May 3, 2010

Submitted via E-mail: E-OHPSCA.EBSA@dol.gov

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-4137-NC
P.O. Box 8017
Baltimore, MD 21244-8010

U.S. Department of the Treasury
Internal Revenue Service
Attention: CC:PA:LPD:PR (REG – 120692-09)
Room 5205
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

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

Dear Sir or Madame:

Aetna[1] welcomes the opportunity to comment on the Interim Final Rules ("IFR") under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 as published in the February 2, 2010 Federal Register (75 Fed. Reg. 5410).

Aetna is one of the nation's leading diversified health care benefits companies, serving members with information and resources to help them make better informed decisions about their health care. Our programs and services strive to improve the quality of health care while controlling rising employee benefits costs. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services,

[1] Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefits coverage include: Aetna Health Inc., Aetna Health of California, Inc., Aetna Health of the Carolinas, Inc., Aetna Health of Illinois, Inc., Aetna Health Insurance Company of Connecticut, Aetna Health Insurance Company of New York, Corporate Health Insurance Company and/or Aetna Life Insurance Company.

including medical, pharmacy, dental, behavioral health, group life, long-term care and disability plans and medical management capabilities.

Aetna has been at the forefront of the enactment of the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). Our organization was a leader in supporting Senate Bill 558 in 2004. We then actively endorsed the Senate-House compromise agreed to in June of 2008 and we were fully and consistently engaged in the enactment of the final legislation.

Because we have been so invested in the enactment of this law, we are equally invested in how it is implemented via the regulations. One in five Americans will suffer from a mental illness this year. The impact of the current economic climate will result in increases in depressive and anxiety disorders and the growing need for behavioral healthcare services may be unprecedented. MHPAEA was enacted to provide better access to quality care for mental health and substance use conditions. With limited resources and costs continuing to be a major concern for purchasers, it is important that the requirements associated with MHPAEA are not administratively cumbersome or costly to the extent that the intent of the statute is defeated or undermined in its implementation. Our specific comments are set forth below.

1. ***We strongly recommend that the application date for the IFR be extended until plan years beginning on or after July 1, 2011.***

The Interim Final Rules are generally applicable to plan years on or after July 1, 2010. The complicated parity calculations and benefit design changes required by the rule require significant work within the next couple of months due to the large number of plans that have already been negotiated and finalized for the 2011 plan year. Given the complexity of the regulations and the significant operational changes required for compliance, the applicability date of the regulations should be extended to plan years beginning on or after July 1, 2011.

The additional time is essential, primarily: (a) to make and communicate plan design modifications as result of the specific formula applications set forth in the regulations and in concert with anticipated plan design changes related to health care reform (as discussed further below); (b) to develop and release the system changes necessary to support revised plan designs; (c) to develop, test and implement system functionality needed to support shared deductibles and out of pocket maximums for behavioral health carve-out business as now required per the regulations; and (d) in order to complete a comprehensive analysis and implement necessary administrative changes specific to the new nonquantitative treatment limitations such as UCR and medical management.

Several new requirements that were recently enacted as part of the Patient Protection and Affordable Care Act ("PPACA") have a significant impact on the mental health parity rules. A delay in the applicability date of the IFR is necessary so that the agencies can analyze and provide guidance regarding how these provisions affect compliance with the IFR. Aetna is also concerned that making design changes that are necessary to fulfill the

parity requirements under the IFR will impact the grandfathered status of plans. Also, non-grandfathered 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 requirement will affect compliance with the IFR's substantially all and predominant tests because it will add to the portion of plan costs that are not subject to cost-sharing. In addition, as part of health care reform there is a change in the definition of the small group market (expanding to groups of 100). But there are open issues as to when those rules become effective and how the small employer exemption under the parity rules will apply in the small group market. These are critical issues that should be addressed in the Final Rule or in other guidance issued by the agencies as soon as possible.

Additional time for planning and restructuring is needed to implement these unanticipated requirements. Adequate lead time will ensure that member service is not disrupted in any way and that all constituents are fully benefiting from the implementation of this Act. In the event that the applicability date of the IFR is extended, we ask that the agencies extend the current good faith compliance non-enforcement policy during such period.

2. ***We request reconsideration of how to apply the parity requirements to deductibles and out of pocket maximums.***

The application of parity to plan financial requirements, including deductibles and out of pocket maximums is a critical component of MHPAEA. In implementing this key element of full parity, we reaffirm that it is essential for plan sponsors to have the flexibility to design plans with either integrated or separate deductibles or maximums. An integrated deductible or maximum would involve a single deductible or maximum applicable to both the medical/surgical benefit and to the mental health substance use benefit. A separate deductible or maximum would involve two parallel, separately accumulating deductibles or maximums for the medical surgical benefit and the behavioral/substance use benefit. The regulations should allow separate deductibles or maximums to be designed to meet the parity standard, meaning that if plan costs subject to a deductible or maximum for medical/surgical benefits pass the substantially all and predominant tests, then the plan would be able to apply a separately accumulating or an integrated deductible or maximum for mental health/substance use disorder benefits.

As acknowledged in the preamble to the IFR, the agencies believe MPHAEA could be interpreted to either permit or allow separate deductibles or out of pocket maximums by stating, “the statutory language does not preclude either interpretation” and “the language of the statute can be interpreted to support either position.”

The IFR requirement that a single integrated deductible be used could result in higher out of pocket costs for some members. A single deductible under the new rule must combine mental health/substance use disorder services with medical services. A plan that includes a $250.00 annual deductible for mental health/substance use disorder services and a separate $250.00 annual deductible for medical benefits is not allowed. Instead, the plan may have a $500.00 annual deductible that includes both mental health/substance use

disorder services. In this example, a member who seeks only mental health or substance use disorder services might need to spend more money before reaching the higher combined deductible than if the plan included a separate but lower deductible. And members who don't use mental health substance use disorder services at all will spend more for medical services before reaching the combined deductible.

The IFR requirement that a single integrated deductible be used will have a very serious impact on implementation costs. A large number of plan sponsors carve out their behavioral health/substance use benefits from their medical plan and utilize separate carriers or administrators for the two benefits. Plan sponsors will now of course, need to ensure that parity is met across these benefits. An integrated deductible in this context will require, however, that the carriers or administrators have the necessary system interfaces to share and coordinate the deductible accumulator. We reaffirm our original estimate that this system functionality costs $750,000 for each interface. This cost estimate does not include resource expenditures needed for related additional manual processes that are also required. Alternative batch processing deemed less expensive by the agencies would require the same signficant expenditure of $750,000 per interface due to lack of a universal file layout (i.e., each carrier has their own format), program development, intensive integrated testing for claim data exchange and reconciliation.

A requirement for integrated, as opposed to separate, deductibles and out of pocket maximums will also have a significant impact on benefit costs and could impact the ability and willingness of many plan sponsors to offer mental health/substance use disorder benefits.

For these reasons, Aetna requests that the agencies reconsider this IFR provision and permit plan sponsors to design or select plans which provide valuable mental health and substance use benefits, in parity with medical surgical benefits, using either integrated or separate deductibles and out of pocket maximums. This range of design options within the framework of parity is essential to encouraging mental health and substance use coverage and keeping such coverage affordable.

Finally, while we think that continuing to require integrated deductibles or out of pocket maximums would be unnecessary, costly and problematic; if that approach is retained, it will be <u>critical</u> that a single industry file layout (format and coding) be implemented and additional time be provided to carriers and plan sponsors to build the interfaces necessary to comply.

3. ***We request that the "substantially all" formula be modified to offer additional and/ or alternative calculations for plan designs that contain multiple types of comparable financial requirements in one classification.***

Per the IFR, a plan is prohibited from imposing a type of financial requirement on mental health/substance use disorder benefits if such financial requirement does not apply to "substantially all" medical surgical benefits in the relevant classification. Types of financial requirements cannot be combined and "substantially all" is defined as applying

to at least 2/3 of all medical/surgical benefits in the classification. Thus, if a particular type of financial requirement such as co-pay or coinsurance does not apply to at least 2/3 of the medical surgical benefits in the classification, that type cannot be imposed on mental health/substance use disorder benefits in the classification.

This rule is problematic because plan designs often include varying types of financial requirements within the outpatient classification. For example, physical therapy visits could be subject to a copay, home health could be subject to coinsurance, and outpatient surgery could be subject to both. Plans designed to have a blend of copays and coinsurance frequently do not pass the substantially all test because no single type of financial requirement applies to at least 2/3 of medical/surgical benefits. In such situations, compliance options include: (a) waiving any financial requirement to mental health/substance use disorder benefits (driving costs up), while most medical surgical services continue to require some member cost share; or (b) changing the plan design for medical/surgical (which is intended to incentivize certain behaviors with lower cost-sharing for specific services) so that financial requirements can be applied to mental health/substance use disorder benefits. Neither of these options appears to be a reasonable or logical outcome of the formula, nor are they consistent with the basic parity goal of MHPAEA.

Using the current guidelines, the cost sharing for an outpatient mental health/substance use professional service (generally office visits) is impacted by cost sharing for outpatient medical/surgical services of a very different nature (e.g., ambulatory surgery or lab/x-ray services). Such services are included in testing results and prevent the "substantially all" threshold from being met. Therefore, in order to keep within what we believe to be the spirit and intent of the law, we recommend that it is most appropriate to permit additional classifications or sub classifications that would allow plans to compare outpatient mental health/substance use disorder professional services, (i.e., counseling/therapy sessions typically performed by a master's level provider, psychologist or psychiatrist) to medical surgical professional services. Additionally, we request that the final regulations permit flexibility (i.e, sub classifications) with respect to all six classifications to take into account severity of illness and intensity of services.

In addition to allowing more flexibility with respect to classifications, we believe there are alternative approaches available that could be included in the final regulations for purposes of determining "substantially all" for plan designs that contain multiple types of comparable financial requirements in one classification. For example, the guidance should permit an actuarial equivalence method of calculating cost sharing in a particular classification (e.g., if 2/3 of the benefits within a classification are subject to some form of cost sharing, then an actuarially equivalent mix of cost sharing, such as determining an equivalent copay value for benefits subject to coinsurance, or vice versa, should be permitted for mental health/substance use disorder benefits). Additionally, the final regulations should permit plans to exclude services that are provided with no cost sharing or with reduced cost sharing from the substantially all and predominant tests (particularly with regard to preventive care). We would be happy to provide more specific examples upon request.

Finally, although we believe that the language of the IFR is clear, we ask that the agencies confirm in the final regulations that where a specialist copay satisfies both the substantially all and predominant tests, the specialist copay could be applied to mental health/substance use benefits. In this regard, we recognize the requirement that a plan cannot automatically use its specialist copay for all mental health/substance use providers. However, where a copay applies to at least 2/3 of the medical/surgical benefits within a classification, and the specialist copay is the "predominant" copay amount, then it appears clear that the IFR would allow the use of the specialist copay for mental health/substance use benefits. Although the above interpretation was verbally confirmed during the technical assistance call held by the agencies on February 19, 2010[2] we request that it also be confirmed in the final regulations.

4. We request that the Final Rule retain the flexibility provided under the IFR with respect to scope of services issues.

MHPAEA does not limit plans and insurers' ability to determine which mental health or substance use disorder conditions plans and insurers will cover. The IFR does not mandate that plans provide coverage for any specific types of mental health/substance use disorders, types of services or treatment or settings of care.

MHPAEA defines mental health benefits and substance use disorder benefits as the benefits "defined under the terms of the plan." Plans need to retain the ability to determine which mental health and substance use disorders will be covered in the same way that plans determine which physical health conditions will be covered.

Additionally, MHPAEA does not mandate that a group health plan cover all possible treatments or treatment settings for a given mental health or substance use diagnosis, any more than a group health plan is required to cover all possible treatments or treatment settings for a specific physical diagnosis. It is essential that the Final Rule retains the flexibility set forth in the IFR with respect to scope of services so that plans may continue to exclude specific mental health/substance use disorder conditions, treatments and treatment settings. For example, plans should be able to exclude coverage for treatment settings or providers where licensure requirements are not met.

MHPAEA prohibits group health plans from applying treatment limitations to mental health or substance use disorder benefits that are more restrictive than the treatment limitations that apply to medical surgical benefits. The law defines treatment limitations to include limits on the frequency of treatment, number of visits, days of coverage "or other similar limits on the scope or duration of treatment."

We reaffirm that we do not believe that the intent of MHPAEA was for a specific type of actual treatment to fall within "scope or duration of treatment" in the same manner as

[2] Regulators in attendance included Pam Hyde, SAMHSA; Richard Frank, HHS; Jim M, HHS/CMS; Amy Turner, DOL; Kevin Knopf, Treasury; Russell Weinheimer, Treasury.

frequency of treatment, number of visits, days of coverage or to compare type of treatment with frequency of treatment, number of visits and days of coverage.

The final regulations should make clear that in administering MHPAEA, an employer may define coverage with respect to particular diagnoses or groups of diagnoses, types of services and settings of care. This interpretation is grounded in Aetna's significant involvement in discussions with the drafters regarding this issue during the evolution of the final bill and is supported by documentation from the Senate Committee Report regarding the application of the parity requirements as follows:

> 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.

See Sen. Rep. No. 110-53, 110th Cong., 1st Session (2007) at p. 7.

Because of significant cost and administration implications not considered in the cost projections for MHPAEA, a requirement to include all diagnoses, treatments or treatment settings could force employers to transition to lower coverage type plans resulting in increased costs for members or cause employers to ultimately drop mental health and substance use disorder coverage entirely. These outcomes are in direct opposition to the purpose and spirit of MHPAEA in increasing access to quality mental health and substance use disorder treatment.

The final regulations should retain the flexibility as to scope as set forth in the IFR as to the conditions, treatments and treatment settings that will be covered by plans.

5. We recommend the removal of the requirements in the Interim Final Rule with respect to "nonquantitative" treatment limitations.

The IFR applies parity to nonquantitative treatment limitations which include, but are not limited to, medical management standards, provider network standards, and methods for determining usual reasonable and customary charges. We do not believe that the intent of the law was for parity to apply to nonquantitative treatment limitations and we strongly request that this aspect of the IFR be dropped from the Final Rule.

Our view is based on our first hand participation in the enactment of the legislation and is supported by MHPAEA's legislative history. The House Energy and Commerce Committee Report makes this clear:

> 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) at p. 33.

The requirements associated with parity application to nonquantitative treatment limitations are ambiguous, leaving interpretation and administration highly challenging. The IFR states that:

> A group health plan 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 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 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.

Practical application of this language is exceedingly challenging without clarification of the phrase "no more stringently." The language included in the IFR furthermore prompts other key questions. For example, do plans have the discretion to manage mental health substance use disorder benefits on the basis of a clinically accepted rationale if less than all medical surgical benefits in a specific classification are managed? Can plans assume that a specific level of care management (i.e., concurrent review), is permissible for select mental health substance use disorder conditions meeting specific criteria even if that level of care management is not conducted for most medical surgical care if the mental health substance use disorder criteria for case selection is based on recognized clinically appropriate standards of care as referenced in the language of the IFR?

Mental health and substance use benefits and medical surgical benefits may use utilization management selectively to manage cases or types of cases that are high volume, high unit cost, include high discretionary factors, and/or are highly variable, but also are an integral component of measuring the effectiveness of treatment. These processes may be applied differently, however, based on a specific condition and/or service and how it differs in a psychiatric context versus a medical surgical one.

For example, in the case of a member with a diagnosis of bipolar disorder, it may be in that member's best interest for the plan to do a concurrent review when that member is receiving ineffective or inappropriate treatment. In this case, the plan's failure to intervene and recommend an evidence based treatment approach may needlessly prolong the member's suffering or risk further deterioration. When treatment deviates significantly from accepted standards and there is an alternate approach likely to result in a more favorable outcome, managing that member's benefits to facilitate that positive outcome is indicated. Such course of action seems reasonable and appropriate, even in

situations where there is no equivalent protocol to manage the medical condition. Because mental health/substance use disorder conditions and medical conditions differ in cause, treatment course and prognosis, equivalent processes and protocols for managing these illnesses may not exist in all situations. However, this fact should not diminish a plan's responsibility to use tools and protocols available to manage benefits, control costs and effect a better treatment outcome for their members.

To further illustrate the impracticality of comparing behavioral health conditions to medical conditions, precertification might be required for psychological testing related to behavioral health conditions and not for medical diagnoses. The rationale for management of the mental health/substance use conditions is due to cost and potential for misuse of the benefit. Questions about differential diagnosis under the mental health benefit can often be answered by assessing symptoms and impairment during the diagnostic interview. Therefore, the psychological testing may not be necessary. However, psychological testing or neuropsychological testing may be an essential tool in making a differential diagnosis among medical conditions. Testing as part of establishing a differential diagnostic assessment would, for example, be done appropriately for medical conditions such as strokes, dementia, or brain injury. Cost of the test battery for these conditions is low in comparison to the cost of the total episode of care. For mental health substance use disorders there is much more potential for misuse of the benefit undermining availability and prioritization of resources. Additionally, many testing requests for mental health issues are for testing of learning disabilities because of long waits for testing in school settings. Many plans exclude coverage of educational services, remedial teaching, and learning differences because such services are not considered to be related to an illness or injury.

In the IFR, the agencies expressed support for managed behavioral health care in containing costs including additional costs incurred as a result of parity, yet the potential impact of the nonquantitative treatment limitations rule runs counter to that position. A New England Journal of Medicine Study quoted in the IFR concluded that these fears were unfounded and "that parity of coverage of mental health and substance abuse services, when coupled with management of care is feasible and can accomplish its objectives of greater fairness and improved insurance protection without adverse consequences for health care costs." It is feared, however, that if nonquantitative treatment limitations, including those for medical management, are part of the Final Rule, those best qualified to treat, manage and coordinate care for those with mental health/substance use disorder conditions will expend inordinate time and resources attempting to force fit customized mental health/substance use disorder practices into a model(s) designed exclusively for medical surgical conditions and in doing so disservice the very constituents this law was designed to protect.

Again, we respectfully request that the nonquantitative treatment limit rule be deleted from the Final Regulation. If this aspect of the IFR is not dropped, we request that it be substantially narrowed. In particular, we believe that the inclusion of parity for provider reimbursement, URC and provider network admission are in no way similar to the "treatment limitations" included in MHPAEA's statutory language and that the parity

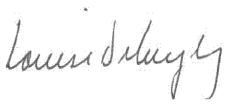
requirements for providers be eliminated. Any rule with respect to medical management should be substantially narrowed so that only differences in medical management programs that are clearly and objectively discriminatory violate the nonquantitative treatment limit rule (e.g., penalties for failing to follow preauthorization are different between medical/surgical and mental health/substance use benefits).

* * *

As presented above, we believe that there are provisions of the IFR that are highly complex and that expand the scope of MHPAEA as set forth in the statute. The primary examples are the "substantially all" formula and the inclusion of nonquantitative treatment limitations. We also believe that the IFR must be reviewed in light of the subsequent adoption of the PPACA. Consequently, we recommend that the IFR be subject to prompt additional regulatory review and public input. The significant confusion and administrative obstacles inherent in any effort to comply with this IFR warrants a re-evaluation by all stakeholders. Requiring extraordinarily aggressive timelines for compliance mandated in light of the significant delay in the release of the IFR runs counter to the balanced approach and collaborative spirit that contributed to the passage of the Act.

Aetna is pleased to have the opportunity to provide comments regarding the IFR. Thank you for considering our comments. Should you have any questions, please feel free to contact Flora Vivaldo at vivaldof@aetna.com (310) 827-0515.

Sincerely,



Louise Murphy
Head of Behavioral Health
On behalf of the Aetna MHPAEA Task Force