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BEHAVIORAL HEALTH SYSTEMS

Behavioral Healthcare Programs for Business & Industry Since 1989

September 7, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9982-NC
P.O. Box 8016
Baltimore, MD 21244-1850

Re: Comments on Proposed Summary of Benefits and Coverage
CMS-9982-NC; 45 CFR Part 147

Dear Sirs:

Behavioral Health Systems (BHS) was formed in 1989 as a privately held Alabama corporation. We created and administer a preferred provider organization (PPO) of mental health-related hospitals, physicians and professionals. BHS markets this PPO to large employers under a "carve-out" arrangement, through which BHS administers their employees' mental health/substance abuse benefits. BHS staff oversees the care provided through this network, and processes all claims between the employer client and BHS providers.

In addition, BHS also includes separate divisions for drug testing administration, employee assistance programs and wellness.

BHS offers the lowest cost structure possible for mental health and substance abuse benefits on a fee-for-service rate basis, with no risk borne by BHS. This ensures maximum cost savings accrue directly to the client, that they have full knowledge of cost and utilization, and that client preferences regarding plan design/coverage limits are easily accommodated.

Employers currently participating in the BHS managed care/EAP programs have realized a savings in the 25 – 50% range, while at the same time increasing benefits to their employees over the previously administered plan.

BHS has the sole endorsement of the Employers Coalition for Healthcare Options (Alabama), the Associated Builders and Contractors of Alabama, and the Louisiana Business Group on Health as the endorsed mental/nervous provider on behalf of their memberships, and maintained a similar endorsement from the Alabama Healthcare Council during its existence.

BHS represents 750 clients, 750,000+ covered lives, and 11,000+ providers across the nation. The opinions expressed below are not only BHS' opinion. We have thoroughly discussed PPACA and the proposed regulation with all BHS clients, and this represents the opinion of the BHS client base.

Self-Funded Group Health Plans

The Departments indicate in the Supplementary Information that the template and related documents were drafted by the NAIC primarily for use by health insurance issuers and additional

modifications may be needed for some group health plans. **We agree that the proposed rule, template, and instructions require modification to accommodate self-funded group health plans.**

For example, many of the items required to be included under the SBC template's "Your Rights to Continue Coverage" are for a fully insured plan (i.e., you or your employer commit fraud or intentional misrepresentations of material fact, the insurer stops offering this policy or services in this state, your employer/sponsor changes insurance carrier, etc.) and do not apply to a self-funded group health plan. Similarly, self-funded group health plans governed by ERISA cannot identify state health insurance customer assistance programs able to help plan members.

We request that the Departments issue a template and instructions applicable to self-funded group health plans. These should be made available for comments/questions prior to the rule's final enactment and compliance date. Otherwise self-funded group health plans will be forced to complete their SBCs without proper guidance or will be delayed in order to seek clarification, leaving themselves open to possible enforcement actions.

Use of Carve-Outs

The proposed rule, template, and instructions require modification to accommodate multiple benefits administrators for self-funded group health plans.

The benefits most commonly carved out are mental health and substance abuse (MHSA) and prescription drugs. Attachment B-1, Coverage Examples, subsection h states:

> "If the insurer provides coverage only for medical services (e.g., pharmacy or mental health benefits are carved out and administered by another insurer), the insurer should complete the Coverage Example for only those benefits that it covers…These non—covered costs for excluded services would show up under the 'limits and exclusions' section of the "You Pay" table. [NOTE: Should we require inclusion of a disclaimer on the Coverage Example (and on the Summary of Coverage) that notes that certain benefits may be administered by a separate insurer? Should we also amend the instructions for the Summary of Coverage to address this issue in terms of how the benefits are described?]"

The plan's benefits are misrepresented if the SBC, prepared by the medical/surgical benefits administrator, lists either MHSA or prescription drug services as 100% paid by the employee. The group health plan does indeed cover these services; the benefits are simply administered by a different benefits administrator.

On the other hand it would be equally confusing to an employee to receive an SBC from each benefits administrator, i.e., the medical/surgical benefits administrator, the MHSA benefits administrator, and the prescription drug benefits administrator, pertinent only to that administrator's benefits.

This confusion would be multiplied in the event the employer offers several plan options, not all of which have benefits carved out. For example, an HMO option may not carve out benefits while an indemnity plan option may carve out MHSA and/or prescription drug benefits.

The SBC must be a cooperative effort on the part of the plan and all benefits administrators to produce one document that accurately reflects the employer's benefit plan or plan option.

Finally, the template and instructions must accommodate multiple plan administrators in the footer, the instructions on how to find a list of preferred or in-network providers, determining whether a referral is needed to access a specialist, contacts for grievances and appeals, etc.

Summary

BHS appreciates the opportunity to comment on this important regulation. We strongly urge the Departments to act promptly to resolve outstanding questions and ambiguities, and issue the final regulation. If the final regulation is not issued well before January 2012, plans will have the burden of rushing to meet the March 23, 2012 compliance date.

Sincerely,

Patricia L. Friedley

Patricia L. Friedley
Executive Vice President & Chief Quality Officer