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Office of Health Plan Standards and
Compliance Assistance Employee
Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
Attention: RIN 1210-AB30

Centers for Medicare & Medicaid Services
U.S. Department of Health
and Human Services
Attention: CMS-4140-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

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

Re: Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health
Parity and Addiction Equity Act of 2008

Dear Sir or Madame:

MHN, a Health Net Company, is writing to provide comments and recommendations in response to Interim Final Rules (IFR) released by the Departments of Health and Human Services, Labor and Treasury on February 2, 2010 (75 Fed. Reg. 5410). The IFR implements the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

MHN, a Health Net Company, is a managed behavioral health organization that has been providing employee assistance and managed behavioral health services for over 30 years. MHN is a member of the Association for Behavioral Health and Wellness and through the association has been supportive of the mental health parity initiative. MHN recognizes the importance of equitable treatment for those individuals with mental illness and substance use disorders, however, MHN is concerned that the interim final rules have created confusion and misinterpret key aspects of the process needed to treat mental

illness and substance use disorders.

By way of history` the managed behavioral health care industry came into existence because the medical managed care approach was and remains unable to appropriately understand and manage the needs and treatments of those individuals suffering from mental illness and substance use disorders. Prior to the development of managed behavioral health care, one of the most common reasons that people were discharged from inpatient psychiatric facilities was exhaustion of benefits. Treatment plans were vague and were tailored more to the length of time allowed by coverage rather than the clinical needs of individuals. At the same time outpatient treatment was often nondirective and displayed a great deal of variability. It became clear that there was a need to address the variability in care and develop processes to enhance effective and efficient care for those with mental illness and/or substance use disorders. Seeing behavioral health as simply another specialty of medicine fails to acknowledge the complexities of behavioral health needs. It has become clear that different approaches were needed in order to address and effectively manage behavior health care.

It is important to note that the majority of providers in behavioral health care (i.e. those providers treating mental illness and substance use disorders) are not physicians, and do not operate from a medically oriented model. These providers come with widely disparate types of educational backgrounds and thus the variability seen in behavior health care has been significant. Before managed behavioral health care there were fewer formal assessments of individuals seeking care and treatment plans therefore tended to be vague with unclear goals and objectives. Outpatient treatment most typically ended when people chose not to come any more. Managed behavioral health, by separating itself from physical medical care management, was able to effect change which has improved access as well as outcomes by requiring providers to develop an understanding of the problem they are treating and develop and document a treatment approach with specific outcome goals. In the past 20 years a significant number of evidence based treatment guidelines have been developed for mental illness and substance use disorders. Through the evolution of behavioral treatment and its management we have been able to develop both highly effective and efficient care. MHN believes the IFR failed to recognize this, and by attempting to the overly match physical medical management and behavior health care in ways that are not appropriate, these rules will bring about an unfortunate result of diminishing the effectiveness of behavioral health care and are very likely to increase overall costs.

In the preamble to the IFR the document acknowledges the fact that the specialization and the effectiveness of managed behavioral health was an important aspect leading to the success in being able to bring mental illness and substance use disorders treatment parity about. The rules, however, inadvertently undermine managed behavioral health by stating that it must match medical management in ways that we know failed in the past. By attempting to shoehorn behavior health back into the approaches used to manage physical medicine cases the IFR is turning back the clock almost 30 years. The IFR preamble recognizes the value of behavioral health care management and its role in

leading to parity, but then within the body of the regulations the proposed new rules attempt to return behavioral health to the times when treatment was unfocused, inefficient, and overly costly.

Specific Concerns

MHN believes that the non-quantitative treatment limitations (NQTLs) should be removed. As noted above the differences in physical and behavioral health management are significant. The tools used by managed behavioral health are key to maintaining access and assuring the delivery of effective and efficient care. The non quantitative treatment limitations are vague, overly complex to administer, and they leave open many opportunities for interpretation that are likely to force behavioral health to use the management tools of physical medicine that have failed in the past and which risk a return to non directed treatment and uncontrolled costs.

Further, along with the negative effects on treatment and costs, MHN believes that these limitations go beyond the MHPAEA. The vagueness of this section and the fact that these rules are attempting to utilize physical medical practices which were abandoned by behavioral health almost 30 years ago because of their ineffectiveness is likely to turn back the clock rather than move the field forward.

MHN supports the position put forward by ABHW regarding the use of NQTL's.

“MHPAEA amended section 712(a) of ERISA (and the parallel provisions of the Internal Revenue Code and the Public Health Services Act) by adding new section 712(a)(3), which states 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." [Emphasis added.] All of the examples used by Congress are limitations that would, under the regulations, fall within the category of "quantitative" limitations. As required by the statute, any other limitations subject to the parity requirement would have to be "similar" to these listed examples. The regulations, however, include nonquantitative limitations and at the same time recognize that the nonquantitative limitations are inherently different from the quantitative limitations and therefore require separate rules. To the extent that these two types of limitations are not "similar," there is, as a matter of logic, no basis for including the nonquantitative limitations in the regulation.

Even beyond the plain words of the statute and a logical reading of this provision, there is ample support for the conclusion that NQTLs should not be included in the IFRs. First, support for this "similarity" analysis can be found by examining the prior mental health parity provisions contained in ERISA § 712 prior to amendment by MHPAEA. Prior to MHPAEA, section 712(b) of ERISA (and the parallel provision of the Internal Revenue Code and Public Health Service Act) provided that the parity requirements were not to be construed "as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage" except as specifically provided by the statute. With the exception of the medical necessity determination (which is addressed elsewhere in MHPAEA and the IFRs), these limits are all quantitative in nature, and are thus similar to the limitations

included in section 712(a)(3), above. Recognizing that these quantitative limits would be subject to the new parity standards, Congress amended section 712(b)(2) to provide that MHPAEA should not be construed "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.) There is no indication in either section 712(a) or (b) as amended by MHPAEA that Congress intended nonquantitative limitations to be included under the new parity rules. Indeed, the language at the end of section 712(b)(2) can only be read as a limitation on the application of the law and on the types of practices that must be subject to parity analysis. This limitation essentially eliminated from the law under the IFRs, which would subject virtually all practices and procedures, quantitative or otherwise, to the parity standard.

Second, the legislative history of MHPAEA supports applying the parity standard only to the type of quantitative standards listed in ERISA § 712(a)(3). The Senate Committee Report discussing the Senate version of the bill that ultimately became MHPAEA contains the following statement:

S. 558 does not prohibit group health plans from negotiating separate reimbursement or provider payment rates, or managing the provision of mental benefits in order to provide medically necessary treatments under the plan.

Sen. Rep. No. 110-53, 110th Cong., 1st Sess. (2007) at p. 3. The Senate Committee specifically indicated that separately negotiated provider payment and reimbursement rates would not be subject to the parity rule. It is impossible to square this clear expression of intent with the inclusion of such items within the NQTL illustrative list. Further, with the exception of medical necessity issues (which as noted above are addressed elsewhere in the IFRs), the Committee report clearly indicates an intention that MHPAEA will not interfere with the management of mental health and substance abuse benefits. Such management would not be possible if the practices listed as NQTLs are open to constant attack and second-guessing under the IFRs."

Shared vs. Combined Deductibles

MHN requests that the departments reverse the decision to require that plans have to use combined deductibles and annual out-of-pocket maximums, rather than allowing separate, but equal, deductibles as has been the practice to this point.. We believe that this disadvantages both those patients with only behavior health disorders or those patients with only medical disorders. A combined single deductible will have to be higher than either of the component single deductibles, so those individuals receiving treatment for a single behavioral or medical illness will now have an increase in their deductibles. It is difficult for MHN to understand how the combining of deductibles is of value to the general population receiving care. There seems little to be gained for consumers by the combination, while additional expenses are being added to payers and plans. We respectfully suggest that the present system of deductibles, and annual and lifetime maximums, as set forth in the Mental Health Parity Act of 1996, with the allowance for separate, but no less restrictive deductibles in behavioral health, is a more



effective and efficient way to manage this aspect of MHPAEA.

As noted above the shared accumulator work will take a minimum of four to six months. Therefore, MHN believes that if the IFR rules on the combination of deductibles and out of pocket maximums are not reversed, then the implementation date for these rules should move a minimum of 12 months to July 1, 2011. This will allow needed time for insurers and payers to create the bridges that are being required as a result of these rules. While we feel that the most appropriate approach is to eliminate the shared deductibles and the shared annual out-of-pocket maximums, should that not occur the rules must leave enough time for the accumulator bridges to be built. Some medical carriers are dragging their feet or refusing to work on shared accumulators with behavioral health organizations, as required under the MHPAEA. MHN is pleased to have had the opportunity to provide comments on the IFR. We are happy to answer any questions that arise from this document.

Respectfully submitted,

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Chief Medical Officer