May 3, 2010

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

Re: Comments on the Mental Health Parity Act Interim Final Regulations
RIN 1210-AB30

Dear Sir / Madam:

The American Benefits Council (the "Council"), the U.S. Chamber of Commerce (the "Chamber") and the National Retail Federation ("NRF") appreciate the opportunity to provide comments to the Department regarding the Interim Final Rules (the "Regulation") under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Act" or "MHPAEA"), 75 Fed. Reg. 5410 (Feb. 2, 2010). We understand that a response submitted to one agency will be shared with the other agencies of jurisdiction ("Agencies").

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly, or provide services to, retirement and health plans that cover more than 100 million Americans.

The Chamber is the world's largest business federation, representing more than three million businesses of every size, sector and region. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 71 percent of which have 10 or fewer employees, yet virtually all of the nation's largest companies are also active members.

The National Retail Federation is the world's largest retail trade association and the voice of retail worldwide. NRF's global membership includes retailers of all sizes, formats and channels of distribution as well as chain restaurants and industry partners from the U.S. and more than 45 countries abroad. In the United States, NRF represents the breadth and diversity of an industry with more than 1.6 million American companies that employ nearly 25 million workers.

Our members typically include mental health and substance abuse coverage in their health benefits plans and strongly believe in the value of such coverage for employees and employers. As key stakeholders directly impacted by the mental health parity rulemaking, we are committed to assisting the Agencies in developing reasonable and administrable guidance for the provision of mental health and substance use disorder benefits provided to group health plans. Our specific comments are set forth below.

1. Delay in Applicability Date and Extension of Good Faith Compliance Period

We recommend that the Agencies delay the applicability date of the Regulation until the first plan year beginning on or after January 1, 2012. The current applicability date of the Regulation for most plan sponsors is the first plan year beginning on or after July 1, 2010. A delay is justified since many of the provisions of the Regulation, including the non-quantitative treatment limit rule and the "substantially all"/"predominant" tests, are unanticipated and much more difficult to comply with than could have been expected. The single group health plan rule is particularly burdensome for the increasing number of larger employers that utilize a behavioral health company on a "carve out" basis to provide and manage mental health and substance use benefits.

A delay is also justified so that the Agencies can consider how the Patient Protection and Affordable Care Act ("PPACA") affects compliance with the Regulation. As a result of PPACA, plan sponsors are concerned that making design changes that are necessary to fulfill the parity requirements under the Regulation will eliminate their status as a "grandfathered" plan. PPACA also requires that employers that set up new health plans will be required to cover preventive care services with no cost-sharing for plan years beginning on or after September 23, 2010. This new rule will have an impact on the ability of plans to pass the "substantially all"/"predominant" tests as to cost sharing.

Additionally, PPACA increases the size of small employers for which the small employer exemption is available from 50 to 100 employees for purposes of the PHSA (see sections 2726 and 2791 of the PHSA), but PPACA does not provide a conforming change in the small employer size under ERISA or the Internal Revenue Code, nor does it provide a clear effective date for this change. None of these important issues could have been considered by the Agencies in issuing the Regulation.

In addition to a delay in the applicability date, we request a continuation of the good faith compliance period with respect to the requirements of the Act that was provided under the Regulation to give plan sponsors additional time to come into compliance with the

Regulation's requirements. If, however, the applicability date is not delayed, we request that the Agencies adopt a good faith compliance period with respect to the requirements of the Regulation for the first plan year to which the Regulation otherwise applies.

2. The Current Scope of the Regulation Should Not be Changed – Plans Must Be Able to Exclude Treatments and Treatment Settings as a Matter of Plan Design

MHPAEA provides that mental health and substance use disorder benefits are defined as benefits with respect to services for mental health or substance use disorder conditions (as applicable) as defined under the terms of the plan and in accordance with applicable federal and state law. See ERISA § 712(e)(4) & (5). Consistent with this language, the Regulation makes clear that plan sponsors have flexibility with regard to designing mental health and substance use disorder benefits. More specifically, under the Regulation –

- group health plans are permitted to exclude coverage for a particular mental health or substance use condition;
- group health plans are permitted to exclude coverage for a particular treatment or treatment setting with respect to a mental health or substance use disorder condition; and
- group health plans are permitted to exclude coverage for treatment settings or providers where licensure requirements are not satisfied.

That flexibility must be retained in any final regulation in order for plan sponsors to continue to provide the most appropriate benefits with regard to plan participants based on clinical effectiveness and in order for plan sponsors to manage costs associated with the provision of mental health and substance use benefits. This is particularly important given the inflexible nature of the Regulation's "substantially all"/"predominant" tests and the unexpected and unwarranted imposition of parity requirements with respect to medical management (discussed below).

3. Provide Relief Under "Substantially All"/"Predominant" Tests

MHPAEA prohibits group health plans that provide medical and surgical benefits and mental health or substance use disorder benefits from applying financial requirements or treatment limitations that are more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and surgical benefits. ERISA § 712(a)(3)(A). The Act does not define the term "substantially all."

The Regulation adopts a "substantially all"/"predominant" test that is inflexible and unnecessarily complicated. Under the "substantially all" test, in order for any type of financial requirement (or quantitative treatment limit) to apply to mental health or substance use disorder benefits, that particular "type" of requirement must first apply to two-thirds of the medical and surgical benefits within a particular classification. This test is

failed by many plans even where the vast majority of the medical or surgical benefits in that category are subject to some form of cost sharing.

The reason the "substantially all" test is failed with some frequency is that plan sponsors do not uniformly use copays or coinsurance in a particular classification – both forms of cost-sharing are commonly used.

This problem is most prevalent for the outpatient classification. For example, coinsurance is typically applied to facility charges (e.g., hospital charges), including facility charges associated with outpatient coverage. However, copays are more typical for outpatient provider charges (e.g., doctor). In such circumstances, most outpatient coverage is subject to cost-sharing, but in many cases no single type of cost sharing (coinsurance or copays) would meet the two-thirds test. In addition, plan sponsors seek to incentivize certain behavior as a measure of cost control as well as encourage certain wellness-related behaviors. Indeed, many plan sponsors exempt certain types of preventive care or wellness visits from cost-sharing altogether. For example, well-child visits and lab tests may be provided without any cost sharing, or office visits for diabetes care may be offered with reduced copays. This approach promotes better health outcomes, benefiting plan participants and plan sponsors.

As a result of the Regulation's "substantially all" test, plan sponsors will have to decide whether to modify their medical and surgical benefits so that either copays or coinsurance will apply to two-thirds of the medical and surgical benefits in a particular classification.

In most cases, the likely modification will be to increase the benefits subject to coinsurance rather than copays, since coinsurance is often the type of financial requirement that comes closest to satisfying the "substantially all" test. This will negatively impact participants by driving up their out-of-pocket costs for medical and surgical benefits. It could also negatively impact participants who utilize mental health and substance use benefits since they will be required to pay coinsurance rather than copays.

Alternatively, plan sponsors could eliminate cost-sharing for mental health and substance use disorder benefits. This approach, however, will likely drive up costs for plan participants through greater cost-sharing for premiums or other out of pocket costs. It is also possible that some plan sponsors will narrow the mental health or substance use disorder conditions that are covered by the plan, or eliminate coverage entirely.

We believe that these results are unintended consequences of the "substantially all" test and the narrow set of classifications permitted under the Regulation. Moreover, we do not believe that MHPAEA requires the inflexible classifications and testing methods imposed under the Regulation. To address these unintended consequences, and to generally ease compliance burdens associated with the test, we recommend the following specific changes:

- The Regulation should allow additional classifications or sub-classifications so that the two-thirds test can be more easily met. In particular, the Regulation should allow outpatient benefits to be divided between facility charges and provider

charges. Other legitimate classifications or sub-classifications should be permitted for comparison purposes, including comparing types of providers (primary versus specialist; physician versus other licensed professionals), durable medical equipment ("DME"), and therapists.

- The Regulations should permit plan sponsors to exclude services that are provided with no cost sharing or at reduced cost sharing from the "substantially all" test, particularly if offered to encourage wellness. This is particularly important since section 2713 of the PHSA, as added by PPACA, requires coverage of preventive services without cost sharing.

- The Regulation should permit testing based on the "actuarial equivalence" of cost sharing in a particular classification. Under this concept, if two-thirds of the benefits in a particular classification are subject to some form of cost sharing, an actuarially equivalent mix of cost-sharing should then be permitted for mental health and substance use benefits.

- The "substantially all"/"predominant" tests are complicated and administratively burdensome and costly. The Regulation should provide that the calculations do not need to be repeated every year absent changes in plan design or indications that actuarial methods were wrong or data is not accurate.

4. <u>Non-quantitative Treatment Limits</u>

One of the most unexpected requirements of the Regulation is the requirement for parity for non-quantitative treatment limits. MHPAEA explicitly imposes parity requirements with respect to treatment limitations and financial requirements, as well as out-of-network coverage. The Act does not, however, expressly extend parity requirements to medical management techniques. In fact, the Act includes a rule of construction that states that nothing shall be construed as affecting the terms and conditions of the plan or coverage to the extent that the plan terms and conditions do not conflict with the Act's parity requirements. ERISA § 712(b). <u>Since there is no explicit parity requirement for medical management in the Act, none should be implied in regulatory guidance by the Agencies.</u> As such, we recommend that the nonquantitative treatment limitations rule be eliminated in the final rule.

Our understanding is that the category of non-quantitative treatment limitations, which includes medical management, was created in response to comments submitted by mental health advocates that equated medical management with denial of access to services that they argued were de facto treatment limitations. This is far from true. Plan sponsors deploy medical management as an important tool for quality improvement by assuring that there is appropriate coordination and level of care. Better treatment outcomes result from the management of mental health and substance use benefits.

Differences in medical management practices exist because of the variability in the evidence base for treatment and services for mental health and substance use conditions as compared to medical and surgical conditions. Most medical and surgical conditions have well established treatment protocols. In contrast, the treatment protocols for many mental health and substance use conditions are less certain.

In addition, many health plans manage the services of a physician different than the services delivered by another licensed provider regardless of whether the provider is delivering mental health services or medical services. For example, a health plan may use a brief notification system when the treating provider is a physician (or psychiatrist). But the same plan may require more information from a non-physician provider such as a licensed counselor or psychologist to certify medical necessity for treatment and services. This practice is similar to the medical management used for medical and surgical benefits, where services of a physician typically are not subject to preauthorization for outpatient care, but other clinicians (such as speech, occupational and physical therapists) may be subject to preauthorization.

We believe that the intent of this Regulation is not to increase the use of medical management for medical and surgical conditions. However, that is the likely result of the non-quantitative treatment limit rule since plan sponsors are unlikely to limit the management of mental health and substance use conditions, given its important role in ensuring the quality and affordability of coverage for those conditions.

If the final Regulation retains the concept of parity for "non-quantitative" limits, it should be narrowed so that any non-quantitative treatment limit is truly "similar" to a day or visit limit as contemplated by the Act's statutory language. The provision could be narrowed so that it only addresses medical management programs that are essentially a subterfuge for a quantitative limit. An example would be a utilization review protocol that provided that the plan would never authorize more than five counseling sessions for a particular condition. In addition, the Regulation could prohibit medical management programs that are objectively discriminatory. An example might be where a plan provides only for retrospective review for medical necessity for outpatient medical and surgical, but all outpatient mental health or substance use disorder benefits are subject to preauthorization, or where a plan provides for different financial penalties for non-compliance with a preauthorization requirement.

In addition to the provisions requiring parity for medical management, we are also concerned with the provision in the non-quantitative treatment limit rule that relates to provider network adequacy and admission standards. We believe that these criteria are in no way similar to the day or visit treatment limits addressed by MHPAEA. Moreover, such rules are unnecessary since states regulate provider networks for insured business, and health insurers use the same networks for their self-insured customers. In addition, a number of accrediting bodies, such as URAC and NCQA, already establish standards for health plans that address the adequacy of networks.

Finally, we object to the inclusion of provider reimbursement and UCR charges as nonquantitative treatment limitations. MHPAEA's goal was to provide parity for mental health and substance use benefits provided to patients. It was not intended to provide parity in reimbursement and UCR practices with respect to providers. It is unreasonable to expect plan sponsors to review provider agreements by July 1, 2010 even in the event a health insurer that provides third-part administrative (TPA) services was willing to share that information. In addition, if a plan sponsor provides medical and surgical benefits, but a separate carve out vendor provides mental health and substance use services, there plan sponsors could assure parity as to provider reimbursement or UCR charge, given the proprietary nature of these payment arrangements and the sponsors' lack of access to that information.

5. EAPs and Wellness Programs

The Regulation should specifically confirm that, if a plan sponsor offers mental health and substance use disorder benefits in all classifications and also offers an overlay of, for example, additional mental health services provided through an EAP or additional substance abuse services (e.g., smoking cessation) offered through a wellness program, the EAP or wellness program would not be subject to the parity requirements.

6. Small Employer Exemption

Changes under PPACA increased the size of the employer for whom the small employer exemption is available to employers with one to 100 employees for purposes of the PHSA. See PHSA §§ 2726, 2791 (as amended by section 1563 (c)(2) of PPACA).

It appears, however, that the PHSA definition of small employer is not specifically incorporated into the parity requirements under ERISA and the Code because new ERISA section 715 and new Code section 9815 do not incorporate by reference section 2791 (defining small employer) of the PHSA (because it is not included in part A of title XXVII of the PHSA). As a result, the definition of small employer under ERISA and the Code might still only apply to employers with an average of two but not more than 50 employees on business days during the prior year. This creates an inconsistency for an employer who offers an insured plan that is covered by ERISA, the Code and the PHSA (with regard to the insurance issuer offering the policy). We request guidance that incorporates the PHSA definition into ERISA and the Code to resolve this inconsistency for purposes of the mental health parity requirements.

We also request guidance as to when the change in the size of a small employer is effective. We believe that this change is effective in 2014, when the key PPACA insurance reforms that affect the small group market take effect (e.g., the rating requirement, the offering of small group coverage through an Exchange).

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We appreciate the opportunity to provide comments with respect to the Interim Final Rule implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Please do not hesitate to contact Kathryn Wilber at 202-289-6700 or kwilber@abcstaff.org, Randel K. Johnson at 202-463-5448 or rjohnson@uschamber.com, or Neil Trautwein at 202-626-8170 or trautweinn@nrf.com with any questions or if we can be of further assistance.

Sincerely,

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