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May 3, 2010

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-4140-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

RE: Request for Comments Regarding the Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

File Code CMS-4140-IFC

Dear Sir or Madam:

UnitedHealth Group is pleased to provide the Centers for Medicaid & Medicare Services ("CMS") with our comments regarding the Interim Final Rules (the "IFR") under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").

UnitedHealth Group, with 78,000 employees serving the health care needs of more than 70 million individuals, recognizes both the specialized nature of behavioral health care and the distinct needs of people requiring mental health and substance use disorder treatment. Our OptumHealth Behavioral Solutions business has 30 years of experience in introducing groundbreaking programs that improve the quality of behavioral care, make treatment more accessible and keep costs down for consumers. OptumHealth Behavioral Solutions serves one in six insured Americans (43 million consumers) and nearly half of the *Fortune* 100 companies. We have the world's largest fully credentialed behavioral health practitioner network, with over 84,000 care providers, and currently provide behavioral health care to consumers in 44 states with existing parity laws.

This dedicated focus on behavioral health – combined with our real-world experience in guiding consumers to effective, efficient and affordable care – enables us to offer a unique perspective on the Interim Final Rules in the form of the comments and data contained in this letter. Our goal is to support development of Final Rules that preserve MHPAEA's intent of increased consumer access to appropriate, quality and cost-effective behavioral health services.

While we firmly support this goal, we are among many in the behavioral health community who believe that the IFR goes beyond the intent of the 2008 parity law, and will have unintended, negative consequences and will disrupt access to appropriate behavioral health care. Families and employers across the country may face higher costs, less assurance of receiving the most appropriate care, and – in some cases – loss of behavioral health coverage altogether. Now more than ever, Americans need stable access and affordable coverage. We are committed to advocating vigorously on behalf of the nearly 43 million consumers we serve to help prevent these consequences.

Accordingly, we welcome the opportunity for constructive dialogue that this IFR comment process provides and the chance to continue this dialogue and provide additional data and information supporting the comments set forth in this letter.

A. Summary of Recommendations & Discussions of Issues

The recommendations offered below stem from our careful reading and assessment of how to implement the IFR's requirements across our behavioral health programs. To support our recommendations, we provide specific examples and data based on our experience as the nation's largest provider of mental health and substance abuse programs. We believe these recommended changes are necessary in order to best serve consumers and to reduce potential unintended consequences associated with the rules in their current form.

Accordingly, we recommend the Final Rule for MHPAEA:

- Postpone the applicability date from the current date of July 1, 2010 to July 1, 2011 to allow proper transitioning and implementation of the new requirements from the current date of July 1, 2010 to July 1, 2011.
- Allow group health plans (or health insurance coverage offered in connection with a group health plan) to continue to treat deductibles for mental health or substance use disorder benefits separately from those established for medical/surgical benefits, provided that such deductibles or other cumulative treatment limitations are no more restrictive than any established for medical/surgical benefits in the same classification.
- Remove the requirement that before a given type of financial requirement or quantitative limitation may be applied to mental health or substance use disorder benefits, that requirement or limitation be present in "substantially all" of the comparable class of medical benefits.
- Remove the elements requiring parity for non-quantitative treatment limitations.

Highlighted below are the primary concerns that drive these recommendations, focusing on the projected unintended consequences to consumers, as well as specific detailed recommendations for the modification of the IFR. Our concerns may be grouped into three key areas: financial requirements & quantitative treatment limitations, non-quantitative treatment limitations and

timing of the applicability of the IFR. We also include, in section B of this letter, commentary on items that were specifically noted for comment in the IFR or where the Agencies solicited feedback.

I. Financial Requirements & Quantitative Treatment Limitations

The IFR's language around many of the quantitative limits and financial requirements is clear and consistent. However, we have concerns about how the requirement for "combined cost sharing" and the "substantially all" calculation. We are specifically concerned that these provisions will result in plan designs that increase consumer cost sharing and create hardship for consumers.

(1) "Combined Cost Sharing"

Issue:
The IFR states that health insurers may not utilize separate cost sharing provisions (such as deductibles and out-of-pocket expenses limits) or separate cumulative treatment limitations (such as limits on number of inpatient days) for medical/surgical and mental health services. Instead, plans must now combine these provisions and limits. We believe this prohibition goes beyond the language of MHPAEA. It also does not align with historic parity practices reflected in the 1996 Mental Health Parity law which permitted separate limits for other financial requirements subject to parity such as annual and lifetime benefit maximums.

We are concerned that this provision could lead to unintended, negative consequences for consumers who seek coverage for mental health and substance use related services. The requirement to combine deductibles and out-of-pocket maximums will result in higher consumer out-of-pocket costs. This will be true both for consumers in need of only mental health/substance use disorder benefits as well as those who use medical/surgical benefits.

These higher out-of-pocket costs in turn may prove a deterrent to consumers who are in need of treatment. This is completely contrary to MHPAEA's intent (namely greater access to treatment) because it may lead consumers faced with higher out-of-pocket expense not to seek necessary treatment.

Illustration of Impact on Consumers:
To understand the potential implications for consumers should the IFR requirements be implemented as written, consider the following two common plan design scenarios: (1) separate deductibles but with the mental health/substance use disorder deductible at a significantly lower level than that for medical (e.g. a $1000 deductible for medical and a $500 deductible for mental health/substance use); and (2) separate but equivalent deductibles (e.g. a $250 deductible for medical and a $250 deductible for mental health/substance use).

In the first scenario, a plan required to combine these deductibles will likely do so at or above the higher medical deductible, as this will have the least impact to the cost for the plan and plan participants EXCEPT for those plan participants who utilize mental health/substance use disorder

services. These participants, who today need only pay $500 to satisfy their deductible and qualify for coverage of their mental health/substance use disorder benefits, will now need to pay at least double that amount ($1,000) to achieve the same coverage simply because the IFR will not permit a separate deductible.

In the case of the second type of plan design where there are separate but equivalent deductibles of $250, a plan sponsor, in order to keep plan costs neutral, will likely adjust their deductible to a higher amount (e.g. $350 or $400) and apply it to both medical and mental health benefits or even combine the two amounts and impose a combined $500 deductible. Again, a plan participant will need to spend more out-of-pocket to meet his or her deductible as a direct result of the requirement to combine cost sharing under the IFR. In this scenario, the impact is not limited to just those plan participants seeking mental health or substance use disorder treatment. This change will also result in greater out-of-pocket costs to plan participants seeking medical care – rather than meeting the previous separate $250 deductible for coverage of medical benefits, the individual will now need to meet the higher combined deductible of $400 or $500.

For those affected, these increased out-of-pocket costs will likely provide a barrier to access to necessary treatment and serve as a disincentive to individuals to seek needed treatment. Many studies have demonstrated the sensitivity of access and duration of treatment in mental health and substance use disorder care, especially substance use disorder care, to financial requirements set by higher cost sharing models.[1]

Our experience in serving large employer carve out programs informs our views of how they will likely implement the IFR. For example, one *Fortune* 100 customer covering over 500,000 members has already combined their deductibles and increased the amounts for both the individual and family deductibles applied to their benefits. The deductible had previously been $250 per individual/ $750 per family and was limited to inpatient classification benefits only; it will now be applied across all benefit classifications and the amounts will be increased.

In addition, several customers, who previously had a deductible for medical/surgical benefits, but no deductible for mental health and substance use disorder benefits, now will apply the deductible amounts to both medical/surgical benefits and mental health/substance use disorder benefits. For example, one customer with over 50,000 members enrolled in consumer-driven health plans, now will, in the coming plan year, subject mental health and substance use disorder benefits, which were not previously subject to plan deductibles, to the plan deductibles of up to $750 for in-network and $1500 for out-of-network benefits.

The examples above are not outlier examples or unusual circumstances. A recent industry survey of employers offering health benefits indicates that deductibles are a commonly used plan design element. In fact, 32% of the plans surveyed indicated they have a deductible of $500 or more, in the smaller employer group market (employers up to 199 employees), that figure is 40%. In both cases, the four-year trend shows significant increase in the number of plans using deductibles.

Over 66% of consumers covered by mental health and substance use disorder carve out plans administered by UnitedHealth Group's OptumHealth business do not have combined deductibles currently.

In addition, the size of deductibles is significant – the same recent survey noted above showed that in the insurance market, 52% of Preferred Provider Option (PPO) plans and 71% of Point of Service (POS) plans have deductibles of $1,000 or more.[2] The impact of this issue for UnitedHealth Group's UnitedHealthcare business alone can be seen in the more than 4 million members who currently have deductibles of $500 or more. Most of these individuals will face higher costs due to the likely approach taken by their plan sponsors to comply with the IFR.

Recommended Modification:
Amend 45 CFR § 146.136(c)(v)(A) to read: "A group health plan (or health insurance coverage offered in connection with a group health plan) may apply any cumulative financial requirement or cumulative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification, provided such separate cumulative financial requirement or cumulative treatment limitation for mental health or substance use disorder benefits is no more restrictive than any established for medical/surgical benefits in the same classification."

(2) Calculation of "Substantially All"

Issue:
The IFR sets forth a mathematical formula for calculating whether or not "substantially all" of the medical/surgical benefits within a specific classification are subject to a specific type of financial requirement or quantitative treatment limitation such as a copayment or visit limit. The purpose of this calculation is to determine whether or not a specific type of requirement or limit can be applied to the mental health and substance use disorder benefits in the same classification. We are concerned that the proposed calculation formula has two flaws: (A) it will lead to the unintended consequence of deeming most current mental health and substance use disorder cost sharing provisions impermissible – thus removing a key tool that helps to reduce the overall plan premium and likely resulting in higher plan premiums for consumers overall; and (B) it will require an excessively complicated, time-consuming and costly actuarial calculation that will create a disproportionate administrative burden on employers and can lead to counterintuitive results.

(A) Unintended Consequence of "Substantially All" Test - Elimination of Cost-Sharing for Mental Health & Substance Use Disorder Benefits

The specific issue with the calculation is that the IFR very precisely states that a plan must compare like type of requirement to like type of requirement only (e.g. copayment MUST be compared to copayment only and not to coinsurance or cost sharing requirements generally). This means for many plans that neither type of cost sharing – copayment or coinsurance – will be permitted under mental health and substance use disorder portion of the benefit plan because

neither can pass the two-thirds threshold of the IFR's "substantially all" test and the IFR does not permit them to be considered together as a single cost sharing type of financial requirement.

Despite the fact that substantially all outpatient medical services have some form of cost sharing type (copayment or coinsurance), no one type is attached to substantially all (two-thirds or more) of services and thus no form of type of cost sharing satisfies the test of the IFR. This means that no type of cost sharing can be applied to outpatient mental health and substance use disorder benefits.

This is particularly problematic in the outpatient benefits classifications where outpatient benefit costs account for 60% of all mental health and substance use disorder benefit costs. The types of medical/surgical treatment delivered on an outpatient basis can include a much broader variety of services than the office visits that make up the outpatient benefits classifications for mental health and substance use disorders. For example the medical/surgical outpatient classification includes ambulatory surgery, lab services, MRIs, and the like – not just the office visits that are typical for mental health and substance use disorder benefits. This imbalance of the array of services within the classification has a dramatic effect on the testing of financial requirements and quantitative treatment limitations.

Illustration of Effect of IFR and Impact on Consumers:
Table 1 illustrates this issue by applying the "substantially all" standard to a typical health plan (based on our customer experience). Total expected payments are derived from expected utilization and cost of services across our medical plan book-of-business.

***TABLE 1* - Application of "Substantially All Standard" to a Typical Health Plan**

Type of Service	Cost Sharing	Total Expected Payments in One Plan Year Type of Service (in thousands)	% Total
Wellness Visits and Tests	None	$80	8%
Outpatient Lab/X-Ray and Minor Diagnostics (excluding Wellness)	None	$150	15%
A. Subtotal – No Cost Sharing		**$230**	**23%**
Non-Wellness Office Visits - PCP	Copayment	$110	11%
Non-Wellness Office Visits - Specialist	Copayment	$140	14%
Urgent Care	Copayment	$10	1%
B. Subtotal – Copayment		**$260**	**26%**

Outpatient Surgery (Facility and Professional Fees)	Coinsurance	$280	28%
Outpatient Major Diagnostic and Therapeutic (CT, PET, MRI, MRA, Nuclear Medicine, Dialysis, Chemotherapy, Radiation Oncology)	Coinsurance	$200	20%
Prosthetics, DME, Home Health, Ambulance	Coinsurance	$30	3%
C. Subtotal – Deductible/Coinsurance		**$510**	**51%**
Total Cost Sharing (B+C)		**$770**	**77%**
Total Expected Payments (A+B+C)		**$1,000**	**100%**

Under this typical medical expense plan design and experience, approximately 23% of the total outpatient in-network benefits payable have no cost sharing; 26% are services subject to a copayment; and 51% are services subject to a coinsurance. Such a plan could not pass the proposed two-thirds test, even though total cost sharing (26% + 51%, or 77%) is greater than two-thirds of the total expected plan payments. This failure to meet the "substantially all standard" would result in the required elimination of copayment requirements on behavioral health services even though copayments would be required on similar medical services.

In order to address this result where a plan is unable to apply a copayment or coinsurance for behavioral health benefits, a plan may modify the benefits such that mental health and substance use disorder office visits are subject to coinsurance (which is subject to first meeting a deductible and increases as the charge for services increases) rather than set flat dollar amount copayments. This would also negatively impact consumers who today have a flat dollar copayment but would now experience a coinsurance level that could result in a significantly higher out of pocket expense.

For example, if a member currently has a $20 copayment for an hour long therapy session that costs $150, and the plan now has to change to a coinsurance at a level of 20% (which is relatively common), the member's out of pocket expense increases from $20 to $30 per session. These increased out-of-pocket expenses can, as we noted previously, prove a disincentive to patients seeking necessary treatment. Alternatively, a plan a might raise the premium contribution amount charged to the plan participants because no cost share for outpatient mental health and substance use disorder benefits can be imposed on participants seeking treatment. Both of these scenarios, changing plan designs from flat copayment amounts to coinsurance amounts or increasing premiums for plan participants, result in consumers having to pay more out-of-pocket for the same coverage.

We believe that this is an unintended outcome of MHPAEA and will have negative consequences for consumers. We request that you modify the "substantially all" test to account for this problem

by allowing plans to meet the "substantially all" threshold with respect to copayments and coinsurance by treating these financial requirements as a single type for purposes of meeting the two-thirds test.

(B) Complex, Costly Approach to Assess Parity That Can Result in Counterintuitive Outcomes.

The IFR establishes a number of defined terms and a formula for assessing parity with regard to financial requirements and quantitative treatment limitations that is overly complex and leads to results that do not support the goals of parity as demonstrated by section (A) above. These defined terms and the formula require a level of complex actuarial analysis and diligence few employers are equipped to handle and adds to our concern about effective implementation of parity in the timeframe provided for under the IFR. We believe the current formulaic test does not result in better access to mental health and substance use disorder benefits and treatment, but simply adds administrative complexity and cost to those benefits. This complexity impacts every employer and health plan with mental health and substance use disorder benefits.

The IFR begins, for example, by establishing the following defined parameters and variables in plan design which must be used in order to assess parity:

- Six (6) benefit classifications – inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; pharmacy and emergency services;
- Two (2), at least, "coverage units" – individual and family;
- Six (6), at least, "types" of financial requirements or quantitative treatment limitations – copayments, coinsurance, deductibles and out-of-pocket expense maximums as well as day limits, visit limits and episodes of care limits;

This means there are at least 72 different plan design elements to be tested to satisfy the "substantially all" test to determine if those elements that are applied on the medical/surgical benefits can even be applied to mental health and substance use disorder benefits.

Then consider a group health plan that utilizes multiple plans and benefits packages and the amount of assessment and calculation grows. For example, if an employer has 5 benefit plan options for employees, with 72 different plan design elements to be assessed and subjected to the IFR's "substantially all" test, that means the plan must conduct over 350 assessments and calculations to determine whether it can even apply those elements (copayments, coinsurance, deductibles etc.) that are commonplace for medical and surgical benefits and are accepted practice. To further illustrate this we have attached as Appendix 1 of this letter a chart showing the systematic data collection classification by classification, plan design type by type for one single plan with one single benefit package.

Add to these parameters the various "levels", as defined by the IFR, of plan design elements that may exist (e.g. differentiated copayments for primary care and specialty) for a given plan and that would need to be assessed to address the IFR's "predominant" test and it becomes very clear that

the IFR's supposition that a plan can assess compliance with one half hour of a professional's time is a gross underestimate of the level of effort employers and health plans will need to undertake to demonstrate parity under the IFR.

Given the current formula and test requirements, employers will be burdened with a substantial new administrative requirement that will add cost and administrative effort to justify plan design elements that – with respect to any other condition for which medical and surgical benefits are available (e.g. cardiology, oncology, dermatology etc.) – are accepted and applied without the need for demonstration of such testing. These elements, by their very inclusion in MHPAEA and IFR, are recognized as elements which are commonly utilized and apply to "substantially all" medical/surgical benefits and accordingly should also be applied to the corresponding mental health and substance use disorder benefits.

We understand the goal of the IFR is to ensure that these same elements are not applied more restrictively for mental health and substance use disorder benefits than they are applied for medical/surgical benefits but the "substantially all" test does not address this issue. The "substantially all test" determines whether or not a plan can apply these elements at all, not whether they can apply them no more restrictively. We believe this is not the intent or goal of parity. There should be no requirement for a plan to substantiate the application of the very requirements and limitations that are otherwise applied to medical/surgical benefits merely because the benefits relate to mental health and substance use disorder treatment.

Recommended Modification:
Amend section 45 CFR §146.136(c)(3)(i)(A) to remove the requirement that before a given type of financial requirement or quantitative limitation may be applied to mental health and substance use disorder benefits that requirement or limitation be applied to "substantially all" of the comparable classification of medical benefits.

In the alternative:
Amend section 45 CFR §146.136(c)(3)(i)(A) to state that for purposes of meeting the "substantially all" test of the general parity requirement, copayments and coinsurance (representing different types of member out-of-pocket cost sharing types) may be combined and treated as a single type of financial requirement.

II. Non-Quantitative Treatment Limitations

Non-quantitative treatment limitations were not identified in MHPAEA nor contemplated in the legislative history of MHPAEA. Moreover, these limitations do not appear to constitute, in the plain language of MHPAEA, "other similar limits on the scope or duration of treatment" (emphasis added) similar to those specifically enumerated in MHPAEA such as day limits and visit limits (both of which are quantitative limits). Non-quantitative treatment limitations are, by definition, distinct from, and not similar to, quantitative limits – a fact reinforced by the separation of the definitions and requirements in the IFR itself.

In addition, the complexity and ambiguity of these provisions will make implementation both disruptive and costly – particularly if the IFR's applicability date is not modified to July 1, 2011. Based on our experience, we believe that this cost and disruption are more likely to hinder than to enhance access to affordable, effective, and quality treatment for mental health and substance use disorder conditions. We focus below on medical management standards portion of the IFR specifically in an effort to illustrate this point.

Medical Management Standards

Issue:
We are concerned that the non-quantitative treatment limitations provisions will undercut and eliminate the very benefits of medical management described in the IFR because such techniques are not applied in a "comparable" (as described in the IFR) fashion for most medical/surgical benefits. The IFR notes that these techniques, employed by managed behavioral health organizations, "...obtain cost savings for plan sponsors by providing focused case management and directing care to a broad network of mental health and behavioral health specialists...who ensure that appropriate care for mental health and substance use disorders is provided."[3] The IFR's requirement that the processes and strategies to apply these standards must be comparable to those applied to medical/surgical benefits at the group health plan level is undefined and complicated to apply. These processes and strategies are applied at the carrier, plan administrator and managed behavioral health organization (MBHO) level. Accordingly, these standards do not vary materially from employer to employer across a specific carrier, plan administrator or MBHO.

Services and practices for the treatment of mental health and substance use disorder are by nature different than those for medical and surgical conditions (i.e. partial hospitalization, intensive outpatient, locked inpatient units, crisis intervention, office visits once or twice a week). These differences extend to the kinds of care factors that affect access to and duration of treatment and quality of care, e.g. 40% – 50% of inpatient admissions are legally forced,[4] 67% of patients engaged in outpatient treatment drop out before completing,[5] prior to the advent of managed care post-discharge follow-up to inpatient treatment occurred in less than 42% of cases.[6] Because of these differences and challenges, it is important to have the ability to utilize the appropriate medical management tool(s) based on demonstrated industry best practices – and not simply be required to align mental health and substance use disorder management to the repertoire of tools and the processes primarily used for medical and surgical management.

Medical management research has demonstrated that not all medical management techniques are effective for every service or condition.[7] Studies have shown that to be effective medical management methodologies must be tailored to fit the unique characteristics and trends of the population served, the conditions being treated and the services being provided (e.g. precertification for some medical admissions identified a less than 2% rate of inappropriate admissions, while precertification for behavioral health admissions reported a 50% reduction in inappropriate admissions).[8] In addition, the research showed that effective medical management

requires the use of combinations of interventions integrated to not only promote medically necessary treatments but also quality care. Recognizing research findings as well as the fundamental differences between behavioral health and medical/surgical services, we suggest refocusing medical management for mental health and substance use disorder treatment to align with these best practice principles (i.e., defined and tailored to the specific needs of the population, the use of multiple strategies with a goal of promoting use of efficient and quality treatment) as the goal. Requiring parity of these medical management standards and processes to each individual plan's medical/surgical management strategy, as proposed in the current IFR, does not facilitate the goals of implementing consistent best practices for behavioral health.

We are aware of concerns around medical management techniques and the degrees of variability in their application. However, we suggest the use of other existing methodologies to address these concerns and to ensure the use of best practices. Accreditation by organizations such as National Committee for Quality Assurance (NCQA) and American Accreditation HealthCare Commission/URAC (URAC) already provides the infrastructure for assessing and reviewing plans and reporting demonstration of quality (MCOs and MBHOs accredited by NCQA cover over 109 million members).[9] We believe that revisiting and revising existing standards and performance metrics to address these concerns and to promote best practices would be a more constructive process. The transparency of the accreditation process and the reporting of performance outcomes can facilitate focused attention and bring better clarity to health care system stakeholders and encourage the proliferation of best practices for medical management.

We therefore recommend that non-quantitative treatment limitation requirements of the IFR be removed. As an alternative, the IFR should be revised to stipulate that behavioral health medical management standards be based on the demonstrated characteristics of the behavioral health population of the plan and that appropriate tools be applied within clinically accepted standards. The IFR should also be revised to remove the requirement that non-quantitative treatment limitations be benchmarked against the "comparable" and "applied no more stringently" standards of the IFR. Instead we recommend the use of an accreditation process with appropriate modifications to confirm and monitor whether best practices are being applied to the management of mental health and substance use disorder benefits.

Recommended Modification:
Amend 45 CFR §146.136(c)(4) to remove the category of non-quantitative treatment limitations.

In the alternative:
(1) Change the IFR's applicability date to July 1, 2011; and
(2) Amend the specified parity standard for non-quantitative treatment limitations in 45 CFR 136(c)(4) to provide that non-quantitative treatment limitations shall be considered to comply with the IFR provided that the plan benefit administrator is accredited by an appropriate accreditation agency or, in the case of a group health plan purchasing coverage on an insured basis, that the plan's insurance carrier or managed behavioral health vendor is similarly accredited.

III. Timing of the Applicability of the Interim Final Rules

Issue

We have significant concerns about the IFR's current applicability date of July 1, 2010. We believe this abbreviated timing will exacerbate the negative unintended consequences of the various provisions of the IFR discussed in this letter and negatively impact millions of consumers in the coming plan year.

The IFR was published on February 2, 2010, less than five full months before this applicability date and well after plans had already made and implemented plan design changes to comply with MHPAEA. The implementation of a new and comprehensive regulation in such a timeframe is a difficult proposition at best, even absent the IFR's complexities and ambiguities.

In general terms, many plans operate on a calendar year basis, and would not, therefore, have to comply with the IFR until January 1, 2011. These plans however typically finalize any desired or necessary plan design changes several months prior to the start of their plan year – for larger employer plans it can be as far in advance as six months or more. This is to ensure they can appropriately revise their plan documents, implement the changes and communicate those changes to plan participants well in advance of the start of the plan year. This timing, in the context of the IFR, means that plans are currently reviewing and making changes to ensure compliance with the IFR, including making changes driven by the current provisions of the IFR that we believe will result in higher out-of-pocket costs and reduced access to necessary treatment that are discussed above in Sections I. and II.

Our initial thinking related to timing was that an applicability date of January 1, 2011, while not as likely to enable thoughtful implementation as a July 1, 2011 date, would nonetheless be helpful in that regard. Having worked through the timing of plan and employer decision making, however, it is clear to us that the damage will be done. Plans and employers will implement the IFR as currently written, resulting in the potential damage to consumers in areas such as higher out-of-pocket costs and greater barriers to treatment arising out of the combined cost sharing, "substantially all" test and medical management standards requirements unless the IFR's applicability date is quickly changed to July 1, 2011 or after.

We believe the applicability date of the rules, unless immediately addressed, will result in negative consequences to consumers even in the event that the Final Rules are modified as we have recommended. Accordingly, we urge the Agencies to immediately address the applicability date of the IFR to allow appropriate consideration and resolution of concerns with the IFR as currently drafted and thoughtful implementation that is less likely to result in negative consequences for consumers.

Recommended Modification:

Amend section 45 CFR §146.136(i) to revise the applicability date for plans to the first day of the plan year beginning on or after July 1, 2011.

B. Review of IFR Comment Requests & Additional Issues

The IFR specifically requested comments in several areas where our experience suggests that it should not be changed. However in an effort to be fully responsive to the IFR as well as to address points that may be raised by other commentators to the IFR, we briefly review the following issues: (1) "Scope of Services"; (2) Disclosure Requirements; (3) Cost Exemption; (4) Cost of Compliance Estimate; (5) Non-Quantitative Treatment Limitations – Provider Reimbursement Rates/Plan Methodologies for Usual, Customary and Reasonable Charges; and (6) Classifications of Benefits.

(1) "Scope of Services"

The IFR addresses "scope of services" by requiring that plans provide services for the treatment of mental health and substance use disorder benefits in each classification for which the plan provides medical/surgical benefits. The IFR specifically requested comments on this topic.

MHPAEA does not contain any mandate of coverage for mental health or substance use disorder conditions, nor would its language or legislative history support it. Accordingly, we believe the IFR should not further attempt to define "scope of services" or impose any form of mandate for a specific set of services or scope of services.

(2) Disclosure Requirements

MHPAEA and the IFR set forth very clear expectations with respect to disclosure and transparency of information for consumers, providers, plan participants and potential plan participants. UnitedHealth Group has been, and continues to be, committed to the goal of providing full disclosure of information regarding benefits coverage and treatment.

The MHPAEA requirements for disclosure of medical necessity criteria and of the specific rationale for denial of coverage for treatment or benefits are addressed through a variety of state and federal law requirements applicable to group health plans, third-party administrators and insurers. For example, denial rationale disclosure is an express requirement of the claims regulations for ERISA group health plans (*see* 29 CFR 2560.503-1), and disclosure of medical necessity criteria to the public upon request is mandated of an insurer under California law by California Insurance Code 10123.135(f)(2)(E)). In many cases insurers, plan administrators and third-party administrators have extrapolated such requirements and made them standard practice across the operations for all consumers for operational efficiency.

We understand some commentators may feel the MHPAEA and IFR requirements are not sufficiently defined. We respectfully disagree. Plans and carriers currently already meet these requirements using a variety of mechanisms driven by the demands of consumers, providers and customers and in response to the laws noted above. MHPAEA and the IFR have recognized these factors and struck an appropriate balance between, on the one hand, being prescriptive in terms

of clearly articulating the requirement that these disclosures be made across all group health plans (or health insurance coverage offered in connection with a group health plan) and on the other hand, the flexibility to deliver these disclosures in the most efficient manner and a manner responsive to consumer demands.

(3) Cost Exemption

The specific procedures for a plan to apply for and obtain the exemption need to be described and published so plans are fully informed as to how to apply for and obtain the exemption if they wish to do so.

(4) Cost of Compliance Estimate

The IFR requested comments on the cost of compliance estimate contained in the IFR. As discussed throughout this document in support of the various recommendations, achieving a July 1, 2010 applicability date will be difficult, complex and costly for employers, health plans and MBHOs wishing to comply with MHPAEA and the IFR as currently written. This is even more of a concern following the passage of the Patient Protection and Affordable Care Act which also requires plans and carriers to review their plans and implement significant changes. The resource and cost implications for plan sponsors and carriers to comply with the IFR as currently drafted are considerable.

Based on our experience, the estimate provided by the IFR that a plan could determine compliance with a half-hour of a professional's time to review the plan and plan documents and make necessary changes significantly underestimates the process and costs for compliance review, operational changes and implementation. For example, a plan that purchases benefits on an insured basis must review its plan design for compliance and communicate desired changes to its insurer of choice. That insurer must then make changes to the necessary certificates of coverage (in many cases such changes must then be filed with State insurance regulators for approval), and the new documents must be issued to plan participants to provide them the opportunity to review and make their enrollment decisions. The IFR's assumption of one half-hour of professional legal or compliance time does not appear to account for or align with these necessary processes.

Based on our experience, a typical plan review to determine compliance, amendment of the plan and implementation of any changes necessitated by the requirements of the IFR as written will likely cost $25,000-$40,000 (this figure is based on the cost of a typical claims compliance audit as a proxy for a parity plan compliance audit/review). This estimate presumes that all the requirements are clearly understood and implementation is straight-forward which, as evidenced by the numerous questions submitted to CMS and the other regulatory Agencies since the publication to the IFR, would seem to be an inaccurate presumption. This cost doesn't include the cost impact of benefit changes to achieve compliance, merely the cost to identify those changes and implement them.

(5) Non-Quantitative Treatment Limitations – Provider Reimbursement Rates/Plan Methodologies for Usual, Customary and Reasonable Charges

We understand some parties may be addressing the issue of non-quantitative treatment limitations with regard to provider reimbursement rates and plan methods for calculating usual, customary and reasonable charges. As a threshold issue, the admission standards used by a plan or insurer to admit providers to its network, including its reimbursement rates and its method for determining usual, customary and reasonable charges are not limits on "the scope or duration of treatment" and are definitely not, in the terms of MHPAEA, limits which are similar to day or visit limits. We do not believe that it is the intent of MHPAEA or the IFR to support alignment of payment for services. There is nothing in MHPAEA or its legislative history that suggests Congress intended parity to require alignment of reimbursement rates for the very different services treating mental health and substance use disorder conditions with those used to treat medical conditions and the IFR should not be altered to support such alignment.

(6) Classifications of Benefits

We understand some observers may request that the IFR be revised to alter the current classifications of benefits. It has been suggested by some that one solution to the calculation of "substantially all" problem, discussed above in Section A.I.2. of this letter, is to sub-divide the outpatient classification of the IFR to provide a classification for "office visits." While this is a potential solution to one concern, it may have other unforeseen consequences which could negatively affect consumers. Accordingly, we note this as a possible alternate solution but we do not believe it is as effective as our recommendation to eliminate the "substantially all" test or, in the alternative, treat copayment and coinsurance as a single type of requirement for this test.

C. Summary of Recommendations & Conclusion

We believe the recommendations highlighted in this letter will ensure that the goals of MHPAEA are met, minimizing unnecessary increases to out-of-pocket costs and potentially negative unintended consequences that ultimately will harm consumers' ability to obtain quality, effective mental health and substance use disorder treatment without the need for significantly greater out-of-pocket costs. On behalf of the 43 million consumers for whom we administer mental health and substance use disorder benefits, we thank you for your thoughtful consideration of these recommendations and the discussion of the issues and concerns underlying them.

While each of our recommendations is important, the most time critical is the need to swiftly revise the applicability date of the IFR. Quick action here is necessary if plans, consumers and health care providers are to understand and implement these complex changes to mental health and substance use disorder benefits without jettisoning behavioral medical management best practices, costing consumers more money out-of-pocket, disrupting the efficient delivery of quality treatment and creating barriers to needed treatment. We urge you to address this concern as expeditiously as possible.

UnitedHealth Group appreciates the opportunity to provide you with our comments on the IFR for MHPAEA. Should you have any questions regarding the information set forth in these comments please do not hesitate to contact us. Thank you again for your time and thoughtful consideration of the enclosed comments.

Sincerely,

Dawn M. Owens
Chief Executive Officer
OptumHealth, a division of UnitedHealth Group

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[2] Henry J. Kaiser Foundation, "Employer Health Benefits 2009 Annual Survey", 2009.

[3] 75 FR 5425

[4] Internal Data from OHBS analysis

[5] Olfson M., *Dropout from Outpatient Mental Health Care in the United States. (2009) Psychiatric Services* 60:898-907

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[8] Wickizer, T.M., & Lessler, D. (2002). *Utilization management: Issues, effects, and future prospects. Annual Review of Public Health*, 23, 233-254.

[9] National Committee for Quality Assurance

APPENDIX 1 – Sample of a portion of our proprietary tool to capture data to assess benefit plan design and the various financial requirements and treatment limitations for parity compliance for a single benefit package.

PART 1: DEDUCTIBLES / OUT-OF-POCKET *(Predominant medical co-pay assumes 'substantially all' test is met)*				
TOTAL IN	*(IP + Intermediate + OP)*	Deductible	Individual (employee)	
			Individual +1	
			Family	
			Other	
			Is behavioral-medical sharing in place today? (Y/N)	
			Count toward OOP Max?	
		OOP Max	Individual (employee)	
			Individual +1	
			Family	
			Other	
			Is behavioral-medical sharing in place today? (Y/N)	
TOTAL OON	*(IP + Intermediate + OP)*	Deductible	Individual (employee)	
			Individual +1	
			Family	
			Other	
			Is behavioral-medical sharing in place today? (Y/N) Count toward OOP Max?	
		OOP Max	Individual (employee)	
			Individual +1	
			Family	
			Other	
			Is behavioral-medical sharing in place today? (Y/N)	
PART 2: CO-PAY / COINSURANCE *(Predominant medical co-pay assumes 'substantially all' test is met)*				
	IP-INN	Co-pay	**Per day**	
			MH	
			SUD	
			Combined MH/SUD	
			Per admission	
			MH	
			SUD	
			Combined MH/SUD	
			Count toward deductible?	
			Count toward OOP Max?	
		Coinsurance	MH	
			SUD	
			Combined MH/SUD	

		Count toward deductible?	
		Count toward OOP Max?	
IP-OON	Co-pay	**Per day**	
		MH	
		SUD	
		Combined MH/SUD	
		Per admission	
		MH	
		SUD	
		Combined MH/SUD	
		Count toward deductible?	
		Count toward OOP Max?	
	Coinsurance	MH	
		SUD	
		Combined MH/SUD	
		Count toward deductible?	
		Count toward OOP Max?	
OP-INN	Co-Pay	**Per visit**	
		MH	
		SUD	
		Combined MH/SUD	
		If plan utilizes tiering, click on the "+" sign at line 188 and provide specifics	
		Count toward deductible?	
		Count toward OOP Max?	
	Coinsurance	MH	
		SUD	
		Combined MH/SUD	
		Count toward deductible?	
		Count toward OOP Max?	
OP-OON	Co-Pay	**Per visit**	
		MH	
		SUD	
		Combined MH/SUD	
		If plan utilizes tiering, click on the "+" sign at line 206 and provide specifics	
		Count toward deductible?	
		Count toward OOP Max?	
	Coinsurance	MH	
		SUD	
		Combined MH/SUD	
		Count toward OOP Max?	
PART 3: DAY / VISIT LIMITS			

(Predominant medical day/visit limits assume 'substantially all' test is met)			
IP-INN	Day Limits	MH	
		SUD	
		Combined MH/SUD	
IP-OON	Day Limits	MH	
		SUD	
		Combined MH/SUD	
IP-INN+OON	Day Limits	MH	
		SUD	
		Combined MH/SUD	
OP-INN	Visit Limits	MH	
		SUD	
		Combined MH/SUD	
OP-OON	Visit Limits	MH	
		SUD	
		Combined MH/SUD	
OOP-INN+OON	Visit Limits	MH	
		SUD	
		Combined MH/SUD	
PART 4: EPISODE LIMITS *(Example: 3 Substance Abuse rehab episodes per lifetime)*			
LIMIT	Applies to:	MH	
		SUD	
		Combined MH/SUD	
		Is behavioral-medical sharing in place today? (Y/N)	
		MH	
		SUD	
		Combined MH/SUD	
		Is behavioral-medical sharing in place today? (Y/N)	