

Mental Health Liaison Group

April 29, 2010

Internal Revenue Service
Department of the Treasury

Employee Benefits Security Administration
Department of Labor

Centers for Medicare and Medicaid Services
Department of Health and Human Services

Re: Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (published in 75 Fed. Reg. 5410 et seq.)

VIA EMAIL: E-OHPSCA.EBSA@dol.gov

To The Departments:

The Mental Health Liaison Group appreciates the opportunity to comment on the interim final rules (“IFR”) for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), as published in the February 2, 2010 Federal Register. For many years this coalition urged passage of federal legislation that would end health insurance benefits discrimination against people needing and seeking coverage for mental health and substance use disorder services. With passage of MHPAEA we believe that Congress has largely ended this discrimination, and we are particularly pleased that the IFR implements the law to its full extent.

1) We agree with and support the parity standard devised by the Departments as one that ensures that mental health and substance use benefits are not discriminated against in health plan benefit design.

We believe that the parity standard devised by the Departments fully and appropriately implements the statutory requirement in MHPAEA. Specifically, the IFR reflects the MHPAEA requirement that a group health plan that provides both medical/surgical and mental health/substance use disorder benefits must ensure that the financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than those requirements or limitations placed on medical/surgical benefits.

The Departments essentially keep in place the current parity standard, effective since 1998, as it applies to annual and lifetime dollar limits. We agree and support retention of this standard for annual and lifetime dollar limits.

National organizations representing consumers, family members, advocates, professionals and providers
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For all other financial requirements and quantitative treatment limitations, the Departments employ a two step test, based on the statutory language of MHPAEA. The first step is to determine whether the type of financial requirement or quantitative treatment limitation applies to substantially all—meaning two-thirds—of all medical/surgical benefits in a classification. If not, the requirement or limitation cannot be applied to mental health/substance use disorder benefits. If it is applied to substantially all medical/surgical benefits, then the second step is applied to determine the predominant level—meaning the level that applies to more than one-half of the medical/surgical benefits. The predominant level may be applied to mental health/substance use disorder benefits. This level may be reached by a combination of levels, the least restrictive of which is then applied.

This second step—applying the predominant level—is necessary for some financial requirements and treatment limitations. The Mental Health Parity Act of 1996 provided parity only for annual and lifetime dollar limits. These are relatively simple financial requirements imposed by health plans or coverage, since plans generally do not apply a limit or have a single limit for the entire benefit.

The concept of the “predominant” level was necessary to address the greater complexity associated with a broader range of financial requirements or treatment limitations, where there may be a number of varying levels associated with a particular financial requirement or treatment limitation. For example, while most health plans have a single lifetime limit that applies to its medical/surgical benefits, it may impose several levels of copayment requirements that are applied to various services, such as primary physician, specialty, chiropractic, physical therapy and various other services.

In implementation of the parity standard with regard to these more complex financial requirements and treatment limitations it is important to ensure that the predominant level is employed so that mental health and substance use services are compared to the prevailing or common financial requirements or treatment limitations imposed on medical/surgical services. Mental health and substance use disorder services should not be compared to outlier requirements or limitations that would, in essence, allow health plans to avoid the intent of the law. Application of the predominant standard as provided in the IFR addresses our concern and will provide parity in the application of these various requirements and limitations to mental health and substance use disorder services.

We also agree with the Departments’ determination of six discrete classifications of benefits in which parity is applied: inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency care and prescription drug coverage. It is reasonable and acceptable to compare inpatient-to-inpatient and outpatient-to-outpatient medical/surgical benefits with mental health/substance use disorder benefits for applying the parity standard to financial requirements and treatment limitations. This reflects the statutory language of MHPAEA, which distinguishes inpatient from outpatient coverage in general. In addition, the MHPAEA is intended to provide for benefits parity and not on a service-by-service basis. The six categories should allow health plans to apply parity appropriately without overburdening them with multiple classifications.

We also appreciate the specific provision in the IFR that applies the MHPAEA to out-of-network benefits, reflecting clear Congressional intent to apply parity to out-of-network services. This provision is particularly important for mental health professionals and their patients, since plan enrollees often seek mental health services out-of-network.

2) We agree with the Departments' determination that the MHPAEA prohibits health plans from applying separate deductibles, out-of-pocket maximums or other cumulative financial requirements on mental health/substance use disorder benefits.

We are pleased that the Departments have determined that, while the statutory language of MHPAEA is not as clear with regard to separate deductibles, out-of-pocket maximums and other cumulative financial requirements, Congress clearly intended to completely end benefits discrimination against mental health and substance use disorder services in enacting the law. Therefore, plans that apply separate, even if equal, deductibles, out-of-pocket maximums or other requirements on plan enrollees for mental health/substance use disorder services, when such requirements are not placed on other services, are engaging in a form of discrimination banned by the new parity law.

Separate deductibles and out-of-pocket maximums have represented a real burden to people with private health coverage who have sought treatment for their mental health and substance use disorders. These individuals and their families have had to meet separate and additional out-of-pocket costs, not imposed on physical health services, before gaining insurance payment for their mental health and substance use disorder treatment. As a result, separate deductibles and out-of-pocket maximums have been a barrier to care where individuals have had to forego care when they could not meet the separate requirements. Prohibiting separate cumulative financial requirements will dramatically improve access to mental health and substance use disorder services for individuals and their families who need and use mental health and substance use disorder services.

3) We agree with the application of the MHPAEA to nonquantitative treatment limitations and urges that this application be retained in the final rules.

As mentioned above, Congress clearly intended to end benefits discrimination upon enactment of the MHPAEA. We appreciate and support that the Departments have applied this Congressional intent to the limitations that health plans place on mental health and substance use disorder benefits that are not quantitative and yet limit the scope or duration of these benefits when compared to medical/surgical benefits.

Specifically, the IFR requires that a group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan, "...any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification, except to

the extent that recognized clinically appropriate standards of care may permit a difference.” This is a reasonable standard to apply to nonquantitative treatment limitations, requiring parity treatment of mental health and substance use benefits with medical/surgical benefits as a general rule while allowing differences only where clinically appropriate.

The illustrative list of nonquantitative treatment limitations to which the MHPAEA applies is also helpful since it includes some of the most common limitations that have been applied inequitably to mental health and substance use disorder services. Mental health professionals and the patients they serve will greatly benefit in the application of the law to the various nonquantitative treatment limitations provided in the IFR. Of course, applying the law to medical management standards that limit or exclude benefits based on medical necessity or appropriateness, or based on whether a treatment is experimental or investigative, will have the broadest favorable impact, and we support its inclusion in the list.

We recommend that the Departments clarify that the MHPAEA applies parity for scope of services, namely that a plan enrollee needing mental health or substance use disorder services is provided coverage for a full scope of services comparable to services for medical/surgical conditions. It is the clear intent of MHPAEA that limits on the scope and duration of benefits must be applied no more restrictively in the mental health and substance use disorder benefit than in the medical/surgical benefit. For this reason the Departments have abided by the intent of the law by requiring parity for nonquantitative treatment limitations, including as it applies to medical management and methods for determining usual, customary and reasonable charges. It is no less critical that the regulation address parity for scope of services. To fully address the spirit of the MHPAEA, the Departments should clarify this important aspect of parity for patients and providers.

How a plan determines usual, customary and reasonable charges can be complex and now under the IFR, if applied on a more restrictive basis, would violate the MHPAEA.

Usual, customary and reasonable charges are typically applied to out-of-network coverage. These charges drive the health plan and patient’s level of financial responsibility. If a plan is allowed to use an unequal formula and process between medical/surgical and mental health/substance use benefits when establishing these charges it can then create an unequal and greater financial requirement on the use of out-of-network mental health/substance use benefits. It is this type of disincentive placed on individuals seeking out-of-network mental health services that MHPAEA is meant to end. For this reason, we particularly support inclusion of this nonquantitative treatment limitation in the IFR.

We turn now to a third nonquantitative treatment limitation to which the MHPAEA would apply, regarding health plan standards for provider admission to participate on a health plan’s network. The Departments cite that approximately half of mental health care is delivered solely by primary care physicians (Wang, et al). As the Departments note, this trend is likely due in large part to discrepancies in cost sharing for services delivered by mental health professionals and primary care physicians.

Patients are being treated by primary care providers also in part because they do not have

adequate access to mental health providers in their health plan's network. We believe that this situation is exacerbated by a stigma that is still associated with seeking services for mental health and substance use disorders. Plan enrollees are reluctant to complain to their employer's human resources department about access to mental health care when they would not hesitate to complain about accessing a pediatrician, orthopedist or other provider for a physical problem. This reluctance to complain may allow health plans to employ higher standards for mental health provider admission to network panels.

We agree with the Departments that a "shift in source of treatment from primary care physicians to mental health professionals could lead to more appropriate care, and thus, better health outcomes" (p. 5423). Therefore, we applaud the Departments for applying the parity law to this nonquantitative treatment limitation that plan enrollees seeking mental health and substance use disorder treatment have faced for many years.

4) We agree with the Departments that mental health and substance use disorder providers should not be classified as "specialists" for the purposes of applying higher copayments. The Departments provide this MHPAEA prohibition in the commentary to the rule, but it should also be included in the rule itself.

We appreciate that the Departments recognize in commentary a common practice by health plans to characterize "a large range of mental health and substance use disorder providers as specialists" for purposes of applying a higher copayment level for psychotherapy and other services and that continuation of this practice would violate MHPAEA (p. 5413). This is indeed a common practice that has had a chilling effect on patient access to the services. In addition, as the Departments discuss in the IFR, application of such higher copayment levels has inappropriately driven patients to seek care for their mental health and substance use disorder needs from primary care physicians (p. 5423).

For these reasons we have wanted the Departments to apply the parity standard so that the copayment level for outpatient psychotherapy visits, for example, should be compared to the primary physician office copayment level rather than a specialist level. As with our discussion of the law's prohibition of separate deductibles and other cumulative financial requirement above, applying MHPAEA to prevent this practice will make an important improvement in the lives of many individuals needing and seeking treatment for their mental health and substance use disorders who have avoided treatment because they could not afford high copayments.

We note, however, that while the Departments discuss the prohibition of this practice in commentary to the rule, this prohibition is not specifically elucidated in the rule itself. We urge that the Departments provide this prohibition in the regulatory provision.

Thank you for considering our comments.

Sincerely,

Alliance for Children and Families
American Academy of Child and Adolescent Psychiatry
American Art Therapy Association
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association of Pastoral Counselors
American Counseling Association
American Dance Therapy Association
American Foundation for Suicide Prevention/SPAN USA
American Hospital Association
American Mental Health Counselors Association
American Nurses Association
American Occupational Therapy Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychological Association
American Psychotherapy Association
American Group Psychotherapy Association
Anxiety Disorders Association of America
Association for the Advancement of Psychology
Association for Ambulatory Behavioral Healthcare
Bazelon Center for Mental Health Law
Center for Clinical Social Work
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Child Welfare League of America
Clinical Social Work Association
Clinical Social Work Guild 49, OPEIU
Depression and Bipolar Support Alliance
Eating Disorders Coalition for Research, Policy & Action
Emergency Nurses Association
First Focus
Jewish Federations of North America
Mental Health America
National Alliance on Mental Illness
National Association for Behavioral Health
National Association for Children's Behavioral Health
National Association for Rural Mental Health
National Association of Anorexia Nervosa and Associated Disorders – ANAD
National Association of County Behavioral Health and Developmental Disability Directors
National Association of Mental Health Planning & Advisory Councils
National Association of Psychiatric Health Systems
National Association of Social Workers
National Association of State Mental Health Program Directors
National Coalition for Mental Health Recovery
National Council for Community Behavioral Healthcare
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National Federation of Families for Children's Mental Health
National Foundation for Mental Health
Schizophrenia and Related Disorders Alliance of America *
School Social Work Association of America
Therapeutic Communities of America
Tourette Syndrome Association
United Neighborhood Centers of America *
U.S. Psychiatric Rehabilitation Association
Witness Justice

** not a MHLG member*