America's Health
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May 3, 2010

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
Room N-5653
200 Constitution Ave., NW
Washington, DC 20710
Attention: RIN 1210-AB30

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1410-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

CC:PA:LPD:PR (REG-120892-09)
Room 5203
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

Submitted via the Federal eRulemaking Portal: www.regulations.gov

Dear Sir/Madam:

America's Health Insurance Plans is writing to offer comments and recommendations regarding the Interim Final Rules (IFR) implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The IFR was published in the *Federal Register* on February 2, 2010 (75 Fed. Reg. 5410).

AHIP is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans. Our members offer a broad range of products in the commercial marketplace and also have demonstrated a strong commitment to participation in Medicare, Medicaid, and other public programs.

Our comments and recommendations address the following:

- Allowing employers and health insurance plans sufficient time to make the extensive changes that are required by the IFR in a manner that does not disadvantage consumers and is consistent with the on-going efforts to implement the recently enacted health care reform legislation.

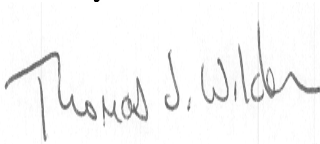
- Permitting existing plan designs, such as combined copayments and coinsurance, that are consistent with the parity requirements of the MHPAEA and do not disadvantage patients accessing mental health or substance use disorder services.

- Allowing the use of health plan strategies to ensure patients receive appropriate medical care and treatment.

AHIP strongly supported the MHPAEA and worked with a broad coalition of stakeholders in developing the legislation. We believe the changes we are recommending to the IFR are consistent with the MHPAEA provisions and will provide for more effective implementation of the law. AHIP and its members look forward to working with you on this important issue.

Please feel free to contact me at (202) 778-3255 or twilder@ahip.org if you have any questions.

Sincerely,



Thomas J. Wilder
Senior Regulatory Counsel

Attachment:

America's Health Insurance Plans
Response to Interim Final Rule
Implementing the Mental Health Parity and Addiction Equity Act
May 3, 2010

America's Health Insurance Plans is writing to provide comments and recommendations in response to Interim Final Rules (IFR) implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

A. Streamlining Implementation of the MHPAEA

Issue 1: Giving employers and health insurance plans sufficient time to make all of the necessary changes to implement the IFR.

Recommendation

The compliance date of the rule should be extended to plan years on or after July 1, 2011.

Discussion

Employers and health insurance plans face significant challenges in implementing the IFR. For example, parity must be calculated for each group health plan for each plan year based on the following factors:

- Type of financial requirement (deductible, copayment and co-insurance).
- Type of financial limitation (number of days or treatment sessions).
- Category of benefits (e.g., out-patient/in-network).
- Type of benefit design (e.g., HMO, PPO or POS plans).

As a result, thousands of complicated calculations and benefit determinations must be made for each year to comply with the IFR and make any necessary changes to benefit designs. This process is even more complex in situations where the group plan must coordinate the parity determination between one or more medical/surgical payers and one or more vendors providing "carve-out" mental health or substance use disorder benefits.

Any changes to financial requirements and treatment limits based on the parity determination will then need to be incorporated into provider and employer client contracts, submitted to state and federal regulators for approval, and communicated to plan beneficiaries and participants.

The IFR was issued February 2, 2010 with full compliance required by July 1, 2010, giving employers, insurers, and plan administrators five months to implement the complicated parity calculations and benefit design changes required by the rule. While a majority of group plans have later plan years (typically December 1st or January 1st), considerable work must be done over the next few months to comply with the IFR given

that most employers, insurers, and plan administrators are already negotiating and establishing health plan designs for the 2011 plan year.

Employers and health insurance plans are currently dedicating extensive resources to implement the recently enacted Patient Protection and Affordable Care Act in addition to the changes required by the IFR. We believe employers and health insurance plans and the employees and consumers they serve would be best served if the July 1 implementation date is extended to give additional time to come into compliance.

B. Establishing a Framework for MHPAEA Implementation

Issue 2: Allowing payment of medical/surgical benefits in connection with mental health or substance use disorder treatment.

Recommendation

Employers and health insurance plans should be permitted to continue reimbursing physicians and hospitals for medical services in connection with the treatment of a mental health or substance use disorder, rather than having to implement new and costly systems to track and classify claims and reimbursements.

Discussion:

The IFR definition of mental health benefits provides that "(a)ny condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines.)" (26 C.F.R. §54.9812(a), 29 C.F.R. §2590.712(a), and 45 C.F.R. §146.136(a)). A similar provision is included in the definition of substance use disorder benefits. According to the Preamble to the IFR, the requirement to define benefits based on the ICD or DSM classification, "is included to ensure that a plan does not misclassify a benefit in order to avoid complying with the parity requirements." (75 Fed. Reg. 5412).

Strictly defining claim reimbursement by the categories established in the ICD or DSM may have unintended negative consequences for consumers. In some cases, employers and health insurance plans may pay medical/surgical claims that include a mental health or substance use disorder component. The following examples illustrate situations that may arise:

- A patient visiting his or her primary care physician (PCP) may complain of depression in addition to other physical symptoms. The PCP submits a diagnosis of depression and prescribes a prescription drug to treat depression in addition to other diagnoses and prescribed treatments.

- A patient with a terminal illness is receiving care from an inpatient hospice

facility. In addition to treating the individual's medical condition, the hospice provides counseling services for the patient and his or her family.

- A patient is admitted to an emergency room and is subsequently admitted to the hospital as an inpatient for de-toxification treatment in connection with a substance use disorder. The hospital is paid for medical treatments provided in connection with the emergency care and inpatient services.

If employers and health insurance plans are required to strictly segregate claims based on ICD or DSM classifications, extensive and costly administrative systems will need to be established to track and reimburse such claims. Additionally, it will be even more difficult to calculate parity and to allocate cost-sharing and treatment limits across benefits in situations where a primary care physician or hospital is providing medical services that have a mental health or substance use disorder component.[1]

We believe a more reasonable approach is to allow employers and health insurance plans to continue the current practice of reimbursing services for certain diagnoses or procedures that may be classified by the DSM or ICD as mental health conditions or substance use disorders as medical/surgical benefits, if the payments are made in the context of the overall medical care provided to the patient.

Issue 3: Ensuring provision of outpatient medical/surgical benefits.

Recommendation

Make clear that the MHPAEA allows employers and health insurance plans to provide inpatient or outpatient medical/surgical benefits if they do not provide similar coverage for mental health or substance use disorder benefits.

Discussion

The IFR requires employers and health insurance plans to provide mental health and substance use disorder benefits in all benefit categories in which medical/surgical benefits are offered. As a result, employers and health insurance plans are not permitted to provide medical/surgical benefits in a care setting (e.g., outpatient or inpatient) if they do not provide such coverage for mental health or substance use disorders.

The MHPAEA only addressed out-of-network care settings and did not address coverage for medical/surgical, mental health or substance use disorder benefits with respect to inpatient or outpatient benefits.

The recently enacted health care legislation includes requirements for the HHS Secretary to develop standards for essential benefits including mental health and substance use

[1] The same issue arises in the context of facilities providing medical care in connection with treatment of a mental health condition or substance use disorder. According to a strict interpretation of the IFR, payment to such facilities for medical care would be considered a medical/surgical benefit.

disorders. We believe the determination of the range of inpatient and outpatient medical/surgical, mental health, and substance use disorder benefits are best made by the HHS Secretary in the context of the essential benefits determination rather than through the IFR.

C. Determining Parity with Respect to Financial Requirements

Issue 4: Allowing use of "hybrid" plan designs combining copayments and coinsurance.

Recommendation

Permit employers and health insurance plans to preserve consumers' access to medical/surgical benefits by combining copayments and coinsurance for purposes of determining parity.

Discussion:

As discussed above, the IFR requires parity to be determined separately with respect to each financial requirement. The first step is to determine if the financial requirement is applicable to substantially all (i.e., two-thirds) of all medical/surgical benefits.

The substantially all test as set out in the IFR may disqualify certain hybrid plans combining copayments and coinsurance. Some employers and health insurance plans apply copayments or coinsurance based on the type of services. For example, copayments may be used in connection with physician office visits, and coinsurance may be applied to outpatient surgery or tests such as MRIs. If the parity determination is made separately for each financial requirement, it is possible neither copayments nor coinsurance will meet the substantially all threshold. As a result, no cost-sharing may be allowed for mental health or substance use disorder benefits.

This result places consumers accessing medical/surgical services at a disadvantage because of the unequal cost-sharing requirements. The medical/surgical benefits should be preserved and the parity determination should allow the combining of copayments and coinsurance.

Two approaches to hybrid plan designs should be permitted. First, employers and health insurance plans should be permitted to make reasonable parity comparisons for types of services within a category of benefits. For example, copayment levels for medical/surgical benefits and mental health and substance use disorder benefits could be compared for routine services such as physician office visits and visits to a social worker, therapist, or other mental health or substance use disorder provider. Additionally, comparisons of coinsurance levels between inpatient hospital stays and stays at an inpatient facility providing mental health or substance use disorder services should be allowed. We believe such comparisons are allowed by the MHPAEA and would not disadvantage patients accessing medical/surgical, mental health or substance use disorder

services.

In addition, employers and health insurance should be allowed flexibility to determine the actuarial equivalent for cost sharing between medical/surgical benefits and mental health and substance use disorder benefits within a benefit category. Under this approach, a reasonable estimate could be determined for the overall level of cost-sharing individuals would be expected to pay during a plan year that combines the copayment and cost-sharing levels for medical/surgical benefits as compared to cost-sharing for mental health and substance use disorder benefits.

There are a variety of approaches employers and health insurance plans may take to ensure that the financial requirements imposed on patients to access mental health and substance use disorder benefits are no more burdensome than the financial requirements applied to medical/surgical benefits. Plan designs that combine coinsurance and copayment features can be constructed to meet the requirements of the MHPAEA, and we believe such hybrid financial requirements should be allowed by the IFR.

Issue 5: Permitting separate deductibles or out-of-pocket limitations for medical/surgical benefits and for mental health and substance use disorder benefits.

Recommendation

Allow employers and health insurance plans to impose separate accumulating financial requirements as long as patients accessing mental health or substance use disorder services do not have higher cost-sharing.

Discussion

The IFR requires use of a single deductible or out-of-pocket expense limit for all medical/surgical, mental health, and substance use disorder benefits. According to the IFR Preamble, the agencies believe a single accumulating financial requirement is more consistent with the MHPAEA, although it is recognized separate limits are not prohibited by the law.

We believe use of separate accumulating financial requirements for medical and surgical benefits and for mental health or substance use disorder services is consistent with MHPAEA policy goals, because it allows patients to more easily access mental health or substance use disorder benefits and may limit overall cost-sharing for such services.

Two examples illustrate this point:

- A plan has a $2,000 deductible for all benefits. As an alternative, the plan uses a $1000 deductible for medical and surgical services and a separate $1,000 deductible for mental health or substance use disorder services. In the latter case, a patient who needs to access mental health services may access such

services sooner because of the lower, separate $1,000 deductible applied to those treatments.

- A plan may have a $5,000 out-of-pocket limit for all benefits. As an alternative, the plan may choose to impose a $2,500 limit for medical/surgical benefits and a $2,500 limit for mental health and substance use disorder benefits. A patient needing mental health or substance use disorder services may have a lower cost-sharing responsibility over the course of a plan year because of the lower, separate out-of-pocket limit for those services.

In addition, allowing separate accumulating financial requirements is easier and less costly to administer in the case of group plans that provide mental health or substance use disorder services through a third-party vendor. In many cases, the mental health or substance use disorder vendor does not coordinate claims reimbursement with payment of medical/surgical claims, and, as a result, it would be very difficult to determine when a patient has met a "global" deductible or out-of-pocket limit applicable to medical and surgical benefits and mental health or substance use disorder benefits.

Using a single accumulating financial requirement also makes the pricing of such benefits more uncertain when mental health or substance use disorder services are "carved out." For example, a payer providing medical/surgical benefits prices the coverage for employer clients based on the assumption that 100% of the cost-sharing under a deductible or below an out-of-pocket limit is allocated to medical/surgical costs. If there is a global deductible or out-of-pocket limit, it is less certain whether the cost-sharing will be applicable to benefits provided by a medical/surgical payer or a mental health or substance use disorder payer. As a result, each payer will have difficulty determining the cost of coverage provided.

We believe the MHPAEA clearly permits the use of separate accumulating financial requirements, and that such an approach benefits consumers since the use of separate deductible or out-of-pocket limits may reduce the financial exposure for patients accessing mental health or substance use disorder benefits. Additionally, not permitting separate deductibles or out-of-pocket limitations may create a significant administrative burden for employers and health insurance plans that carve-out mental health benefits to a separate vendor. The IFR should be modified to allow separate accumulating financial requirements so long as patients accessing mental health or substance use disorder services do not have a greater cost-sharing responsibility.

D. Determining Parity with Respect to Treatment Limitations

Issue 6: Clarify how parity is determined with respect to treatment limits.

<u>Recommendation</u>

Make clear that the MHPAEA governs limitations on the number or days of treatment and not plan requirements for the provision of appropriate medical care, provider

credentialing or reimbursement.

Discussion

The IFR applies parity requirements to “nonquantitative” treatment limits, which are defined to include medical management standards, formulary design for prescription drugs, provider network standards (including reimbursement rates), plan methods for determining usual, customary, and reasonable charges, step therapies and “fail first” requirements, and exclusions based on failure to complete a course of treatment.

Such plan provisions are intended to ensure patients receive appropriate medical care and to address provider credentialing standards or contracting provider reimbursements. The MHPAEA was intended to provide better access to benefits by requiring parity with respect to limits on the number or days or treatments. The law was never intended to require a balancing other plan design features between medical/surgical benefits and mental health and substance use disorder benefits.

MHPAEA Definition of Treatment Limits

The MHPAEA defines a “treatment limitation” as “limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.” (29 U.S.C. §1185a(a)(3)(B) and 42 U.S.C. §300gg-5(a)(3)(B), *emphasis added*). The MHPAEA further requires plans to ensure that:

> (T)he treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(26 U.S.C. §9812(a)(3)(A)(ii), 29 U.S.C. §1185a(a)(3)(A)(ii), and 42 U.S.C. §300gg-5(a)(3)(A)(ii), *emphasis added*). It is clear from the wording of the MHAPEA that it is intended to address parity in the context of numerical limits on benefits such as cost-sharing requirements or day or treatment limitations.

Application of Standards for Appropriate Care

Health insurance plans use a variety of approaches to ensure patients receive appropriate care based on their health condition and recommendations from treating providers. The goal of these requirements is not to deny needed care or limit access, but rather to make sure the individual is receiving treatment and services appropriate to their condition and health needs. For example, an individual with a serious behavioral health condition may be paired with a case manager who is responsible for coordinating medical, behavioral health, and social services received by the patient.

Another medical management tool used to ensure appropriate care is creation of a plan by the patient's health care provider that sets out goals and a strategy for treatment. Reimbursement is based on the services in the treatment plan so that the patient receives care from designated providers based on the needs and condition of the individual.

Challenges in Applying the Parity Standards to Nonquantitative Limits

The IFR requirements for determining parity in the context of nonquantitative treatment limits are not clearly defined and will be difficult to administer. The IFR states the following with respect to nonquantitative limitations:

> A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

(26 C.F.R. §54.9812(c)(4)(i), 29 C.F.R. §2590.712 (c)(4)(i), and 45 C.F.R. §146.136(c)(4)(i)).

The IFR language raises a number of questions:

- What does it mean to apply a nonquantitative limitation for mental health and substance use disorder benefits "no more stringently than" such a limitation for medical/surgical benefits?
- How should these standards be made "comparable" between medical/surgical benefits and mental health and substance use disorder benefits?
- What does the exception, "to the extent that recognized clinically appropriate standards of care may permit a difference," mean in the context of nonquantitative limitations?

Applying parity in the context of nonquantitative treatment limits is even more complicated for plans using separate vendors to provide medical/surgical benefits and mental health and substance use disorder benefits. Assuming the various payer vendors can agree on a parity definition for nonquantitative treatment limitations, the IFR may raise antitrust-related concerns by requiring the sharing of extensive information on policies and procedures, including proprietary data (e.g., provider reimbursement rates and prescription drug formula designs), to ensure compliance with the regulations.

We believe the MHPAEA was not intended to address plan standards to ensure appropriate medical care or provider credentialing or reimbursement. Even if such standards are governed by the MHPAEA, the IFR provides an unworkable and complicated framework that should be revised to more clearly explain how such parity determinations will be made by employers and health insurance plans.

Issue 7: Issues related to "Scope of Services"

Recommendation:

Any discussion with respect to scope of services should be addressed in the context of the essential benefits process of the Patient Protection and Affordable Care Act.

Discussion:

The Preamble to the IFR requests public input on issues related to the types of treatments or services provided by employers and health insurance plans. We believe Congress did not intend the parity requirements to govern the types of services or settings of care that may be covered. Such discussion is more appropriately addressed by the process HHS will use to determine the essential benefits offered by qualified health benefit plans under the PPACA.

The MHPAEA provides that nothing in the Act is intended to affect "the terms and conditions of the plan or coverage relating to such benefits . . . ." (26 U.S.C. 9812(b), 29 U.S.C. §1185a(b), and 42 U.S.C. §300gg-5(b)). This provision makes clear Congressional intent that employers and health insurance plans may determine what conditions, treatments, services, or settings of care are covered under the terms and conditions of the plan or insurance policy.

This view is supported by the legislative history of the MHPAEA. The Senate Committee Report includes the following statement with respect to the application of the parity requirements:

> The bill would not require plans to offer mental health benefits, nor would it require that those plans cover all types of mental health services or ailments if the plan covered any mental health services or ailments.

(Sen. Rep. No. 110-53, 110th Cong., 1st Session (2007) at p. 7). The House Energy and Commerce Committee Report included similar language:

> In addition, this requirement does not change the current ability of an insurer or provider to determine medically necessary and appropriate care and treatment for their patients. It merely ensures that patients are not denied mental health coverage based on the specific disorder they have. For example, a person cannot be denied coverage by their health plan merely because they have autism. A plan may determine, however,

> whether a treatment is medically necessary or appropriate for a given person at a given time based on their individual situation.

(H. Rep. 110-374, Part 3, 110th Cong., 2nd Session (2008)).

As discussed above, the PPACA establishes a process for the HHS Secretary to determine essential benefits offered by a qualified health benefits plan. We believe this process is a more appropriate venue to determine what types of services or care settings should be included.