



**American Hospital
Association**

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May 26, 2009

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-4140-NC, Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Request for Information (Vol. 74, No. 80), April 28, 2009

Dear Ms. Frizzera:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to respond to the request for information from the Centers for Medicare & Medicaid Services, Employee Benefits Security Administration and Internal Revenue Service (referred to as “the agencies” hereafter) on the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA).

The manner in which this landmark legislation is implemented will greatly impact access to and affordability of mental health and substance use disorder health benefits. This request for information takes an important step in making certain that implementation is complete, systematic and thoughtful. We have identified several areas where greater clarification is necessary, as well as certain policies that would help ensure that those who suffer from mental health and substance use disorders can obtain the care they critically need. Our detailed responses to those questions in which hospitals have an interest follow.



Question i: What policies, procedures, or practices of group health plans and health insurance issuers may be impacted by the MHPAEA? What direct or indirect costs would result? What direct or indirect benefits would result? Which stakeholders will be impacted by such benefits and costs?

Some health plans will likely aim to improve their networks of mental health and substance use-related providers prior to and after the effective date of the MHPAEA. While we welcome this effort, such actions in combination with bringing mental health and substance use disorder benefits to parity in general, could greatly increase demand for and utilization of these benefits, as well as plans' costs for these benefits. However, group health plans that experience certain cost increases as a result of the law – 2 percent for the first plan year and 1 percent for each subsequent plan year – can obtain exemptions from the law after they comply for one year. Therefore, those plans that incur such increased costs can obtain cost exemptions.

We are concerned that the mental health and substance use disorder health benefit structures of certain plans would then fluctuate significantly as they comply with and then obtain exemptions from the MHPAEA. This would cause substantial indirect costs and disruption in treatments and services for providers and, most importantly, for beneficiaries.

In addition, while the law requires plans that offer mental health and substance use disorder benefits to offer them at parity, it does not preclude employers from simply dropping plans that include these benefits. If plans experience increased costs and shift those costs to employers, it could lead employers to drop their mental health and substance use disorder health coverage, thereby decreasing access to these services.

We also are concerned that decreased access to mental health and substance use care could result from increased demand and utilization that occurs without a corresponding increase in providers. In 2008, when Massachusetts significantly expanded health coverage, we saw that demand, particularly for primary care, increased substantially and beneficiaries had major problems accessing care. While the implementation of the MHPAEA is not exactly analogous to Massachusetts' efforts, **we urge the agencies to carefully consider the potential for dramatic decreases in access to care as a result of increased demand and utilization and reductions in benefits, as discussed above. Beneficiaries who suffer from mental health and substance use disorders are among the most vulnerable Americans; if they cannot easily access necessary care, or if fluctuations in their health benefits occur each year, it will only exacerbate the large challenges they already face.**

Question ii: Are there unique costs and benefits for small entities subject to the MHPAEA (that is, employers with greater than 50 employees that maintain plans with fewer than 100 participants)? What special consideration, if any, is needed for these employers or plans? What costs and benefits have issuers and small employers experienced in implementing parity under state insurance laws or otherwise?

Small entities subject to the MHPAEA face unique challenges. They cover fewer participants and therefore have a substantially smaller “sample size.” For those entities that are subject to “experience rating” for their health insurance, this smaller sample size puts them at great risk because they are more vulnerable to aberrant events or circumstantial anomalies that occur among the participants they cover. This risk also exists for medical and surgical benefits, but is unique in relation to mental health and substance use benefits. While the law requires plans that offer mental health and substance use benefits to offer them at parity, it does not preclude employers from simply dropping this coverage all together. If small entities find their risk levels unacceptable, it could lead them to drop their mental health and substance use coverage. There are certain states that have addressed this problem by providing small entities with state funding if they have incurred costs above a certain threshold. While the agencies likely cannot do the same, **we urge them to carefully consider this unique challenge for small entities subject to the MHPAEA and look to states for possible solutions.** Again, individuals who suffer from mental health and substance use disorders are among our most vulnerable populations, and their access to necessary care should not be impeded.

Question 2: What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?

We have identified several areas where clarification and additional guidance and detail are necessary.

We request clarification as to the entities and types of benefits to which this law applies. While it is clear that the MHPAEA does not apply to Medicare, the law’s applicability to several other entities, such as Medicare employer-offered plans, Medicaid managed care plans, employee assistance plans and student health plans, is unclear. In addition, we would like clarification as to whether this law applies to “carve outs.” Employers often “carve out” mental health and substance use disorder health benefits and integrate them with employee assistance, disability and other benefits, all under a single vendor. Are “carve out” benefits subject to the MHPAEA?

The law also includes an exemption provision for group health plans that experience certain cost increases as a result of the law. To obtain this exemption, “a qualified and licensed actuary” must determine and certify a plan’s costs. However, it is not clear exactly what this means. **We request clarification as to the exact qualifications the actuary will need in order to satisfy the law.**

We request a more detailed definition of “parity” as it is used in the law.

Specifically, we would like the agencies to explicitly state that parity means “equal to *or better than*.” Certain employers have inquired as to whether or not they can have lower copayments for mental health benefits than for medical and surgical benefits, and we would like the agencies to make it abundantly clear that such benefits are acceptable.

We also would like more detailed definitions of other terms, including “no more restrictive than,” “predominant” and “substantially all.” For example, the law defines the “predominant” financial or treatment limit as “the most common or frequent” type of limit, but what is the unit of analysis? Does a plan determine the most common limit by counting the copayments for each distinct type of benefit as one (e.g., physician, inpatient hospital and outpatient hospital)? By looking at how often beneficiaries utilize each distinct type of benefit and its associated copayment? By another method? It would be extremely helpful if the agencies created a quantifiable definition of this term, as well as a quantifiable definition of the term “substantially all.” Similar additional guidance on the other terms also would be useful.

In addition, the law states that financial requirements and treatment limits for mental health or substance use disorder health benefits can be no more restrictive than the predominant financial requirements and treatment limits applied to substantially all medical and surgical benefits covered by the plan. However, we request clarification on how this comparison should be made. For copayments, for example, would each plan compare a certain medical and surgical benefit to its analogous mental health or substance use benefit and then apply that same or better copayment to the analogous mental health or substance use benefit? This approach seems to be the most appropriate method for making the comparison.

Some mental health and substance use treatment settings are not directly analogous to medical and surgical treatment settings. We request that the agencies provide a formal crosswalk that links medical and surgical benefits to their most analogous mental health or substance use benefits. Table 1 gives our suggestions of the most appropriate linkages. While this is not an all inclusive list of mental health and substance use services, it provides examples along the continuum.

Table 1: Suggested Linkages of Medical and Surgical Benefits to Their Most Analogous Mental Health or Substance Use Benefits

Medical and surgical benefit	Mental health or substance use benefit
Primary care physician visits	Psychiatrist visits
Inpatient general acute hospital treatments	Inpatient psychiatric hospital treatments
Outpatient hospital treatments	Partial hospitalization program Intensive outpatient program Electroconvulsive therapy treatments
Skilled-nursing facility treatments	Psychiatrically based residential treatments 3

In addition, this type of crosswalk would encourage plans to integrate their mental health and substance use disorder benefit and medical and surgical benefit structures into one benefit structure, where an inpatient hospitalization is simply considered an inpatient hospitalization, whether it is for psychiatric or general acute care. By no longer thinking of mental health and substance use and medical and surgical as two distinct types of health care benefits, we can make progress toward overcoming the stigma and discrimination often associated with mental health and substance use disorders.

We also request that the agencies clarify how plans will be required to treat deductibles under the MHPAEA. The financial requirements for mental health or substance use disorder benefits can be no more restrictive than the predominant financial requirements applied to medical and surgical benefits. However, under this provision, can plans continue to have separate deductibles for both mental health or substance use disorder benefits and medical and surgical benefits, as long as they are at parity? If this is the case, we urge the agencies to carefully consider what alternative protections they can provide to help ensure that this additional deductible does not impair beneficiaries' access to these critical mental health and substance use disorder benefits.

In regard to the preservation of state law under the MHPAEA, the current *Health Insurance Portability and Accountability Act of 1996* pre-emption standard will still apply. This standard is extremely protective of state law, and only a state law that "prevents the application" of the MHPAEA will be pre-empted, which means that stronger state parity and other consumer protection laws will remain in place. However, in many cases it is not clear whether a state law will be pre-empted. For example, there are certain state laws that address parity for mental health benefits, but do not address parity for substance use disorder benefits – what is the relation of the MHPAEA to this type of state law? **Therefore, we request the agencies provide guidance to the states on which state laws are and are not pre-empted.**

Question 6: Which aspects of the increased cost exemption, if any, require additional guidance? Would model notices be helpful to facilitate disclosure to federal agencies, state agencies, and participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption?

The law exempts group health plans that experience certain cost increases as a result of the law. When plans obtain this cost exemption, they do not have to comply with the provisions of the parity law. However, we urge the agencies to clarify that this exemption does not mean that these plans must stop offering mental health and substance use disorder benefits, but rather that they simply do not have to offer them at parity to medical and surgical benefits.

Plans must comply with the law for at least the first plan year in which the law applies because determinations are made after the first six months of the plan year involved, and the exemption applies for the following year. If a plan obtains an exemption for the second plan year, it will then have to comply with the law for the third plan year in order

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to obtain an exemption for the fourth plan year, and so on, because, again, determinations are made after the first six months of the plan year involved and the exemption applies for the following year. Therefore, the potential exists for certain plans to change their mental health and substance use disorder health benefit structures every other year as they obtain a cost determination and exemption in one year and then have the exemption in place for the next year. This cycle of compliance and exemption could put an undue burden on providers and cause significant and inappropriate disruptions to beneficiaries, as also discussed in response to “Question i,” above. **We urge the agencies to give careful consideration to the potential for such increased administrative burden and disruption.**

These cycles of compliance and exemption will likely increase plan costs; however, these increased costs should not be permitted to be included in the costs considered when seeking an exemption. In addition, given the substantial disruptions that these cycles could cause, **we ask the agencies to provide a detailed outline of the process by which plans will notify employers, providers and beneficiaries of the exemption, including the timeframes in which these notifications must be made.** We also urge the agencies to consider mandating that beneficiaries in plans that obtain an exemption for the following year must have an open enrollment period that will allow them to change plans for the following year.

Finally, model notices would be useful to facilitate disclosure of the plan’s election to implement the cost exemption. We thank the agencies for making this effort.

If you have any questions, please feel free to contact me or Joanna Hiatt, senior associate director for policy, at (202) 626-2340 or jhiatt@aha.org.

Sincerely,

Rick Pollack
Executive Vice President