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Comment On: EBSA-2009-0010-0409

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

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General Comment

May 3, 2010

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Employee Benefit Security Administration
U.S. Department of Labor
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Washington, D.C. 20210

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
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Filed Electronically
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Regulations.gov

RE: Comment on MHPAEA Interim Final Regulations

Dear Sir or Madam:

The Society of Professional Benefit Administrators appreciates the opportunity to comment on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Interim Final Regulations ("IFR") under 29 CFR Part 2590 issued on Feb. 2, 2010.

The Society of Professional Benefit Administrators (SPBA) is the largest national association representing independent third party administration firms who are responsible for the administration of the employee benefits of nearly forty percent of all United States workers. SPBA represents over 90 percent of the firms which make third party contract administration of employee benefit plans their primary line of business.

Third party administrators (TPAs) provide continuing professional outside claims and benefit plan administration for employers and benefit plans. TPAs very often become the "employee benefits office" for the covered workers of many small employers. The average TPA client employs some degree of self-funding and clients range from large Taft-Hartley union/management jointly-administered plans, customized plans for single employers of all sizes, and cost-effective plans designed for related groups of employers in trade associations and other multiple employer configurations.

We commend the Departments on their foresight in seeking information from private industry on the impact this change in the law will have on employers, especially small employers who self-insure their benefit plans. Benefit administrators need immediate guidance from you on how to administer requests for coverage. As the preeminent representative of third party contract administration firms, SPBA wishes to discuss some of the issues, particularly as they relate to the responsibilities of employers, and this letter is meant to highlight those issues.

Benefit Category Provisions

MHPAEA and the Interim Final Regulations establish that for each benefit category the financial requirements and treatment limitations be equivalent to the same medical and surgical benefit category. If a group health plan does not have a network of providers for in-patient and out-patient coverage, all benefits are treated as out-of-network for determining the equivalency of coverage. When originally enacted, MHPAEA required group health plans to eliminate caps on the number of visits per year and differences between co-payments and co-insurance for mental health or substance abuse treatment and medical or surgical benefits. The interim final regulations clarify that the "equivalency requirement" reaches further than originally expected to include using the same standard for admitting providers to the network. The change places an extra burden on employer plan sponsors to be mindful of the depth of the equivalency requirement in reviewing insurance and/or administrative services contracts.

The final regulations should permit employer plan sponsors to apply parity requirements to each benefit category under the group health plan. The change would be consistent with Congressional intent that does not specify whether the parity requirement applies to the plan as a whole or to each different benefit category offered under the plan, such as a consolidated benefit package offered under a consolidated benefit plan by many large employers. Under such plans, a variety of benefit options are available to different groups of employees to respond to their different needs--a single plan might cover union-represented employees with one particular set of health benefits and also offer non-union employees with a different set of options; they may offer a high-deductible health option combined with health savings accounts; they may offer an HMO option or Medicare supplemental option for retirees. These benefit packages provide coverage in different geographic regions to address the needs of a diverse employee base with widely divergent health options. Employers benefit from being able to offer a single benefit plan through reduced administrative costs, filing only one annual report and compliance with other Federal statutes.

Third party administrators have heard from their client employer plan sponsors who say that it would be very difficult to apply the requirements under MHPAEA to a group health plan as a whole because of the complications under the new IFRs. The Departments have established that employers cannot require employees to exhaust their EAP benefits before they receive mental health care unless the plan has a similar requirement for general medical and surgical benefits. For example, in the case of a retail chain employer group that has full coverage for mental and nervous and substance use disorder benefits in their plan for full-time employees but only offers a Mini-Med Plan for part-time employees working for this company. With the new rule, employers who want to continue to provide these employees the previous benefits are not sure whether

they are permitted to do so.

Other employer plan sponsors seek guidance on how to treat day treatment centers under the new MHPAEA IFR. We request clarification on whether they can treat as an inpatient facility and therefore subject to inpatient medical and surgical requirements for co-pay, co-insurance, pre-certification, etc.? Or will the Departments automatically consider them to be an outpatient facility and subject to outpatient medical/surgical requirements? If outpatient surgery requires pre-certification, will they be able to equate Day Treatment Center to outpatient surgery and require pre-certification even if outpatient medical diagnostic procedures are not required to be pre-certified? Further clarification regarding ancillary services is also requested. Recovery of persons in services, such as crisis diversion facilities, residential support services, are not addressed in the current rules. Some State requirements cover the scope of these services and without clarification from the Departments, serious gaps in compliance may exist.

Changes Required by Interim Final Regulations cause Ripple Effect

Employers are clamoring to have third party contract administrators review the design of their group health plan to determine whether the design complies with the Interim Final Regulations. Employer plan sponsors are concerned for two reasons, first if they fail to comply, they become subject to an IRS self-reporting excise tax payable by the employer. Secondly, many employers proposing to make changes to comply with MHPAEA in time for the application date deadline find themselves holding back because they are unsure whether they will lose their "grandfather" status under the Patient Protection and Affordable Care Act "PPACA" H.R. 3590 signed into law on March 23, 2010.

Conditions Covered

We ask the Departments to clarify the regulations to allow group health plans to exclude specific mental health or substance use diagnoses from coverage. Although MHPAEA requires parity for mental health benefits and substance use benefits offered under a group health plan, the statute does not limit the employer's ability to determine which mental conditions or substance use disorder conditions the plan chooses to cover.

MHPAEA defines mental health benefits and substance use disorder benefits as the benefits "defined under the terms of the plan." The statute establishes that a group health plan is not required to cover mental health conditions or substance use disorders at all. Accordingly, the statute contemplates that employers will continue to determine the scope of the plan's coverage for mental health conditions and substance use disorders, just as employers determine which physical health conditions the plan will cover. We ask that the Departments clearly establish in the final regulations that an employer may exclude particular diagnoses or groups of diagnoses from coverage under its group health plan, without the requirement that it also demonstrate that a comparable exclusion exists for physical diagnoses.

Without this flexibility, many employers may choose to eliminate benefits for mental health and/or substance use disorders altogether. A rule that forces employers to curtail their coverage of mental health and substance use disorder benefits will not serve the purpose of the MHPAEA, which was designed to expand employees' access to these benefits. The regulations should make clear that MHPAEA does not prohibit treatment-based exclusions.

There is an additional concern by employer plan sponsors who choose to cut mental health and substance use disorder benefits on what to do with prescription drugs. Employers want to know whether they can cut benefits for mental health and substance abuse, but maintain coverage for prescription drugs associated with these conditions? The issue exists because presumably mental/nervous drugs can be prescribed for other conditions. If they choose to continue prescription drug coverage, can they cover mental/nervous prescription drugs the same as any other drug under the plan?

Scope of Services

Under the new IFR, employer health plans will make determinations on whether their plan policies will be consistent with generally recognized independent standards of current medical practice across six classifications of benefits. To further clarify the law's stated intention that limitations are not more restrictive for mental health or substance use benefits, additional guidance is necessary to establish the "categories" of treatment services, where services for mental health or substance use treatments are provided. The treatment categories generally

include treatment services and rehabilitative services which are routinely associated with mental health and substance use. We note that the regulations do not address whether the employer health plan has responsibility to provide coverage for court-ordered treatments, involuntary holds or State hospital stays as a covered service. If a medical provider has established that a person poses an imminent threat to others, the current rules do not provide guidance to employers on whether the scope of services or benefit categories include coverage in these situations.

Another issue of confusion is that of providers within the six service classification categories. We would like to see the MHPAEA regulations clarified on the issue of whether providers delivering services within the same classification fall under the scope of services. For example if a medical and surgical provider's scope of service for out-of-network and in-network and outpatient services are covered by MHPAEA, are the same services by mental health and substance use providers that mirror the scope of services permitted to offer in out-of-network and in-network/outpatient settings.

In light of the diversity of State laws, employers and group health plans that provide benefits across State boundaries have considerable work to do in order to assure compliance with MHPAEA given the labyrinth of complexity working within the State mandates structure. In order to achieve the purpose of MHPAEA, the regulations should also make clear how employers should interpret the parity requirements when "scope of services" will be covered and health services will be offered to persons receiving services in the various States that do not mandate mental health or substance abuse benefits. For plans in states with mandated mental health or parity applying to specific conditions and disorders, it is clear that fully-insured plans must comply. It is more problematic for self-insured plans and ERISA groups who aren't subject to State law and employer health plans operating in those states with no mandates for mental health and or substance benefits. The challenge lies in deciding which diagnosis, conditions and disorders to cover and which treatment services, providers, etc. to extend benefits to.

Management Techniques

SPBA requests that the Departments clarify the definition of "generally accepted medical criteria" which establishes that parity is required for benefits, but not for management techniques. MHPAEA requires parity in the financial terms and treatment limitations that apply to mental health and substance use disorder benefits. We maintain, however that the management of benefit delivery is not a "financial term" or a "treatment limitation," and thus should not come within the scope of the parity requirement. The regulations should make clear that a group health plan does not violate the parity rules if it uses different techniques for managing medical/surgical conditions and mental health/substance use disorders, or even if it applies case management techniques to one category of benefits and not to the other category. The regulations should confirm that MHPAEA does not require parity in the management of benefits. Employers use a number of techniques to manage the delivery of health care in order to control costs and ensure that participants receive effective treatment.

Third party administrators assert that management techniques such as prior authorization of services, concurrent review of services, treatment plans, case management, discharge planning, retrospective review, and similar methods to manage participants' health care apply to a particular condition and are specific to that condition. Furthermore, mental health conditions or substance use disorders might require specific management techniques that are unique and different enough from the techniques applicable to physical conditions. Third party administrators have shared with us their concerns that the nature of some mental health conditions and substance use disorders require more closely-managed or intensive period, in order to achieve a positive outcome for the patient. Because techniques for managing the delivery of benefits are tailored to a particular condition and/or a particular patient, we strongly urge that the Departments clarify that MHPAEA does not require parity in the management of care provided under a group health plan.

Disclosure and Compliance under ERISA

The ERISA claims review procedures are extensive and well established that all participant rights must be set forth in writing to inform all participants of the terms of the group health plan. The existing regulation also sets out requirements that must be met under a time deadline in order to protect the rights of plan participants.

The extensive protections under the ERISA's claim review procedures provide significant

protection as it applies to mental health and substance use disorder benefit as well as to medical and surgical benefits provided under an employer group health plan. As such it is unnecessary to layer yet another requirement under MHPAEA imposing new requirements that impose a burden on plan sponsors while achieving essentially the same purpose.

It would however, be very useful for the Departments to reiterate the existing claims regulations requirements under ERISA and clarify that a group health plan may establish separate claim review procedures for medical and surgical benefits and for mental health and substance use disorder benefits, as long as the review procedures each comply with the requirements under ERISA and are designed to protect participant rights. (Section 503 of ERISA and the Department of Labor's regulations at 29 C.F.R. Section 2560.503-1 et seq.)

Complicated Regulatory Changes Require Longer Application Date

Third Party Administrators work vigorously to maintain employer regulatory compliance, however, as service contractors, additional time is required in order to adequately review current practices by their client employers and adequately apprise employees of their responsibilities under MHPAEA. Given the window of opportunity for compliance with the release of regulations, employee benefit plans have fewer than six months to reconfigure plan policies, processes and systems and come into compliance. Some plans may find that aspect of this effort challenging at best.

The MHPAEA Interim Final Regulations create a very complex method of determining benefits and the criteria for compliance for mental health and substance use disorders is unduly complicated. Employer benefit plans and Third Party Administration firms will have a considerable communication challenge to write benefit design changes addressing financial factors and underwriting of benefits that may result in premium increases while explaining the necessary changes to employees and plan participants. The test of a regulation is in its implementation and in this case, employers and professional both have determined that it's complicated and confusing structure leads more employers to eliminate coverage rather than to implement coverage incorrectly and face a violation penalty.

SPBA respectfully requests a generous "good faith" provision be provided to encourage employer plan sponsors to amend their plan documents to comply with the changes set forth in the final regulations. Further, we request that it be made clear that employers who act in good faith to make regulatory changes are not be penalized for modifying their plans to be in compliance with both health care reform and MHPAEA as discussed previously.

The provisions of MHPAEA apply for plan years beginning after October 3, 2009. However, the IFR established a later "application date" of July 1, 2010 for the financial and treatment limitations changes. Employer plan sponsors of all sizes find it difficult to comply with this short application date because they must begin working with the plan administrator well in advance to get the necessary design changes the health plan. After coordinating the final plan design, the TPA must also program software systems, revise employee handbooks and train customer service representatives to be able to administer the benefits properly. Each of these steps must be taken in each geographic region and with each separate plan design. We all agree that the goal is to educate employers to ensure proper implementation and administration of the regulatory changes, this cannot be done unless the implementation and application date of the new changes takes place at least 12 months into the future. Compliance is complicated and requires cost comparisons, benefit analyses, etc. sometimes with various parties. To do less will place employers in the precarious position of having to face potential violation for enforcement or application of the new regulations. In addition, with the IRS' new regulations which require self-reporting of violations to regulations, the employer would be subject to a tax based on a violation that he was unable to comply with at the outset and designed to ensure failure and guarantees a tax assessment. For these reasons, we believe that an applicability date of July 1, 2011 would provide the best opportunity to preserve the aims and goals under MHPAEA and give employer plan sponsors an opportunity for orderly transition and success in understanding the new regulations and full compliance with them; something that is not possible with an application date prior to 2011.

SPBA recommends that any final regulation interpreting the MHPAEA become effective and apply no earlier than the first plan year beginning at a minimum of 12 months after the final regulation is published in the Federal Register. Unless there is a change to the Applicability Date, the final

regulations will lead to large-scale disruption to health benefit administration with a consequence of potentially reducing access and quality of benefits and treatment for many Americans covered through their employer sponsored health plans.

On behalf of third party contract administration firms, the Society of Professional Benefit Administrators appreciates the opportunity to express our comments on this issue. It is respectfully requested that the recommendations cited above be considered in the final regulations. SPBA would like to reserve the opportunity to provide future comments when the final regulations are released. Additionally, if a hearing is scheduled, SPBA requests the opportunity to testify. As the preeminent representative of third party contract administration firms, SPBA would be happy to provide you with additional information or to respond to any additional questions arising as a result of this submission. Please contact me at 301-718-7722 if we can be of further assistance.

Sincerely,

Elizabeth Ysla Leight
Director of Government Relations and Legal Affairs
Society of Professional Benefit Administrators