May 28, 2009

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

Re: Comments on the Mental Health Parity Act – Request for Information

Dear Sir / Madam:

The American Benefits Council (the "Council") and the U.S. Chamber (the "Chamber") appreciate the opportunity to respond to the Request for Information ("RFI") regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Act"). 74 Fed. Reg. 19155 (April 28, 2009). We understand from the RFI, that a response submitted to one agency will be shared with the other agencies of jurisdiction ("Agencies").

We are filing these detailed comments with the Agencies at this early stage of the rulemaking to ensure that the collective voice of our member companies is heard in the event the Agencies issue Interim Final Regulations, rather than a Notice of Proposed Rulemaking, by or before October 3, 2009, the Act's effective date.

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly, or provide services to, retirement and health plans that cover more than 100 million Americans.

The Chamber is the world's largest business federation, representing more than three million businesses of every size, sector and region. More than 96 percent of the

Chamber's members are small businesses with 100 or fewer employees, 71 percent of which have 10 or fewer employees, yet virtually all of the nation's largest companies are also active members.

Our members strongly believe in the value of such coverage for employees and employers and their health benefits plans typically include mental health and substance abuse coverage. As key stakeholders directly impacted by the mental health parity rulemaking, we are committed to assisting the Agencies in developing reasonable and administrable guidance for the provision of mental health and substance use disorder benefits provided to group health plans. Our specific comments are set forth below.

Adopt a Non-enforcement Policy or Good Faith Compliance Period

We recommend that the Agencies adopt a non-enforcement policy or good faith compliance period for the first plan year for which the Act applies to any particular plan.

The Act is generally effective for plan years beginning after October 3, 2009. It is our understanding that the Agencies may issue interim final regulations by that date, but not in time to provide guidance to plan sponsors who are currently making decisions regarding plan design and contractual arrangements in order to be ready for fall open enrollment season. As a result, employers will not have sufficient time to modify their group health plans in compliance with agency guidance issued this year. In the absence of guidance, our members have had to make judgments on a range of ambiguous implementation issues. This uncertainty weighs strongly in favor of a non-enforcement policy or good faith compliance period for at least one year following the Act's effective date.

It is well-established that the Agencies have the discretion to modulate their enforcement approach in the initial years of the Act and to formally promulgate such a policy. Importantly, the Agencies adopted a similar approach after the first Mental Health Parity Act was passed, and agencies frequently adopt such policies.[1] A non-enforcement policy or good faith compliance period would allow group health plan sponsors the necessary time to appropriately and adequately implement the Act's new requirements without fear of unfair litigation and enforcement actions.

Clarify the Effective Date for Plans with Union and Non-Union Employees

We recommend that the Agencies clarify the effective date for a plan covering both union and non-union employees. The Act includes a special rule for collectively

[1] See, e.g., Mental Health Parity; Interim Rules HIPAA Mental Health Parity Act; Proposed Rule, 62 Fed. Reg. 66931, 66956 (Dec. 22, 1997); Health Insurance Reform: Modifications to the Electronic Data Transaction Standards and Code Sets, 68 Fed. Reg. 8381, 8384 (Feb. 20, 2003); Technical Release No. 92-01, DOL Enforcement Policy for Welfare Plans with Participant Contributions (May 28, 1992).

bargained plans. In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of enactment (October 3, 2008), the Act shall not apply to plan years beginning before the later of (1) the date on which the last collective bargaining agreements relating to the plan terminates, or (2) January 1, 2010.

Where a plan covers both collectively bargained and non-collectively bargained employees, we request clarification that whether the extended effective date for collectively bargained plans is applicable may be determined based on all the facts and circumstances. For example, where a majority of plan participants are union employees, the extended effective date may apply. On the other hand, where only a few plan participants are subject to a collective bargaining agreement, then the general effective date may apply to the plan as a whole.

Expand the Cost Exemption to Permit Actuarial Projections

Under the cost exemption, if the application of the Act with regard to a particular group health plan results (after six months) in an increase for the plan year of the actual total cost of coverage (including medical/surgical benefits and mental health/substance use benefits) of 2% in the first plan year and 1% in subsequent plan years, then the plan is exempt from the parity requirements under the Act for one year (the second plan year).

One possible reading of the Act would be to require plans with an increase in total cost in excess of 2% in the first plan year to again comply with parity requirements under the Act in the third year, exempting the plan from the parity requirements for only the second plan year. If the increase in total cost of coverage attributable to the application of the parity requirements is more than 1% in the first six months of the plan year, then the plan would again be exempt from the parity requirements of the Act during the fourth plan year, but would have to comply with the parity requirements once again in the fifth plan year, and so on.

It would be extraordinarily difficult for employers to administer this exemption and extraordinarily difficult for participants to understand a group health plan that shifts in and out of compliance each plan year with the Act's parity requirements. As such, we request guidance that provides that, once the cost exemption is met by a particular plan, an actuary can make a projected determination of total cost of coverage for subsequent plan years. Otherwise, as a practical matter the cost exemption will be unavailable to employers and employers will be more likely to drop mental health and substance use coverage altogether, rather than provide a more limited benefit pursuant to the exemption.

Confirm that Classification of a Mental Health Condition is Determined by the Sponsor of a Group Health Plan as a Matter of Plan Design.

The regulations should confirm that the classification of a mental health or substance use disorder is a matter of plan design as determined by the plan sponsor. Early versions of the Act would have required that group health plans use the DSM-IV to define mental health and substance use disorders. Congress, however, ultimately rejected that approach and provided that mental health and substance use disorder benefits are defined as benefits with respect to services for mental health or substance use disorder conditions (as applicable) as defined under the terms of the plan and in accordance with applicable federal and state law. See ERISA §712(e)(4) & (5). This reflects Congress' clear intent that plan sponsors (and insurers) have the flexibility to classify disorders as either medical or mental health conditions in their plan documents, so long as there is scientific or medical support for the classification and the classifications are not designed to circumvent the parity requirements (e.g., by classifying a condition that is clearly a mental health condition, such as depression, as a medical condition).

Confirm that Plans May Exclude Certain Conditions, Treatments, Providers and Treatment Settings as a Matter of Plan Design

As noted above, the Act provides that mental health and substance use disorder benefits are defined as benefits with respect to services for mental health or substance use disorder conditions (as applicable) as defined under the terms of the plan and in accordance with applicable federal and state law. See ERISA § 712(e)(4) & (5). Based on this language, the regulations should make clear that:

- group health plans are permitted to exclude coverage for a particular mental health or substance use condition,
- group health plans are permitted to exclude coverage for a particular inpatient or outpatient treatment or treatment setting with respect to a mental health or substance use condition that is otherwise covered so long as there are meaningful other treatments available for that mental health or substance use condition (this would be consistent with typical provisions for medical and surgical coverage where a medical and surgical condition is generally covered, but certain treatments, settings or providers are excluded); and
- group health plans are permitted to exclude coverage for treatment settings or providers where licensure requirements are not satisfied.

Clarify that Parity Can Be Determined Based on Categories of Services.

The Act prohibits group health plans that provide medical and surgical benefits and mental health or substance use disorder benefits from applying financial requirements or treatment limitations that are more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and

surgical benefits. ERISA § 712(a)(3)(A). The Act does not define the term "substantially all."

Notably, the 1996 Mental Health Parity Act used the term "substantially all" with respect to annual and lifetime limits. The term was interpreted in subsequent regulations which provided useful guidelines in the context of parity in annual or lifetime limits. See 29 C.F.R. § 2590.712(b). We recommend that future guidance retain the current guidelines for annual or lifetime limits, but clarify the meaning of substantially all for purposes of financial requirements and treatment limits. We believe a similar method (i.e., one that focuses on the dollar amount or costs based on actual claims experience or reasonable actuarial estimates) should be used to determine if a treatment limitation or financial requirement applies to substantially all medical and surgical benefits.

We further recommend clarification that parity of treatment limitations and financial requirements for mental health or substance use disorder benefits with those for medical and surgical benefits be based on a comparison of similar benefits. In particular, we believe that it is appropriate to analyze treatment limits based on the same categories of services that are generally available for treatment of medical and surgical conditions as well as mental health and substance use disorder conditions.

As such, a plan should be permitted to compare inpatient days for medical and surgical benefits with inpatient days for mental health and substance use disorder benefits; outpatient visit limits for medical and surgical benefits with outpatient visit limits for mental health and substance use disorder benefits; and so on. Additionally, we request that the guidance provide flexibility in allowing plan sponsors to determine the categories of services for parity purposes. Adopting this interpretive approach ensures parity between treatment categories, which is consistent with the overall objectives of the Act.

Confirm that the Parity Requirements Continue to be Applied Separately to Different Benefit Package Options

Section 712(d) of ERISA provides that, where a group health plan offers two or more benefit package options under the plan, the parity requirements are applied separately to each benefit package option. This provision was unchanged under the Act and existing regulations confirm that the parity requirements apply separately to each benefit package. Existing regulations provide examples of a group health plan that offers two or more benefit packages, including a group health plan that offers employees a choice between indemnity coverage or HMO coverage and a group health plan that provides one benefit package for retirees and a different benefit package for current employees. 29 C.F.R. § 2590.712(c). Since Section 712(d) was not amended by the Act, we are requesting confirmation that the parity requirements continue to be applied separately to different benefit package options.

Clarify the Application of the Parity Requirements to Employee Assistance Programs ("EAPs")

Employers offer a variety of EAPs to their employees. Some EAPs offer more substantive medical, mental health and substance use services, while other programs offer more non-personalized, typically referral-only services. The Department of Labor has issued guidance that indicates that non-personalized, referral-only EAPs are not benefit plans subject to ERISA, but programs that deliver more personalized treatment are subject to ERISA. See , e.g., DOL Adv. Op. 91-26A (July 19, 1991); DOL Adv. Op. 88-04A (Mar. 11, 1988).

EAP programs are delivered differently than typical medical benefits. EAPs are generally offered as a separate benefit that is not part of the employer's medical plan, typically under a separate agreement with a separate service provider and with a separate set of eligibility rules and contribution requirements. The EAP may be offered as part of a comprehensive ERISA health and welfare plan, or as a stand alone non-ERISA benefit to all employees.

Compliance with the Act will be virtually impossible if the provision of limited mental health or substance use benefits under an EAP must be compared with the medical benefits provided under the employer's medical benefit option. It would discourage EAP programs from being offered and discourage the provision of these limited mental health and substance use programs.

We seek the following clarifications regarding the treatment of the various types of EAPs for purposes of application of the parity requirements:

- If an EAP is not a welfare benefit plan subject to ERISA, we request confirmation that such an EAP is exempt from the requirements of the Act.

- In the event the EAP is an ERISA benefit, to the extent it is offered separate from the employer's major medical benefit and pursuant to a separate contractual arrangement, we request that the EAP be considered a limited, excepted benefit under ERISA §732(c)(1), as defined in ERISA §733(c)(2)(C), that is not subject to the Act. In such circumstances, the EAP would be a limited benefit and it would not be an integral part of the plan and, as such, should qualify as an excepted benefit. Similar to health flexible spending accounts, which are group health plans that are considered excepted benefits (if certain requirements are met)[2], many EAPs do not offer significant medical benefits and are not integral to the employer's medical plan.

[2] 62 Fed. Reg. 67687 (Dec. 29, 1997).

- Where an EAP is an ERISA benefit, and it does not qualify as an excepted benefit, we request confirmation that the EAP is not compared with the plan's medical benefits for parity purposes, so long as the EAP is separate benefit from the medical benefit offered by the employer (e.g., with distinct eligibility rules -- such as automatic enrollment, no employee contributions -- or offered through a separate vendor). In other words, the EAP and the medical benefit would be treated as different benefit package options to be analyzed separately under the parity requirements. Treatment limits and financial requirements applicable to mental health benefits offered under the EAP would be compared against the medical benefits offered under the EAP, if any, not against the medical benefits offered under the medical plan. If there are no medical benefits offered under the EAP, the imposition of treatment limits or other limits on the mental health or substance use disorder benefits offered under the EAP would not violate parity.

Confirm that Parity is Not Required for Medical Management Tools

We request guidance confirming that the Act does not preclude group health plans from employing medical necessity provisions, precertification requirements or other medical management tools for mental health or substance use disorder benefits and that such tools need not be the same as those used for medical and surgical benefits covered under the plan.

The Act explicitly imposes parity requirements with respect to treatment limitations and financial requirements, as well as out-of-network coverage. The Act does not, however, expressly extend parity requirements to medical management techniques. In fact, the Act includes a rule of construction that states that nothing shall be construed as affecting the terms and conditions of the plan or coverage to the extent that the plan terms and conditions do not conflict with the Act's parity requirements. ERISA § 712(b).

Since there is no explicit parity requirement for medical management in the Act, none should be implied in regulatory guidance by the Agencies. We further note that the Act requires plans to disclose, upon request or as otherwise required by law, criteria used to make medical necessity determinations and the reasons for any denial of reimbursement for services. This provision indicates that Congress was aware of medical management tools, and rather than impose parity mandate, imposed a disclosure requirement on such practices.

Additionally, we request guidance that plans are permitted to impose the customary consequences for failing to satisfy medical management requirements. For example, a typical consequence of failing to obtain a preauthorization is that a particular treatment is not covered or the participant is required to pay an additional cost for the treatment. These consequences are an integral part of the medical management tool permitted by

the Act and should not be considered to be financial requirements or treatment limits subject to the parity requirements.

Confirm that Separate Deductibles are Permitted

We request guidance confirming that separate but equal deductibles are permitted under the Act. This issue involves the interpretation of the financial requirements parity provision, ERISA § 712(a)(1)(A)(i), which includes language that creates uncertainty regarding the ability of plans to impose separate but otherwise equal deductibles for medical and mental health benefits (e.g., each is subject to a $1,000 annual deductible).

We believe the provision permits plans to impose separate but equal deductibles for medical and surgical and mental health or substance use disorder benefits for several reasons. Importantly, the Act specifically defines the term financial requirements to include deductibles (and out of pocket expenses). ERISA § 712(a)(3)(B)(i). As such, the Act mandates parity between the deductibles that apply to medical and surgical benefits and the deductibles that apply to mental health or substance use disorder benefits. If separate deductibles were not permitted, then the requirement in the statute explicitly mandating parity in deductibles would have no meaning. Accordingly, we believe the Act permits separate deductibles for mental health (or substance use disorders) provided that the deductibles are no more restrictive than the deductibles applied to substantially all medical and surgical benefits covered by the plan.

This is a vitally important issue for many group health plans that offer mental health benefits through "carve-out" arrangements with behavioral health service providers that is different from the service provider used to administer the medical benefits, while still under the same group policy. In such circumstances, the recordkeeping between service providers are not typically coordinated and requiring the administration of a single deductible would result in a substantial and costly administrative burden to the plan.

Confirm that a Plan May Charge Specialist Copays for Mental Health Providers

A common plan design involves establishing lower copayments for patients who seek care from a primary care provider (e.g., internal medicine or a pediatrician) and higher copayments for patients that seek care from specialty providers. As a general matter, primary care physicians are the primary care providers for diagnosing and treating many common medical and mental health conditions. Where the primary care provider has insufficient expertise for the medical or mental health condition, they refer the patient to specialists. As such, group health plans should be permitted to classify all mental health providers as specialists and apply the plan's specialist co-pay to such providers, so long as any specialist co-pay assigned to mental health providers is no

more restrictive than the co-pays applied to substantially all of the plan's medical/surgical surgical specialists.

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We appreciate the opportunity to provide comments with respect to guidance implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Please do not hesitate to contact Kathryn Wilber at 202-289-6700 or kwilber@abcstaff.org with any questions or if we can be of further assistance.

Sincerely,

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American Benefits Council

Randel K. Johnson
Vice President, Labor, Immigration & Employee Benefits
U. S. Chamber of Commerce