

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

To Whom It May Concern:

Mental Health America appreciates the opportunity to respond to the *Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*, published in the April 28, 2009 Federal Register.

For over a century, Mental Health America (MHA) has been dedicated to improving access to quality behavioral health services for all Americans. Along with our network of over 300 state and local affiliates nationwide, we are committed to improving mental health care and substance use treatment and promoting mental wellness. Advocacy by MHA and our affiliates along with other mental health and addiction treatment organizations over the course of many years resulted in enactment of the MHPAEA to prohibit unequal treatment of mental health and substance use conditions by employer-sponsored and other group health plans.

Most people diagnosed with mental health and/or substance use conditions are employed. And, untreated mental health and substance use conditions can greatly affect employee productivity and attendance. Moreover, if left unaddressed, these conditions can become extremely disabling and costly. In fact, the World Health Organization has pronounced mental health disorders to be the leading cause of disability in the United States based on burden of disease.¹ Serious mental illnesses alone are estimated to have cost \$193 billion in lost wages in 2002,² which exceeds the gross revenue of 499 of the Fortune 500 companies.

In enacting the MHPAEA, Congress made clear that the goal of this new law was to remedy the long history of employers and insurers not providing comparable coverage for mental health and substance use conditions compared to medical and surgical benefits.³ In order to achieve this goal, the implementing regulations must reflect the patient/consumer focus and protective intent of the law and ensure access to a meaningful range of evidence-based interventions.

With striking scientific advances over the last half century, mental disorders can now be reliably diagnosed and for virtually every such disorder, there are a range of treatments

and services that have been shown to be effective. Those treatments have efficacy rates comparable to or exceeding those for many medical and surgical conditions.

The MHPAEA explicitly requires group health plans that provide mental health or substance use benefits to ensure that the financial requirements (for example, copayments, deductibles, and out-of-pocket expenses) and treatment limitations (for example, limits on the number of visits, days of coverage) are no more restrictive for mental health and substance use benefits than the predominant financial requirements or treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

An overly strict interpretation of the MHPAEA could thwart its fundamental purpose and result in a situation similar to the outcome following enactment of the Mental Health Parity Act of 1996 (Pub. L. 104-204). The General Accounting Office (GAO) found in a May 2000 review of the 1996 parity act's implementation that 86% of employers surveyed reported that they had complied with the 1996 mental health parity law, but the vast majority of those employers substituted new restrictions on access to mental health benefits, thereby evading the spirit of the law. As GAO documented, employers were routinely limiting mental health benefits more severely than medical and surgical coverage, most often by restricting the number of covered outpatient visits and hospital days, and by imposing far higher copayments, deductibles, and other cost-sharing requirements on mental health care. As a result, many people with "good insurance coverage" were not getting needed treatment for mental health conditions at all.⁴

In light of these issues and concerns, our responses to questions posed in the *Request for Information* are as follows:

1. Financial Requirements and Treatment Limitations

Do plans currently impose other types of financial requirements or treatment limitations on benefits?

The MHPAEA defines the term "financial requirement" as *including* deductibles, copayments, coinsurance, and out-of-pocket expenses. The statute likewise defines the term "treatment limitation" as *including* limits on the frequency of treatment, number of visits, or days of coverage "or other similar limits on the scope or duration of treatment."

But the lists of types of limitations and requirements included in these definitions are illustrative and should not be interpreted as the only treatment limitations and financial requirements to which parity applies under the new law. Use of the term "includes" in these definition makes this point clear. The first question in the *Request for Information*

asking for other examples of treatment limitations and financial requirements indicates recognition of the illustrative nature of these definitions. As pointed out above, an overly restrictive interpretation of these definitions will result in a new federal parity standard that does little to achieve the goal of this legislation which is essentially to end discriminatory limits on access to mental health and substance use treatment.

Other examples of treatment limitations that health plans disproportionately use to limit the “scope or duration of treatment” for mental health or substance use conditions include the following:

- Prior authorization requirements that are applied more frequently and with higher standards for approval;
- More restrictive medical necessity and appropriateness criteria;
- “Fail first” policies that require consumers to suffer adverse outcomes from a preferred treatment or medication before the treatment or medication recommended by their providers will be covered;
- “Step therapy” requirements that require consumers to try a series of preferred medications or treatments prior to accessing the recommended treatment;
- Exclusion of certain specialized services like collaborative care, assertive community treatment, residential treatment, and partial hospitalization;
- Higher evidence-based standards;
- More frequent restrictions on treatments due to experimental status;
- Stricter cost effectiveness requirements;
- Lower provider fees;
- Limitations on covering specific types of providers;
- More restrictive provider licensure requirements;
- More limited preferred provider networks or phantom networks with invalid phone numbers and names of providers no longer practicing or accepting new patients;
- Requirement to prove current threat of harm to self or others as the justification for inpatient care; and
- Separate deductibles or lifetime limits.

The MHPAEA regulations should clarify that the parity standard applies to these other types of treatment limitations as well. The law certainly contemplates that mental health and substance use benefits will be managed by group health plans using some of these techniques but the overriding principle of parity dictates that management must be conducted in a fair and non-discriminatory way.

These treatment limitations could also be characterized as imposing higher financial requirements if as a result of discriminatory application of these limitations the consumer is subjected to higher out-of-pocket costs for mental health or substance use therapies compared to medical or surgical treatments.

How do plans currently apply financial requirements or treatment limitations to (1) medical or 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?

Health plans often impose higher co-payments, deductibles, and other cost-sharing requirements, as well as restrictions on the number of outpatient visits and inpatient days covered. However, these benefit design limitations are only the most obvious examples of discriminatory treatment of mental health and substance use care. Regulations implementing the MHPAEA must also take into account evidence indicating mental health and substance use benefits have historically been much more strictly managed than medical and surgical benefit in ways that, were they to continue, would circumvent congressional intent and objectives explicitly delineated in the new law.

States with preexisting parity laws have not seen large increases in mental health and substance use care utilization, presumably due to strict medical management. Research shows that while health care costs in general have been increasing, the share going to mental health has remained steady with spending on general health care growing twice as fast as spending on mental health care over a 30-year period through 2002.⁵ There have also been reports of low rates of spending on mental health services in health maintenance organizations relative to overall mental health spending⁶ and private insurance spending on substance use treatment has declined over the last decade.⁷ Moreover, a recent study reported that about two-thirds of primary care physicians could not get outpatient mental health services for their patients – a rate that was at least twice as high as that for other services – due in part to health plan barriers and inadequate coverage.⁸

How do plans currently apply financial requirements or treatment limitations to (1) medical or 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?

In light of this question, we analyzed health care utilization data from Milliman, Inc., a leading actuarial firm, and contrasted service utilization for a number of mental health, substance use, and general health conditions to determine if there were patterns of differential treatment.⁹ We examined rates at which individuals received services for differing diagnoses, rates of in-network and out-of-network utilization, and the

stringency with which services were managed. What we found is that the data indicates health plans treat behavioral health and general health conditions unequally in several important respects:

- The rates at which individuals receive care relative to the overall prevalence of disorders are substantially lower for behavioral health conditions than for general health.¹⁰
- Reimbursement rates are less generous for behavioral health disorders than other chronic illnesses. This points towards a differential pattern of reimbursement for mental health and substance use conditions, as contrasted with other chronic general health conditions, as a partial explanation for the differential rates of service utilization.¹¹
- Out-of-network utilization is higher for behavioral health disorders than general medical conditions.¹² Out-of-network utilization can reflect the adequacy of the in-network provider panels and also the reimbursement rates, since poorer reimbursement attracts fewer providers into the panel. Additionally, out of network use is typically associated with higher out-of-pocket expenses, which would indicate differential cost sharing for the treatment of behavioral disorders as contrasted with other chronic conditions.
- Behavioral inpatient care is more stringently managed than inpatient care for general medical conditions.¹³

These differences reflect differential access to care, *i.e.*, a treatment limitation. In addition, out-of-network utilization often results in greater cost sharing for those with behavioral health conditions, which is a financial inequity. Reimbursement rate differentials may impact the composition of behavioral health provider panels which in turn could influence the greater out-of-network utilization.

Testimony provided at field hearings on the MHPAEA legislation conducted by Representatives Patrick Kennedy from Rhode Island and former Representative Jim Ramstad from Minnesota is consistent with these actuarial analyses. Many witnesses reported that mental health and substance use conditions are managed much more restrictively than general health benefits and that children and adolescents in particular have great difficulty accessing care:

- The father of a 17-yr old girl with alcoholism, after exhausting all the female adolescent inpatient options in Rhode Island, decided to admit her to the Hazelden Center in Minnesota. The parent was exasperated with the failure of his insurance provider, United Behavioral Health, in reimbursing for services

United had authorized. “I have a master’s degree in business, I have worked in the health care field for 27 years; yet I found it extremely difficult trying to obtain reimbursement for medically necessary services.”¹⁴

- Another Rhode Island resident detailed the need for the appropriate scope of services as well as problems that he had experienced in accessing care. “We could all agree that covered benefits should include inpatient, emergency services, crisis intervention, psychiatric and psychological evaluation, medication management, counseling, psychotherapy, to name a few, but consideration should also be given to include day treatment, intensive outpatient program, partial hospitalization, outreach, home visiting and specialized services for individuals with co-occurring disorders and social case management...[P]ayment and administrative practices need to be examined. Examples still prevalent in Rhode Island are low reimbursement rates and inadequate payment structure, high service co-pays and deductibles, limitation on number of visits and services, significant payment delays, capricious and arbitrary denials usually blamed on the computer or on human error and continual requests for claims resubmission...There exists, in some cases, selective micro management through frequent requirements for service authorizations and reauthorizations. For some outpatient services, especially our child and family intensive treatment services, we are frequently told that authorization is not needed and, after several months of services, payment is denied due to lack of authorization.”¹⁵

It is critical that the regulations make clear that the inequitable use of plan characteristics (including, but not limited to, utilization management techniques, reimbursement rates, and adequacy of provider panels) will qualify as treatment limitations and, as such, may not be applied to mental health and substance use benefits in a discriminatory and more restrictive fashion.

2. Terms/Provisions in the MHEAPA

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

The regulations should include the following clarifications:

- Parity means “equal to” – The regulations should emphasize that financial requirements and treatment limitations for mental health and substance use benefits must be “no more restrictive than” those for medical and surgical benefits as stated in the MHPAEA.

- Effect on state parity laws – The regulations should clarify and emphasize the continued applicability of state laws that provide for greater protection of mental health and substance use benefits.
- Application to Medicaid managed care plans – The 1996 mental health parity law applied to Medicaid managed care plans and the regulations should make clear that MHPAEA applies to these plans as well.
- Application to the Children’s Health Insurance Program (CHIP) – The 1996 mental health parity law applied to CHIP and the regulations should make clear that MHPAEA applies to CHIP as well.
- Cost Sharing and Treatment Limits – MHPAEA prohibits unequal financial requirements. Separate deductibles for behavioral health and other health services would comprise unequal financial requirements. The regulations should clearly indicate that separate deductibles are not consistent with the intent of the Act.
- Number of employees – For purposes of the small employer exemption, there needs to be clarification on how the total number of employees be calculated if there are groups that pool their resources to offer coverage.
- Application to non-federal government plans – There needs to be clarification on whether the provisions of the law also apply to state and local government group health plans.

3. Medical Necessity

What information, if any, regarding the criteria for medical necessity determinations made under the plan 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?

MHPAEA requires plans to provide the criteria they use to make medical necessity determinations to current or potential enrollees or contracting providers, upon request.

Most medical necessity standards used by health plans focus on the following criteria:

- Customary standard of practice, *i.e.*, whether the treatment accords with professional standards of practice;

- Evidence-base, *i.e.*, whether there is sufficient evidence to demonstrate effectiveness;
- Medical service, *i.e.*, whether the treatment is considered medical rather than social or custodial; and
- Cost, *i.e.*, whether the treatment is considered cost-effective by the insurer.

The following additional clarifications would strengthen these criteria:

- Evidence from national experts should be considered if rigorous trial data are not available for a particular treatment service;
- Services must be available to maintain or restore function and to prevent or ameliorate medical conditions in addition to treating injuries or illnesses; and
- Cost effectiveness must include the patient's desired outcomes and not simply changes in clinical status.

In addition, the regulations should require health plans to do the following:

- Set timeframes for disclosure of medical necessity criteria;
- Detail appeal and enforcement mechanisms;
- Make available to beneficiaries, upon request, the standards used to determine medical necessity judgments (*e.g.*, standard of practice, strength of the evidence base, definition of medical conditions); and
- Make available to beneficiaries, upon request, the standards used to assess medical necessity for medical and surgical benefits.

4. Denials of Reimbursement/Payment for Services

What information, if any, regarding the reasons for any denial under the plan 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?

The MHPAEA requires plans to provide the reasons for any coverage denials with respect to mental health or substance use benefits to any current or potential enrollee upon request.

The regulations should require health plans to do the following:

- Specify that consumers may receive at no charge copies of the documentation the plan used to make the coverage determination at issue;
- Set timeframes for disclosure of reasons for claims denials; and
- Outline the process for appealing the determinations, including time frames and enforcement mechanisms.

5. Out-of-Network Coverage

To gather more information on the scope of out-of-network coverage, the Departments are interested in finding out whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. If so, how is such coverage the same as or different than out-of-network coverage provided for medical and surgical benefits?

Under MHPAEA, plans that cover medical or surgical services provided by out-of-network providers must also cover mental health or substance use services provided by out-of-network providers if the plan covers mental health or substance use benefits at all.

The regulations should require that plans provide information to consumers regarding the relative availability of in-network and out-of-network providers for each of the medical specialties in order to evaluate the adequacy of the networks and their equivalence

6. Cost Exemptions

Which aspects of the exemption for increased cost resulting from the parity requirement, 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?

MHPAEA provides that plans may be exempt from the law if they can show that the parity requirements result in an increase in total costs of coverage by over 2 percent in the first year and one percent for each subsequent year.

The regulations should clarify that assessment of whether a plan qualifies for a cost exemption must be determined on a retrospective basis and based on real experience with increased cost instead of hypothetical costs.

The regulations should provide guidance on the evidence that would be required to attribute any cost increase to the provision of equitable services as opposed to other market conditions, such as differential fee adjustments for differing specialties.

7. Other Issues

Comments on other issues relevant to the development of the MHPAEA regulations.

The regulations should provide a methodology for comparing types of service across medical specialty areas to determine their equivalence. In addition, the regulations could outline broad categories of care within which parity will be required; for example, inpatient in-network services as a category and inpatient out-of-network as a separate category.

Another issue to be clarified in the regulations is whether the inclusion of mental health medications on a plan formulary constitutes providing a mental health benefit such that the parity requirements in the MHPAEA are triggered. Our position is that since psycho-pharmaceuticals are a commonly used treatment for behavioral health disorders – often as the sole treatment – inclusion of them on the formulary would constitute a mental health benefit and therefore trigger the application of the MHPAEA.

Passage of the MHPAEA signals the end of the historical discrimination against the treatment of mental health and substance use conditions. Clear patterns of discrimination and the methods used to effect this discrimination have been summarized here. Effective, clear, and prescriptive regulations are needed to insure that the intent of the Act is fully realized in its implementation such that persons with these disabling illnesses receive care equitably.

On behalf of Mental Health America, we thank you for the opportunity to comment and look forward to working with you in implementing this landmark legislation.

Sincerely,

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¹ World Health Organization, The World Health Report 2004: Changing History, Annex Table 3: Burden of disease in DALYs [“disability-adjusted life years”] by cause, sex and mortality stratum in WHO regions (2004).

² Ronald C. Kessler, Steven Heeringa, Matthew D. Lakoma, *et al.*, “Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results from the National Comorbidity Survey Replication,” American Journal of Psychiatry, May 7, 2008.

³ United States House of Representatives, Committee on Education and Labor, House of Representatives Report No. 110-374, Part 1 (2007).

⁴ United States Government Accounting Office, Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited, May 2000.

⁵ Richard G. Frank, Howard Goldman, and Thomas G. McGuire, “Trends in Mental Health Cost Growth: An Expanded Role for Management,” Health Affairs, May/June 2009.

⁶ M. Audrey Burnam and Jose J. Escarce, “Equity in Managed Care for Mental Disorders: Benefit Parity is Not Sufficient to Ensure Equity,” Health Affairs, September/October 1999.

⁷ Jon Gabel, *et al.*, “Substance Abuse Benefits: Still Limited After All These Years,” Health Affairs, July 2007.

⁸ Peter Cunningham, “Beyond Parity: Primary Care Physicians’ Perspectives on Access to Mental Health Care,” Health Affairs, April 2009.

⁹ The Milliman *MedStat MarketScan* data set includes service utilization data from 45 large employers representing approximately 100 payers and 24.2 million covered lives.

¹⁰ For example, when looking at hypertension and depression as the contrast conditions, and controlling for the differences in prevalence rates, the Milliman data indicate that the rates at which individuals received treatment for hypertension was 2.9 times greater than the rates at which individuals received treatment for depression.

¹¹ The data show that services for depression were reimbursed less generously than those for hypertension. To compare reimbursement rates, we had to control for differences between the base rates at which different services are reimbursed. We therefore expressed the actual payment for services relative to a standard – in this case the Medicare allowable rate. On average, services for depression are reimbursed at 105% of the Medicare allowable rate and hypertension at 109%. Services for hypertension are therefore reimbursed more generously than those for depression. When the analysis is expanded to include a number of mental health and substance use conditions, the overall rate of reimbursement is approximately 103% of the Medicare allowable rate while the comparable number for chronic general health conditions is 113% of the Medicare standard.

¹² The data show that services for depression were more frequently provided out-of-network than those for hypertension. Approximately 83% of services and treatment for depression were provided in-network while over 91% for hypertension were provided within the network.

¹³ The data show that behavioral health disorders were 1.3 times more likely to be stringently managed than the services for other chronic illnesses: 60% of behavioral health conditions were stringently managed as contrasted with 43% of episodes for other chronic medical conditions.

¹⁴ Testimony of Michael Noonan, Transcript of *Campaign To Insure Mental Health and Addiction Equity Congressional Field Hearing on the Mental Health Equity Bill*, Providence, Rhode Island, January 16, 2007, 62. www.mentalhealthamerica.net/equitycampaign/Rhode_Island_Equity_hearing_transcript.pdf.

¹⁵ Testimony of Richard LeClerc, Transcript of Providence Field Hearing, 78.