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May 28, 2009

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

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

CC:PA:LPD:PR (REG-120692-090)
Room 5205
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Submitted via the Federal eRulemaking Portal: www.regulations.gov

Re: Request for Information Regarding the Paul Wellstone and
Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
(74 Fed. Reg. 19155, April 28, 2009)

Dear Sir/Madam:

Managed Health Network, Inc. A Health Net Company (“MHN”) is pleased at this opportunity to respond to the request for information regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). We are responding to a Request for Information (RFI) published in the *Federal Register* on April 28, 2009 (74 Fed. Reg. 19155). We applaud the efforts to improve the equity for those suffering from mental illnesses and substance use disorders (behavioral illnesses). Within the Act there are several areas that MHN requests clarification and we have identified those below.

Financial Requirements

The MHPAEA may require some plans to significantly change their administration of financial requirements. Due to some ambiguity in the law, there needs to be clarification on whether plans can continue to have separate and no more restrictive financial requirements

(specifically deductibles and out of pocket maximums (OOP)) for behavioral illness services as compared to medical services or whether plans must only have a single deductible and/or out of pocket maximum that includes both medical and behavioral services. We strongly believe that the law is written to allow either separate or shared financial requirements as long as the deductibles and out-of-pocket maximums are no less restrictive for the behavioral health services .

Moving away from a separate, but no less restrictive, deductible alternative would also pose substantive administrative challenges and additional cost for plans and members. Because management of behavioral health is considered a specialty service, plans and purchasers have often chosen to directly contract with a specialized Managed Behavioral Healthcare Organization to administer the behavioral health services. Therefore, if a single deductible were mandated, there would be two organizations involved in the benefit administration, the medical plan or insurer and the separate behavioral health plan or insurer. Communicating accurate, up to date deductible information for accurate management of the benefit (i.e. cross-accumulation of the deductible) will be an intensive administrative process with significant costs. In some circumstances, a single employer may have multiple medical insurers (offering various medical benefit options) but a single behavioral health specialty insurer. If a single deductible were mandated the specialty insurer would have a nearly insurmountable administrative burden of tracking and coordinating benefits across multiple, disparate systems that count the cost of each benefit against the deductible, potentially simultaneously. In effect the two (or more) carriers would need overlapping, redundant claims functions and systems.¹

In addition, the impact on the member from shared or separate financial requirements can be very negative, depending on member circumstances and financial requirements of the plan. The general assumption is that a shared deductible is less costly for the member since the costs of behavioral and medical care are assessed against the same deductible and out of pocket maximum. We believe that, if forced to offer a single deductible, many plans will opt to increase the behavioral health benefit deductible to match the already higher medical deductible. In behavioral health the barrier of high first dollar cost is great. Many studies have demonstrated the sensitivity of access and duration of treatment in behavioral health to deductibles, co-payments and out of pocket maximum levels. A number of plans have chosen to use low first dollar costs in behavioral health to enhance access. This is likely to be lost by a requirement of a single, higher cost deductible and is likely to reduce access to care for some who need it most.

Having the ability to construct separate, equal or lower deductibles and out of pocket maximums for members needing behavioral health services and faced with high medical deductibles allows those members to have less financial first dollar barriers to accessing behavioral health treatment. Purchasers are not likely to be willing to adjust the medical deductible downward (thereby increasing premium costs) to keep the behavioral health

¹ A shared deductible in this context would require that the carriers or administrators build the necessary system interfaces to share and coordinate the cost accumulators. We estimate that this could have a range of cost from \$200,000 - \$750,000 for each interface.

financial requirements lower, since approximately 95% of the insured population only accesses the medical surgical benefit. Without the ability to have separate deductible and out of pocket maximums, purchasers are forced to adopt higher financial requirements for behavioral health. It would be our recommendation to allow the purchaser to offer either shared or separate deductibles and out of pocket maximums so that they can minimize impact on access to behavioral health care.

Our recommendation is supported by the FEHBP Carrier Letter dated April 20, 2009 that directs carriers to implement the MHPAEA and which states, while indicating a preference for one deductible, “expenses incurred for mental health or substance use disorders may be applied to the same medical and surgical deductibles and catastrophic limits or to separate deductibles and catastrophic limits so long as they are for the equivalent amounts.” In addition, the existing regulations that apply to annual and lifetime limits allow for both one aggregate limit and two separate but equal limits.

The MHPAEA will also require changes in co-payment levels. The requirement that co-payments for services be in parity, will mean that plans will need to “map” behavioral health services to “comparable” medical services. This is fairly straightforward for outpatient services such as medication visits and therapy sessions. However, clarification is needed as to whether behavioral health represents a specialty service or a primary care service, since many plans have different co-pays on the medical side for each type of service. Inpatient services are also straightforward, but behavioral health has a group of intermediate level services between inpatient and outpatient that have no clear equivalent in the medical services. Intensive Outpatient Services (IOP, 3 hours a day of therapy in a program, 3-5 times a week), Partial Hospital Programs (PHP, 4 or more hours a day of therapy in a program 3-5 times a week), and Residential Treatment Centers (RTC, 24 hour supervision, 7 days per week, but often with no MD on site), are all examples of behavioral health services with no clear medical equivalent. Decisions about how to determine equivalence of co-pays (and deductibles) will impact how the plans administer benefits, the costs to employers, and the costs to members. In some cases this may reduce the co-pay for members seeking behavioral health services, but in other cases it may increase those co-pay costs.

Medical Management of the Benefit:

We understand that the Congressional Budget Office took into account the use of managed care arrangements in their analysis of potential costs in the implementation of MHPAEA. Without the ability to uniquely manage the mental health and substance use disorder benefit costs can potentially return to the dramatic 20% plus year over year increases in behavioral health costs that led to the formation of managed behavioral health organizations.

The treatment of behavioral health conditions is based on scientific data, as is the case in the practice of physical medicine. For most medical conditions there are clear standards of care derived from confirmatory objective outcomes and/or research based clinical practice guidelines. While behavioral illness treatments also have clearly defined

approaches, therapists have variations in training and experience at delivering these treatments. As has been noted in the 2006 Institute of Medicine report, Improving the Quality of Health Care for Mental and Substance Use Conditions, there is significant, often unjustified variation in treatment for some behavioral illnesses. Therefore, behavioral health requires a different management approach that is case and provider specific and that includes reviews against practice standards, outcomes management, concurrent and retrospective reviews/consultations during the course of the treatment and/or treatment record reviews to ensure the quality and efficacy of the treatment. OPM has recognized this issue, in FEHBP's implementation of MHPAEA, stating that "plans may manage care through referrals, prior authorization, treatment plans, pre-certification of inpatient services, concurrent review, discharge planning, case management, retrospective review, and disease management programs."

Medical Management of Out of Network Benefits

The MHPAEA will also impact the Out of Network (OON) benefits which many plans offer. The requirement that plans must offer behavioral health OON benefits if they offer medical OON, will require plans and employers to offer OON behavioral health benefits to some members who did not previously have such a benefit. With OON services it tends to be difficult to control the quality of the services (with an even greater variability in treatment provided) and to coordinate the care. The services are more costly and harder to manage and as a result it is expected that this provision will result in higher costs for consumers, plans, and employers.

We believe that the MHPAEA explicitly allows plans to require the OON provider to follow the terms and conditions of the plan that may include utilization and medical management of the benefit. Implementation of this provision will be a key to trying to coordinate care, maintain or improve quality, and keep employers and consumers costs down.

Interfacing with State Laws

Guidance is needed regarding how to determine the relationship between state and federal laws with regard to parity. There are state-specific mandates regarding the treatment of mental health and substance use disorders. For example, many states mandate the coverage of a specific mental health condition but only up to a certain cost level or within specific treatment limits. We believe that, in many cases, the financial and treatment limitations were the *quid pro quo* for the state legislative decision to create the mandate. It is not clear how the financial requirements and treatment limitations inherent in these mandates relate to the federal parity law. We do know that the intent of the parity law was to not preempt state coverage mandates. We look for guidance on how to interpret state benefit mandate limits within MHPAEA

Medical Necessity Criteria

MHPAEA requires disclosure of medical necessity criteria. Criteria for medical necessity determinations are currently made available to plan participants, beneficiaries and contracting providers upon request and, in some cases, as a matter of routine disclosure, without the need for a request by the participant, beneficiary and contracting provider. The information disclosed may range, depending on the circumstances, from the specific criteria relevant to a plan participant or beneficiary's particular request for benefits or may be a broad disclosure of the complete set of medical necessity criteria for all benefits under the plan to a contracted clinical provider.

This practice of disclosure is a result of market-driven demand by health care consumers and providers for transparency in the elements that define benefits available to plan participants, beneficiaries, and contracted providers. In addition, there are existing state and federal legal and regulatory disclosure requirements for plan and health issuer benefit plan information including medical necessity criteria information. This transparency, and the prior development of federal and state law disclosure requirements, along with private accreditation standards, has driven plans and health issuers to make the disclosure of medical necessity criteria utilized by plans a routine function of the business of administering plan benefits. We fully support the need for such transparency and disclosures.

We interpret the MHPAEA as codifying, in plain language, the existing best practices for disclosure of this information in accordance with existing law and current practices and operating procedures prevalent in the health care industry.

Further, health insurance carriers (including both insurers and managed care entities such as health maintenance organizations) who are accredited by organizations such as the National Committee on Quality Assurance (NCQA) or URAC (which is also known as the American Accreditation HealthCare Commission, Inc.) also have this requirement placed upon them within the existing accreditation standards. Specifically, NCQA standards UM 2 and UM 7A require the disclosure of medical necessity criteria to participants and beneficiaries (UM 7A) and practitioners (UM 2). URAC standard HUM 4 also addresses a disclosure requirement for utilization management requirements and procedures including medical necessity criteria.

Implementation:

While the federal parity law stipulates that regulations will be promulgated by October 3, 2009, the guidance contained within these interim regulations will not be timely enough for plans with an implementation date of January 1, 2010. It is common for plans to require their members to choose a health plan with a January 2010 start date in the prior October, and so regulations promulgated by October 3, 2009 will be too late to provide guidance for plans. Plans must complete design and any needed regulatory filings well before the October enrollment period. We request that if a plan implements a parity-

compliant benefit in good faith on January 2010, without the benefit of reviewing the interim final regulations at the time of filing the benefit plan, then the plan should not be subject to penalties “after the fact”. Furthermore, any changes that are required to make the benefit plan compliant with the parity law should not be implemented in mid-year. This would be onerous, costly, and confusing for members. Any such changes should be implemented in the following plan year.

Respectfully submitted,

Ian Shaffer MD, MMM
Chief Medical Officer