AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

May 3, 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 American Psychological Association ("APA" or "we"), the professional organization representing more than 152,000 members and affiliates engaged in the practice, research and teaching of psychology, 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 on February 2, 2010, in the Federal Register (75 Fed. Reg. 5410 et seq.). For several years the APA sought passage of federal legislation that ends health insurance benefits discrimination against people needing and seeking treatment for mental health and substance use disorder services. With passage of MHPAEA we believe that Congress has ended this discrimination, and we are particularly pleased that the IFR implements the law to its full extent.

Our comment focuses on our agreement with the parity standard provided in the IFR, the appropriate prohibition on separate deductibles and other financial requirements that insurers have applied to mental health and substance use disorder benefits, and the application of the new law to "nonquantitative" treatment limitations. While we fully agree with and support the IFR as published, we offer some relatively minor suggestions that may assist insurers in implementing the law and providers and consumers in understanding it.

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The APA agrees with and supports the parity standard devised by the Departments as one that ensures that mental health and substance use disorder 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, providing 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.

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.

In our comments in response to the Departments' Request for Information ("RFI") published on April 28, 2009 (74 Fed. Reg. 19155 et seq.), the APA had urged the Departments to adopt a parity standard like the two-step standard in the proposed rule. Having engaged for many months in discussions regarding and in the drafting of the MHPAEA with other insurance, consumer and provider groups in an effort to assist Congress in writing the law, the APA believes that the parity standard being implemented by the Departments fulfills Congress's intent with respect to the law.

During this discussion and drafting it became apparent to the various participating groups that this second step—applying the predominant level—would be 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.

The APA's primary concern with implementation of the parity standard with regard to these more complex financial requirements and treatment limitations was to ensure that the "predominant" level was employed so that mental health and substance use disorder services are compared to the prevailing or common financial requirements or treatment limitations imposed on medical/surgical services. In other words, we sought to ensure that mental health and substance use disorder services were not compared to outlier requirements or limitations that would, in essence, allow health plans to avoid the intent of the law. We believe that the 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.

The APA also agrees 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. In our comments to the RFI, we had suggested that 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. 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. This provision is particularly important for our members and their patients, since plan enrollees often seek and psychologists often provide out-of-network services. We are pleased that the IFR reflects clear Congressional intent to apply parity to out-of-network services.

<u>The APA agrees 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.</u>

We are pleased that the Departments have determined that, while the statutory language of MHPAEA is vague 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. The Departments' determination to fully implement the MHPAEA by 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.

The APA agrees with the application of the MHPAEA to nonquantitative treatment limitations and urges that this application be retained in the final regulation.

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 disorder 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. Psychologist practitioners 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 for our members, and we support its inclusion in the list.

For more than a decade, we have heard from our members about health plans using intensive management of mental health benefits as a way of discouraging psychologists and their patients from seeking necessary and appropriate services. For example, we have had recent complaints from member psychologists about health plans conducting lengthy and intrusive telephone interviews—as much as half an hour long—in which the psychologist must argue at

length about the medical necessity of further treatment. Many of our members believe that such tactics dissuade psychologists and patients from requesting needed services, while unnecessarily invading patient privacy. Services on the medical side are not subject to such intense management. For further discussion regarding intensity of management of mental health services see Finch RA. Phillips K. Center for Prevention and Health Services. *An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services.* Washington, DC: National Business Group on Health; 2005.

We also comment specifically on two other non-quantitative treatment limitations provided in the IFR for which parity would be required. The first concerns health plan methods for determining usual, customary and reasonable charges, and the second would address standards for provider admission to participate in health plan networks.

How a health plan determines usual, customary and reasonable (UCR) charges can be complex, but such charges drive the plan enrollees' level of responsibility for out-of-network payment. Now under the IFR, if UCR charges are applied on a basis that requires higher payments as applied to mental health/substance use disorder services than for medical/surgical services these charges would violate the MHPAEA.

We would argue that health plan UCR determinations are in fact a quantitative financial requirement, rather than a nonquantitative treatment limitation, since these determinations have a direct impact on enrollee out-of-pocket expenses related to their access to out-of-network benefits. While more obscure than, for example, the imposition of a higher copayment requirement, a UCR determination that results in a higher out-of-pocket expense for mental health and substance use disorder services is a type of financial requirement—as an out-of-pocket expense—to which the MHPAEA clearly applies.

As with medical/surgical services, plan enrollees often prefer to choose their mental health/substance use disorder providers from outside a plan's provider network. In-network providers are paid for services under a negotiated reimbursement schedule, and in-network reimbursement contracts typically prohibit balance billing (charging the patient for a payment amount beyond the negotiated in-network payment rate).

Health plans reimburse providers for out-of-network services, however, based on formulas where there is no industry standardized formula. As a result, insurance industry reimbursement practices have made patients seeking and receiving out-of-network mental health/substance use disorder services vulnerable to higher and discriminatory requirements. Since there exists no industry standard, health plans can establish arbitrary and discriminatory formulas that would now violate MHPAEA when applied to mental health/substance use disorder services.

For medical/surgical services most health plans follow a process of establishing out-of-network payments based on a formula determination of UCR. A typical UCR determination is based on payment at a percentile (e.g. 50-75th percentile) of *non-negotiated* insurance billings for a specific service code or current procedural terminology (CPT) code. A formula

is applied to the aggregated insurance industry data and is used to determine the applicable percentile and reimbursement amount.

While it is difficult to determine what formulas are in use by any particular health plan—with a lack of transparency, the formulas are arcane and often considered proprietary—it is believed that some health plans use a different formula for mental health/substance use disorder services. Unlike medical/surgical services where out-of-network services' reimbursement is based on *non-negotiated* rates these plans use *negotiated* rates for purposes of mental health/substance use disorder services' reimbursement. As a result, plan enrollees accessing out-of-network mental health and substance use disorder services may be subject to higher balance billing amounts.

For example: a health plan enrollee seeks care from an out-of-network primary care medical provider, who charges $175 for the visit. The health plan pays $125 for the visit, which is at the 75th percentile using a generally accepted industry UCR database based on non-negotiated rates. Of this $125 payment the patient pays a $25 out-of-network copayment and the plan pays $100. The patient is responsible for $50 related to the balance billing amount. Under the same plan, the health plan enrollee also seeks out-of-network mental health care by seeing a psychologist, who charges $175 for the visit. The health plan pays only $100 for the visit based on a negotiated reimbursement schedule. Of this $100 payment, the patient pays a $25 out-of-network copayment and the plan pays $75. The patient is responsible for $75 related to the balance billing amount. The different processes used by the plan to determine out-of-network UCR charges for medical/surgical versus mental health/substance use disorder services has resulted in a $25 higher balance billing charge for the enrollee for the psychologist office visit.

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, the APA is particularly supportive of inclusion of this nonquantitative treatment limitation in the IFR, where the same process for determining UCR rates will be required of health plans when enrollees receive out-of-network medical/surgical and mental health/substance use disorder services.

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. (See 75 Fed. Reg. 5410 at 5423, citing Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, and Kessler RC (2005, June). "Twelve month use of mental health services in the United States," *Archives of General Psychiatry*, 62, 629-640.) 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. We briefly discuss below, for example, the impact of plan classification of psychologists and other mental health providers as "specialists" for purposes of imposing higher patient cost sharing, which represents an aspect of this discrepancy.

The APA also submits that patients are being treated by primary care providers in part because they do not have adequate access to mental health providers in their health plan's

network. We hear frequent complaints that patients cannot access mental health providers on health plan networks. This is often signaled by our psychologist members receiving calls from desperate prospective patients, who say that they have called several mental health providers in a health plan's network but cannot get an appointment for a visit. We also receive complaints from member psychologists who are told that a network is closed to psychologists seeking to join, even where there is evidence of inadequate patient access to mental health services.

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, as compared to panels for medical/surgical benefits.

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" (75 Fed. Reg. 5410 at 5423). Therefore, the APA applauds 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.

<u>The APA agrees with the Departments that psychologists and certain other mental health 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.</u>

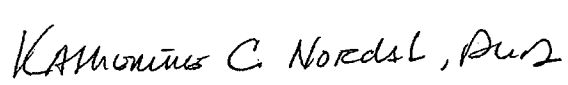
The APA appreciates that the Departments recognize in commentary a common practice by health plans to characterize psychologists and certain other mental health providers as "specialists" for purposes of applying a higher copayment level for psychotherapy and other services and that continuation of this practice would violate MHPAEA (75 Fed. Reg. 5410 at 5413). This is indeed a common practice that has had a chilling effect on patient access to the services that psychologists provide. In addition, as the Departments discuss in the IFR such higher copayment levels as applied to psychologists' services has inappropriately driven patients to seek care for their mental health and substance use disorder needs from primary care physicians (75 Fed. Reg. 5410 at 5423).

For these reasons the APA had urged the Departments in our comments to the RFI last spring 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 strongly urge that the Departments provide this prohibition in the regulatory provision.

Thank you for considering our comments. We look forward to publication of the regulation that implements the cost exemption provided in MHPAEA in the near future. The APA would appreciate the opportunity to assist the Departments with any clarification regarding our comments or regarding any other aspects of the rulemaking in which we may be of assistance. Please contact Doug Walter, Legislative & Regulatory Counsel, Government Relations, American Psychological Association Practice Organization at (202) 336-5889 or dwalter@apa.org.

Sincerely,



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