AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

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:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments 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. Our comments focus on the following important areas: parity standards; prohibition of separate deductibles; and nonquantitative treatment limitations.

Parity standards

The AMA agrees with and supports 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.

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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. In implementation of the parity standard for these more complex financial requirements and treatment limitations it is important to ensure that the predominant level (the level that applies to more than one-half of the medical/surgical benefits) 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 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. These six categories should allow health plans to apply parity appropriately without overburdening them with multiple classifications.

Prohibition of separate deductibles

The AMA supports 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.

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.

Nonquantitative treatment limitations

The AMA supports application of the MHPAEA to nonquantitative treatment limitations and urges that this application be retained in final regulations.

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 there are recognized, clinically appropriate standards of care that 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.

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 thank you for the opportunity to comment on these important issues and look forward to working with the Departments on improving access to quality mental health and substance use disorder services.

Sincerely,

Michael D. Maves, MD, MBA