $1,500 out-of-pocket maximum could apply to covered medical/surgical expenses and an additional, separate $1,500 out-of-pocket maximum could apply to MH/SUD expenses.

Under the second interpretation, if an out-of-pocket maximum were available for medical/surgical expenses, MH/SUD expenses would have to be applied to the same out-of-pocket maximum, such that once $1,500 in medical/surgical and/or MH/SUD covered out-of-pocket expenses were incurred, all covered expenses would be paid at 100% for the remainder of the plan year.

2.

Predominant:	**" ...** mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements [or treatment limitations] applied to substantially all medical and surgical benefits…" [ERISA § 712(a)(3)(A); IRC § 9812(a)(3)(A)] "A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement." [ERISA § 712(a)(3)(B)(ii); IRC § 9812(a)(3)(B)(ii)]

Group health plans often impose different copays for primary care physicians than for specialists. Specialist copays tend to be higher. Generally, primary care physicians include family physicians, general practitioners, internists, obstetrician-gynecologists and pediatricians. Psychiatrists – medical doctors that treat MH/SUD conditions – are widely viewed as specialists. However, if the incidence of office visits by plan participants is tallied, the number of primary care visits in a population typically exceeds that of specialty care visits. [7]

Question: Is the term "predominant" to be interpreted in this context to mean that MH/SUD office visit financial requirements are to be in parity with those imposed for primary care physicians? Or, can plan sponsors apply the specialty office visit copay (and other financial requirements) since psychiatry is widely viewed as a medical specialty?

[7] http://www.aafp.org/online/etc/medialib/aafp_org/documents/press/charts-and-graphs/

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3.	**Treatment limitation:**	"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." [ERISA § 712(a)(3)(B)(iii); IRC § 9812(a)(3)(B)(iii)]

Alternative care settings (described above) are used when an MBHO clinician has reviewed the patient's condition/treatment needs and determined that an alternative care setting is able to render appropriate care. A parallel in medical/surgical services occurs when patients are transferred from a hospital to a Skilled Nursing Facility, which are similar to Residential Treatment Centers. Treatment at the least intensive level of care suited to the patient's needs is a basic tenet of the definition of medical necessity for MH/SUD and medical/surgical services.

Out-of-network residential treatment centers (RTCs) present the most significant challenges to MH/SUD plans, both from a quality and cost perspective. RTCs for troubled youth have been the subject of thousands of allegations of abuse and even death. The Federal Trade Commission published a set of recommendations for parents considering residential treatment for youth in July 2008. [8]

In October of 2007, the U.S. Government Accountability Office (GAO) published an investigation of 10 criminal and civil cases involving teenagers who died while enrolled in RTCs and reported the findings below:

> GAO found significant evidence of ineffective management in most of the 10 cases, with program leaders neglecting the needs of program participants and staff. This ineffective management compounded the negative consequences of (and sometimes directly resulted in) the hiring of untrained staff; a lack of adequate nourishment; and reckless or negligent operating practices, including a lack of adequate equipment. These factors played a significant role in the deaths GAO examined. [9]

As the two federal government documents cited above suggest, the cost and quality challenges likely to be posed by out-of-network RTCs will increase if regulations require that out-of-network RTCs be covered the same as out-of-network medical/surgical inpatient stays.

Question: Does the term "treatment limitation" apply to alternative care settings and require that they be covered? Or can the decision to cover alternative care

[8] www.ftc.gov/bcp/edu/pubs/consumer/products/pro27.pdf

[9] www.gao.gov/new.items/d08146t.pdf

remain with clinical care managers, based on clinical and medical necessity criteria? If the MHPAEA's requirement to provide parity in "treatment limitations" is to be applied to alternative care, does parity have to be achieved with inpatient medical/surgical or is the intent to require that alternative care be covered the same as a comparable level of medical/surgical services (e.g., Skilled Nursing Facilities and Residential Treatment Centers)?

4.

Financial requirement:	"The term 'financial requirement' includes deductibles, copayments, coinsurance, and out-of-pocket expenses..." [ERISA § 712(a)(3)(B)(i); IRC § 9812(a)(3)(B)(i)]

Most group health plans require participants to obtain precertification for certain medical/surgical and MH/SUD treatment. Precertification requires the participant to notify the plan administrator prior to receiving certain services so that a medical necessity determination can be made.

Precertification for inpatient treatment is commonly required for medical/surgical as well as MH/SUD. Outpatient treatment is also subject to precertification. Medical/surgical examples include certain outpatient surgical procedures, private duty nursing and durable medical equipment in excess of a specified amount. MH/SUD outpatient precertification is commonly required for psychological testing.

Precertification penalty – reduction in benefits: The penalties for failure to precertify care vary and are commonly different for medical/surgical than for MH/SUD. Usually, the financial penalties for MH/SUD are larger than those for medical/surgical. For example, participants are sometimes required to obtain precertification for all treatment from network providers (both inpatient and outpatient). If precertification for MH/SUD treatment is not obtained, network benefits may be reduced to the out-of-network level, which are generally considerably lower (e.g., a reduction from 80% coverage to 50%). This reduction may occur even if the participant is under the care of a network provider. In contrast, failure to precertify medical/surgical care is commonly subject to a smaller reduction in benefits (e.g., 20%) or a flat dollar amount (e.g., $500).

Question: Do the financial penalties for failure to precertify MH/SUD treatment need to be no higher than the financial penalties for failure to precertify medical/surgical treatment?

Precertification penalty – denial of benefits: Failure to precertify may result in a denial of the claim. Generally, a medical/surgical claim is denied after a retrospective review is conducted and the care is deemed not medically necessary. Here again, it is not uncommon for a denial of an MH/SUD claim to occur absent a

retrospective review while medical/surgical denials are almost universally based on such a review.

Question: If medical/surgical benefits are denied only if a retrospective review establishes that the services were not medically necessary, must a similar review process be undertaken before such MH/SUD claims are denied?

Reasonable and Customary: Out-of-network professional services claims are subject to "reasonable and customary" (R&C) reductions in determining the amount the plan will pay. Generally, R&C reductions involve a two step process: (i) creating a distribution of billed charges for a specific procedure code (Current Procedure Terminology or CPT code) in a geographic area and (ii) obtaining the percentile (e.g., the 80th percentile) in the distribution that the plan sponsor wants used in calculating the R&C reduction. For example, if a psychiatrist bills $120 for CPT code 90862 (a medication management visit), the R&C may be $110. The out-of-network benefit level (e.g., 70%) is then applied to the R&C amount. In this case, the plan would pay $77.00 and the member pays $43.00 (see table below).

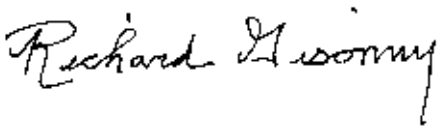
Because different companies often administer medical/surgical and MH/SUD benefits, the methodology for establishing R&C can yield significantly different financial requirements for participants. Sometimes the MH/SUD plan administrator has been instructed to use the network fee schedule as a basis for R&C, while the medical/surgical plan administrator uses the methodology described above. Because the network fee schedule is generally considerably lower than R&C for MH/SUD, the out-of-network plan payment is lower than would be the case using a more standard R&C reduction methodology. Currently, the medication management visit fee schedule averages $55. If the 70% benefit level is applied to the network fee schedule amount, the plan pays $38.50 and the member pays $81.50.

	R&C @ 80th percentile	R&C based on network fee
Billed charges	$120.00	$120.00
R & C reduction	$110.00	$55.00
Plan pays	$77.00	$38.50
Member pays	$43.00	$81.50

Question: Do out-of-network R&C plan payments for MH/SUD professional services need to be in parity with the methodology applied to medical/surgical services?

We thank you for the opportunity to submit our comments. We would welcome the opportunity to discuss any of these comments in further detail. If you have any questions, please contact any of us below.

Sincerely,



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