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May 3, 2010

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

Submitted via the Federal eRulemaking Portal

Dear Sir or Madam:

The Association of Federal Health Organizations ("AFHO") appreciates this opportunity to provide comments on the HHS Interim Rule implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") published at 75 Fed. Reg. 5,410 (February 2, 2010) (the "Rule"). AFHO is a national association of Federal Employees Health Benefits ("FEHB") fee-for-service plan carriers. AFHO's member organizations sponsor FEHB plans that provide health benefits to over three million federal and postal employees and annuitants.[1]

MHPAEA requires parity between mental health or substance abuse ("MH/SA") benefits[2] and medical/surgical benefits with respect to quantitative financial requirements and treatment limitations under group health plans ("GHP") and health insurance coverage offered under a GHP. A FEHB plan is a GHP for purposes of MHPAEA and this Rule. The Rule applies to plan years beginning on or after July 1, 2010, which creates a January 1, 2011 effective date for plans under the FEHB Program.

FEHB plan carriers must file their 2011 benefit and rate proposals with the U.S. Office of Personnel Management ("OPM") by May 31, 2010. In order to engage in this process, FEHB plan carriers must anticipate and incorporate mandatory changes that affect rates and benefits, such as those

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[1] AFHO's members include American Foreign Service Protective Association, American Postal Workers Union, Compass Rose Benefits Group, Government Employees Health Association, Mail Handlers Benefit Plan, National Association of Letter Carriers Health Benefit Plan, National Rural Letter Carriers' Association, Panama Canal Area Benefit Plan, Special Agents Mutual Benefit Association, and Associate Member Blue Cross Blue Shield Association. AFHO members reserve the right to comment individually on this interim regulation.

[2] While the Rule refers to "substance use disorders," these comments will refer to "substance abuse conditions."

required by the MHPAEA. OPM seeks to complete these negotiations by mid-August 2010. 5 C.F.R. § 890.203(b). Consequently, we would appreciate resolution of the following issues as soon as possible:

- Reevaluation and redefinition of the "predominance" and "substantially all" standards to address the anomalies created by the Rule that result in a lack of parity caused by the tests set forth in the Rule;
- Elimination of the prohibitions concerning "nonquantitative treatment limitations;"
- Recognition of OPM's established regulatory disputed claims process as MHPAEA compliant; and
- Removal of the combined deductible requirements.

* * * * * * * * * *

The MHPAEA became applicable to the FEHB Program on January 1, 2010. In OPM's April 20, 2009, call letter for 2010 benefit and rate proposals,[3] OPM required FEHB plans pursuant to the MHPAEA "to apply equivalent (or no more restrictive) financial requirements (coinsurance, co-payments, deductibles and out-of-pocket maximums) and treatment limitations (visit and day limits) to both out-of-network medical and surgical benefits and out-of-network mental health or substance use disorder benefits" (p. 4). OPM explained that

- In-network financial requirements and treatment limits for medical and surgical services should be the same as those applied to in-network mental health or substance use disorder benefits.
- Out-of-network financial requirements and treatment limits for medical and surgical services should be the same as those applied to out-of-network mental health or substance use disorder benefits.

Id. OPM permitted FEHB plans to 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" (p. 5). OPM did not require parity in managed care practices. OPM "strongly encourage[d} FEHB plans to offer combined deductibles and catastrophic limits which include expenses for both medical and surgical and mental health and substance use disorder services and you should provide a reasonable explanation and justification for not doing so." *Id.*

FEHB plans implemented OPM's guidance for the 2010 contract year, and until HHS, the Labor Department, and the Internal Revenue Service (the "Departments" or the "regulators") released the interim rules on February 2, 2010, FEHB plans expected that they had achieved compliance with the MHPAEA.

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[3] A copy of that letter is available at this OPM website -- http://www.opm.gov/carrier/carrier_letters/2009/2009-08.pdf

The Rule, however, has upended the FEHB Program's successful mental health parity program by

- Creating implementation standards that simply do not create parity and are mathematically unsupportable; and
- Imposing an unanticipated restriction on non-quantitative treatment limitations which interferes with FEHB plans' effective managed care practices.

We ask the regulators to remedy these problems and address the issues outlined above as explained below. Further, we support the regulators' decision not to address the scope of services.

A. The Parity Tests set forth in the Rule Create Anomalies That Contradict the MHPAEA's Parity Goals

The MHPAEA provides that GHPs must ensure that

> financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits;

42 U.S.C. 300gg–5(a)(3)(A)(i).

While Congress framed MHPAEA from a global perspective, the regulators took a very granular approach to implementing the law in the Rule. In an effort to apply this statutory provision, the Rule states that if a particular type of financial requirement (copayment, coinsurance, etc.) or quantitative treatment limit (e.g. visit or treatment limit) does not apply to at least two-thirds of the medical-surgical benefits in a benefit classification, that type of requirement or limit is not "predominant" and therefore may not be applied to MH/SA benefits in that classification. 45 C.F.R. § 146.136(c)(3)(i)(A).

This "predominance" standard can be applied to financial requirements that co-exist, such as deductibles, coinsurance, and quantitative treatment limitations. However, the "predominance" standard breaks down when applied to financial requirements that are mutually exclusive, such as copayments and coinsurance.

It is a common health plan design to include both copayments and coinsurance under one of the MHPAEA's benefit classifications, e.g., in-network, outpatient treatment. It is mathematically impossible for two mutually exclusive types of financial requirements to apply to two-thirds of the medical/surgical benefits. In fact, it is quite possible that neither mutually exclusive financial requirement will reach the two-thirds threshold.

By way of example, if both coinsurance and copayments apply for in-network, outpatient benefits, it would be impossible for two-thirds of the benefits to be copayment related AND for two-thirds of the benefits to be coinsurance related because the total would then be four-thirds of the benefits, exceeding 100% of the benefits. Therefore, true

definitional parity cannot be achieved with this Rule, whereby coinsurance and copayments could both apply as they do for medical/surgical benefits. If a copayment applied for doctor's visits and coinsurance applied for lab work for medical/surgical in-network, outpatient benefits, the same could NOT apply to MH/SA benefits, contradicting the purpose and intent of parity. Either a copayment for doctor's visits and lab work, or a coinsurance for doctor's visits and lab work would have to apply, resulting in a lack of parity and what appears to be an unintended result of the implementing Rule.

Furthermore, since the methodology laid out in the Rule includes services that have no cost sharing, and applies to a broad spectrum of outpatient services, often any one method may be precluded from representing two-thirds of the total plan payments. For example, plans may have a distribution of in-network outpatient services in which 25% have no cost sharing, 25% have copayments and 50% are subject to deductible/coinsurance. Yet, applying the Rule as drafted, no cost-sharing or copayments could be applied to MH/SA benefits. The Rule, if followed literally, thus has the potential to greatly increase a plan's MH/SA costs if health plans are required to pay outpatient benefits at 100%, with no member responsibility, because in the same benefit category no one financial requirement meets the requisite threshold.

These examples illustrate a key defect in the Rule. In contrast to OPM's 2010 call letter guidance, the Rule does not allow plans to mirror the quantitative financial requirements and quantitative treatment limitations of their medical/surgical benefits with their MH/SA benefits. The definition of parity is the quality or state of being equal or equivalent. To achieve parity, we ask that the Rule be revised to reflect a global – as opposed to a granular -- approach to implementing this law, substantially similar to OPM's 2010 call letter guidance, so that parity can be achieved without these anomalous results. To remedy this problem, plans should be permitted to evaluate benefits under the substantially all and predominance standards by evaluating on a financial requirement by financial requirement basis (i.e., copayment to copayment; coinsurance to coinsurance) to avoid the unintended results created by the Rule.

B. <u>The Rule's non-quantitative treatment restriction should be discarded.</u>

The FEHB Program's successful mental health parity program permits carriers to use stronger medical management techniques on MH/SA benefits vis a vis medical/surgical benefits. OPM's approach reflects the fact that medical/surgical care and mental health/substance abuse care management simply cannot be compared "apples to apples".

The MHPAEA Rule undermines the effectiveness of medical management by prohibiting discrimination in the application of "nonquantitative treatment limitations," such as medical management standards, prescription drug formulary design, standards for provider admission to participate in a network, determination of usual, reasonable and customary amounts, step therapy, and conditioning benefits on completing a course of treatment. 45 C.F.R. § 146.136(c)(4)(ii). In our view, this limitation conflicts with the MHPAEA and therefore should be discarded.

Valid regulations must be consistent with the statute under which they are promulgated. *United States v. Larionoff*, 431 U.S. 864, 872 (1977). The MHPAEA states that GHPs must ensure that

> **treatment limitations** applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate **treatment limitations** that are applicable only with respect to mental health or substance use disorder benefits.

42 U.S.C. 300gg–5(a)(3)(A)(ii) (emphasis added) The MHPAEA defines "treatment limitation" by reference to **quantitative measures** as follows:

> The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

42 U.S.C. 300gg–5(a)(3)(D). The MHPAEA makes no mention of the nonqualitative treatment limitations introduced by the Rule. In our view, the regulators' decision to expand the term "treatment limitation" beyond the quantitative measures specifically encompassed by the MPHAEA flatly conflicts with the statute and should be reversed.

C. <u>The Scope of Services / Continuum of Care should not be regulated</u>.

The regulatory preamble explains that the Departments did not regulate on this scope of services or continuum of care issue:

> The Departments recognize that not all treatments or treatment settings for mental health conditions or substance use disorders correspond to those for medical/surgical conditions. The Departments also recognize that MHPAEA prohibits plans and issuers from imposing treatment limitations on MH/SA benefits that are more restrictive than those applied to medical/surgical benefits. These regulations do not address the scope of services issue. The Departments invite comments on whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a GHP or health insurance coverage.

75 Fed. Reg. at 5,416-17.

In our view, the MHPAEA prohibits FEHB plans from imposing treatment limitations -- as statutorily defined -- on MH/SA benefits that are more restrictive than those applied to medical/surgical benefits. MHPAEA's statutory definition is limited to quantitative treatment limitations and therefore may not be expanded to reach the continuum of care. Indeed, the MHPAEA does not require a plan to even cover MH/SA care.[4]

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[4] Source CMS website -- http://www2.cms.gov/HealthInsReformforConsume/04_TheMentalHealthParityAct.asp which states that

D. OPM's Disputed Claims Procedures Should be Recognized as MHPAEA Compliant

The preamble to the Rule, explains that

> MHPAEA also provides that the reason for any denial under a GHP (or health insurance coverage) of reimbursement or payment for services with respect to MH/SA benefits in the case of any participant or beneficiary must be made available, upon request or as otherwise required, by the plan administrator (or the health insurance issuer) to the participant or beneficiary in accordance with regulations. These regulations clarify that, in order for plans subject to ERISA (and health insurance coverage offered in connection with such plans) to satisfy this requirement, disclosures must be made in a form and manner consistent with the rules for GHPs in the ERISA claims procedure regulations, which provide (among other things) that such disclosures must be provided automatically and free of charge. **In the case of non-Federal governmental and church plans (which are not subject to ERISA), and health insurance coverage offered in connection with such plans, these regulations provide that compliance with the form and manner of the ERISA claims procedure regulations for GHPs satisfies this disclosure requirement. The Departments invite comments regarding any additional clarifications that would be helpful to facilitate compliance with MHPAEA's disclosure requirements regarding denials of MH/SA benefits.**

75 Fed. Reg. at 5,417 (emphasis added). We ask that the Rule be clarified to state that FEHB plan compliance with the form and manner of the OPM claims procedures regulations and related instructions satisfies this disclosure requirement for FEHB plan carriers.

FEHB plans meet ERISA's definition of employee welfare benefit plans but are exempt from ERISA as governmental plans. 29 U.S.C. §§ 1002(a)(1), 1003(b)(1). Instead, FEHB plans are regulated under the FEHB Act, 5 U.S.C. Chap. 89. Pursuant to the FEHB Act, 5 U.S.C. §§ 8902(j), 8913, OPM has issued its own FEHB claim procedure regulations at 5 C.F.R §§ 890.105, 890.107 and 48 C.F.R § 1652.204–72. In the 2010 call letter (see note 3), OPM expressly instructed carriers that

- Plans must make information available to current or potential enrollees or contracting providers upon request, regarding the criteria used for making medical necessity determinations related to mental health or substance use disorder benefits.
- The reason for any denial of benefits, reimbursement, or payment for services must be made available to enrollees upon request.

"MHPAEA does NOT require large GHPs and their health insurance issuers to include MH/SUD benefits in their benefits package."

OPM's detailed and established claim procedure regulations and guidance should be deemed to satisfy MHPAEA's disclosure requirements in the same manner as ERISA's claim procedure regulations.

E. The Combined Deductible Prohibition Should Be Removed

The preamble to the Rule discusses the options considered by the regulators with respect to separately accumulating deductibles and combined deductibles. In the preamble, the regulators noted that:

> The provisions of the statute imposing parity on financial requirements and treatment limitations do not specifically address this issue: the language of the statute can be interpreted to support either position.

75 Fed. Reg. 5415. The regulators noted that commentators in favor of separately accumulating deductibles asserted that "the projected cost of converting systems to permit unified deductibles would be extremely high for the many plans that use a separate managed behavioral health organization (MBHO)." *Id.* (footnote omitted). The Departments, after again acknowledging that "the statutory language does not preclude either interpretation," found that "prohibiting separately accumulating financial restrictions and quantitative treatment limitations is more consistent with the policy goals that led to the enactment of MHPAEA" and required that deductibles be combined. *Id.* at 5415-16.

We would acknowledge that the Departments believe the costs to be lower than some predicted, but point out that there are still increased costs associated with their interpretation that do not seem warranted, particularly based upon the Department's view that the law can be read not to require combined deductibles.

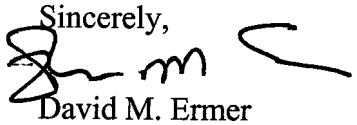
For many plans, a mandated combined medical/surgical and MH/SA deductible presents complicated and expensive issues and challenges, as noted in comments previously submitted and reflected in the Preamble.

In addition, the Workgroup for Electronic Data Interchange (WEDI) has resumed their initiative to standardize health identification cards. These standards will allow the healthcare industry to more easily promote network development and interoperability. The goal is to develop a machine-readable health identification card that has the potential of optimizing the confirmation of benefit process between the provider and the health insurer. The card would be able to accurately capture the patient's eligibility information and the health insurance benefit, including a "real time" deductible and patient out-of-pocket costs. The combined deductible for medical/surgical and MH/SA benefits would be a stumbling block for the transmission of an accurate real time deductible and works

against trends in electronic data transmission in health care. Accordingly, we ask that the Departments reconsider their position on this issue and permit separately accruing deductibles.

Thank you for your consideration of these comments.

Sincerely,



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