



May 28, 2009

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

**RE: Request for Information Regarding the Paul Wellstone and Pete Domenici  
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (PL110-  
343)**

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On behalf of the sixty coalition members and over 10,000 employer members of the National Business Coalition on Health (NBCH) appreciates the opportunity to comment on the implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) in effort to ensure that employers, purchasers, consumers and providers can effectively comply with this new law. In terms of comments, we will begin with general observations about the state of our nation's health care system and the opportunity for reform, and then transition to specific MHPAEA issues.

**GENERAL COMMENTS:**

Our coalition members and their employers understand the vital importance of mental health and substance abuse benefits, and its integration and equity with medical and surgical insurance benefits. Even during our nation's difficult economic situation, employers can justify comprehensive mental health benefits given the strong connection to total health status. Untreated mental health and substance abuse conditions can greatly affect employees' productivity and attendance, as well as become extremely debilitating and costly. In fact, the World Health Organization (WHO) has pronounced mental health disorders to be the most burdensome health conditions in the United States.<sup>1</sup> It is indeed in the employers' best interest to cover behavioral health benefits and to appropriately manage them to maximize employee productivity. However, these are challenging times for employers with considerable economic instability, increasing burden for employers to provide basic employee

health benefits, and impending national health care reform. An appropriate balance needs to be found to ensure that with the implementation of MHPAEA, employers can appropriately contain health care costs, manage resource utilization and improve population health status. Burdensome, inefficient benefit mandates that are difficult for plans and employers to understand and to implement will preempt the original intent of MHPAEA.

As our nation's health care system continues to escalate in cost and complexity, people link into the system in a variety of different ways depending on their employment, insurance eligibility, health status, financial circumstances and citizenship status. A major concern is that rising health care costs put America's business industry at a competitive disadvantage in a global economy, while adding to the economic insecurity of the American public who must increasingly contribute their own hard earned dollars to an ever growing health care industry. We all gain from accessible, efficient, thoughtful, evidence-based health care but we all lose from perpetuating an opaque system of inefficiency, and inaccessibility. We need a new, integrated system based on a complete transformation of the health care system towards higher performance, population health status improvement, integration and care coordination, system-wide reengineering, and a strong information technology infrastructure. All of these concepts are highly applicable and integral to behavioral health care.

Ultimately, NBCH and our coalition members believe that a strong employer-based health care delivery system holds the key to driving efficient, effective health care in this country. Employers as purchasers working in unison with large public stakeholders (i.e. Medicare and Medicaid) could aggressively institute a value based purchasing strategy that combines performance measurement, transparency, payment reform, and consumer activation and choice to drive system-wide quality improvement standards while controlling costs.

In terms of MHPAEA, it is important to strike an appropriate balance between protecting consumers and creating a business-friendly environment for purchasers, insurers, providers and other stakeholders. Relative to NBCH's mission and focus, we would like to offer the following comments, as well as seek clarification and confirmation regarding the proposed mental health and substance abuse parity regulations.

#### **MHPAEA-SPECIFIC COMMENTS:**

##### **Define the coverage parity requirement.**

Health insurers and employers often offer beneficiaries an array of health plans to choose between. These health plans may have very different coverage of medical/surgical and behavioral health benefits, different financial limitations such as deductibles and co-payments, and different designs of in-network and out-of-network providers. The unique care settings of behavioral health care can make it challenging to implement parity in benefit plan designs. The parity requirement in the law is "no more restrictive than the predominant financial requirement (or treatment limitation) applied to substantially all medical and surgical benefits". It

is important to ensure that the comparison of care is made between similar aspects of coverage. For example, outpatient is compared to outpatient and inpatient to inpatient. This clarification also needs to be made for out-of-network coverage. Some employers offer employees a choice between multiple health plans but contract with a single behavioral health vendor whose benefits are “carved-out” from the medical/surgical benefit. This issue is vague is the new law so guidance is needed To what standard are health plans and employers held in these instances?

**Clarify that employers/plans can choose the diagnosis covered.**

MHPAEA does not mandate coverage of mental health or substance use disorder benefits. It allows employers/plans to choose what mental health conditions and substance use disorders that they will cover and whether they will cover no mental health or substance use disorders at all. Is a plan required to cover a full continuum of services for alcohol and drug use disorders, if it covers a full continuum of services for medical conditions under the medical/surgical benefit? Also, it is important to reinforce that employers, through contracted health benefit plans, decide what diagnosis to cover and not cover. The ability to choose the diagnosis covered impacts the cost of providing parity.

**Confirm that the law allows for management of the benefit and does not require “parity” in the management of the benefit.**

MHPAEA uses the words “terms and conditions of the plan or coverage” to allow for the management of the benefit. The intent of the parity requirement was for it to apply to financial and treatment limitations not the management of the benefit. Managed care is what makes parity affordable for employers. There are unique clinical differences between behavior health disorders and medical and surgical conditions which make equitable management of these benefits unrealistic and costly. The Office of Personnel Management (OPM) has recognized the need for flexibility in the Federal Employee Health Benefit Plan (FEHBP) implementation of MHPAEA in 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.”

**Confirm that separate but equal deductibles and out-of-pocket maximums are an option.**

In the financial requirements section of the law it states “there are no separate cost-sharing requirements that are applicable only with respect to mental health or substance use disorder benefits”. The business and insurance community understands the intent of this language to mean that there cannot be cost-sharing or a financial requirement that is applicable to mental health and substance abuse and not have an equal one for medical/surgical benefits. Separate but equal deductibles and out-of-pocket maximums are current practice and the regulation for the 1996 law specifically allows for separate but equal annual and lifetime limits. There is concern that single deductibles will be costly to track and administer.

How can employers that provide multiple health plans with multiple and very different benefits, cost-sharing, deductibles and co-pays meet MHPAEA’s

requirements? Can employers offer multiple health plans and a single carve-out behavioral health plan?

**Confirm that the law does not require coverage of all evidence-based treatments.**

The MHPEAE definition of treatment limitation includes the language “or other similar limits on the scope or duration of treatment”. We are concerned that this language could be misconstrued in that employers must cover all evidence-based treatments for the diagnosis they choose to cover. We do not believe this was the intent of the legislation and we do not believe that actual treatments are “similar” to the number of visits or days of coverage. In addition, the definition of mental health benefits states that services for mental health conditions are defined under the terms of the plan and in accordance with applicable Federal and State law (i.e. the plan decides what services, or treatments, it covers). Also, the medical/surgical side does not require coverage of all evidence-based treatments. It is possible that this provision could result in increased costs if regulators decide to require coverage of all evidence-based treatments.

However, we recommend quality of care measures to be developed and implemented by plans to encourage the use of established best practices and to identify patients who are not receiving appropriate care.

**Clarification of Prescription Drug Coverage.**

Plans are not obligated by MHPEAE to provide mental health and substance use disorder benefits. The Act only applies to a plan that provides both medical and surgical benefits and mental health or substance use disorder benefits. Assuming that the plan offers both of these types of benefits, the question can be raised whether the Act applies to medications. The text of the legislation does not specifically address coverage of medications. Does MHPAEA require plans to cover medications that treat mental health and substance use disorders at the same level as medication coverage for medical and surgical conditions?

**Clarification of Size and Cost Exemption.**

Do small employers with not more than fifty employees need to formally file for a parity coverage exemption? MHPAEA also needs to be clearer on the process for filing a cost exemption. Our questions include: how should an employer file? What is the time frame for filing? what is the process for filing an exemption?, will model forms be provided for filing?

**Clarification of HIPAA Preemption.**

MHPAEA uses the Health Insurance Portability and Accountability Act (HIPAA) preemption standard. What will be the process for determining which state laws are and are not preempted?

**Clarification of Applicable Carve-out Entities.**

Some large employers offer employees a choice between multiple health plans but contract with a single behavioral health vendor whose benefits are “carved-out” from the medical and surgical benefit. With mental health and substance addiction benefits included, this could be administratively burdensome and nearly impossible for vendors trying to track co-payments and deductibles across multiple plans.

Health plan cooperation would be absolutely essential. Clarification is needed regarding MHPAEA applicability to carve-out vendors. To what standard are health plans and employers held?

**Clarification of Applicability to Medicaid**

Clarification is needed as to whether or not MHPAEA’s “no more restrictive” standard applies to Medicaid managed care plans. Does MHPAEA require that Medicaid managed care plans provide mental health and substance use treatment services that are comparable to medical and surgical services, even when the full range of services are not reimbursable under the States' Centers for Medicare and Medicaid Services (CMS) approved state Medicaid plans? Must States reimburse Medicaid managed care plans for mental health and substance use treatment services that are not included in state Medicaid plans or CMS approved waivers?

**Request no penalty for acting in good faith.**

Because the final MHPAEA regulations will be issued late in 2009 and many self-insured employers will have either already filed with the state or finalized health plans with beneficiaries, it would be helpful to not apply the financial penalty if an employer or plan can show that it acted in good faith in implementing the law. It also makes sense for the Agency to specify the actions that qualify as acting in good faith by employers. Furthermore, we are requesting that employers that have acted in good faith not have to make changes to the plan mid-year. Employers do not have the resources to re-review selected plans and to change a benefit package in the middle of a benefit cycle. This would be a costly and burdensome requirement.

I appreciate the consideration extended to our comments and concerns regarding implementation of MHPAEA. If there are questions, please feel free to contact me directly at [awebber@nbch.org](mailto:awebber@nbch.org) or 202.775.9300.

Sincerely,



President and Chief Executive Officer  
National Business Coalition on Health

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<sup>i</sup> D. Shern, K Beronio, H.T. Harbin-“ After Parity-What’s Next:” *Health Affairs*, Volume 28, no. 3 (2009): 660-662.