Mental Health Liaison Group

May 28, 2009

Internal Revenue Service
U.S. Department of the Treasury

Employee Benefits Security Administration
U.S. Department of Labor

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (published in 74 Fed. Reg. 19155 et seq.)

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

To The Departments:

The undersigned members of the Mental Health Liaison Group welcome the opportunity to respond to the request for information as you begin the rulemaking process on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Passage of legislation to address insurance discrimination against people with mental and addictive disorders has long been a goal of this coalition.

The statutory language of the MHPAEA does not allow an employer to avoid the spirit of its parity requirement by restricting mental health/substance use benefits in a manner that is isolated from its coverage for medical/surgical benefits, since the law requires parity in all aspects of benefits coverage. We urge that a central consideration in regulatory implementation be a straightforward assessment of Congressional intent to require group health plans with more than 50 employees to provide benefits coverage for mental health and substance use services that is no more restrictive than medical and surgical benefits coverage.

We here address several questions you asked in the request for information.

> *Do plans currently impose other types of financial requirements or treatment limitations on benefits? How do plans currently apply financial requirements or treatment limitations to (1) medical and surgical benefits and (2) mental health and substance use disorder benefits? Are these requirements or limitations applied differently to both classes of benefits? Do plans currently vary coverage levels within each class of benefits?*

An issue of paramount concern is that a group health plan may not impose financial requirements or treatment limitations on mental health/substance use benefits that are separate from, even if no

more restrictive than, those imposed on medical/surgical benefits. Specifically, MHPAEA states that there are to be "no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits." This same condition is provided with respect to treatment limitations. (Section 712(a)(3)(A)(i) and (ii) of the Employee Retirement Income Security Act, section 2705(a)(3)(A)(i) and (ii) of the Public Health Service Act, and section 9812(a)(3)(A)(i) and (ii) of the Internal Revenue Code, as added by section 512(a), (b) and (c) of the Emergency Economic Stabilization Act of 2008.)

Separate, even if equal, financial requirements, for example, would place a greater financial burden on plan enrollees who require mental health or substance use services, by requiring them to essentially pay twice to meet plan financial requirements when receiving these services. As such, "separate but equal" would violate the parity law.

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

Clear explanations indicating how to compare mental health to medical/surgical with regard to limits in a benefit package and cost-sharing requirements are also necessary. For example, Section 512(a)(3)(A)(i) states that financial requirements for mental health benefits should be "no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan." There is almost identical language in subsection (ii) with respect to treatment limits. The regulations must clarify and explain these terms in order to ensure that any limits on mental health services are appropriate given the overall coverage (including limits and financial obligations of the insured) in a particular plan.

The regulation should make clear that the plan may also provide for improved coverage of mental health and addictions services, allowing parity to mean equal to or better than medical/surgical services. For example, some plans waive cost-sharing for the first few outpatient visits in order to encourage individuals into treatment. A plan that chooses to provide residential treatment with lower cost-sharing than hospital care should be free to do so.

Clarification is necessary to assist with the identification of those instances when state laws are to be preserved. It is particularly important to provide examples that illustrate how broader mandates that remain in effect in states interact with the new federal law. For example, any mandate to cover mental health services (whether only for people with certain serious mental disorders or only for a certain number of days) should remain in force. The federal law would then preempt any inappropriate limits on those services, and thus a mandate for 30 days of inpatient care would become a mandate for coverage of inpatient mental health care at parity with other inpatient health services. Additionally, statements that explain how a mandated minimum benefit becomes a parity benefit and how mandated coverage of serious mental illness remains in effect and becomes mandate for parity for serious mental illness are necessary.

Also, clarification is needed regarding the application of the MHPAEA to Medicaid managed care plans. Uncertainty in the field continues to exist, despite statutory language or references in Medicaid to the 1996 Parity Act. Explanation is also needed to affirm that parity applies to

SCHIP plans, as provided in MHPAEA and clarified by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

> *Are there unique costs and benefits for small entities subject to 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?*

Currently, there is no provision in MHPAEA that allows for special considerations for small entities. We agree that the law should not permit such special considerations, and that small entities that are subject to MHPAEA should be required to comply in the same manner as other plans subject to the law.

> *Are there additional paperwork burdens related to MHPAEA compared to those related to MHPA 1996, and, if so, what estimated hours and costs are associated with those additional burdens?*

While acknowledging the potential for MHPAEA to create additional paperwork hours and costs is necessary, there should be no consideration given to any additional burden on plans associated with the costs of making a request to the federal government for exclusion from the parity requirements.

> *What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?*

Individuals should be provided with more information than is now typically received when a service is denied to them based upon medical necessity. A plain language explanation of why this particular service was not considered appropriate at this time for this person should be required.

> *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?*

Regulations that restrict the use of the exemption for a plan based on their documentation of increased costs are needed – the regulation on this matter should be identical to the regulation in

the 1996 law. Model notices would indeed be helpful to assist with disclosure to participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption.

Thank you for consideration of our views. We look forward to the next steps in your implementation of this vital law.

Sincerely,

Alliance for Children and Families
American Academy of Child and Adolescent Psychiatry
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association of Practicing Psychiatrists
American Counseling Association
American Group Psychotherapy Association
American Occupational Therapy Association
American Mental Health Counselors Association
American Nurses Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychological Association
American Psychotherapy Association
Anxiety Disorders Association of America
Association for the Advancement of Psychology
Association for Ambulatory Behavioral Healthcare
Bazelon Center for Mental Health Law
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
Mental Health America
NAADAC, the Association for Addiction Professionals
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 Social Workers
National Association of State Mental Health Program Directors
National Coalition of Mental Health Consumer/Survivor Organizations
National Council for Community Behavioral Healthcare
National Disability Rights Network

National Federation of Families for Children's Mental Health
National Foundation for Mental Health
Suicide Prevention Action Network USA, a Division of AFSP
Tourette Syndrome Association
United Jewish Communities
United Neighborhood Centers of America
U.S. Psychiatric Rehabilitation Association
Witness Justice