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Department of Labor, Employee Benefits Security Administration
29 CFR Part 2590
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Department of Health and Human Services, Centers for Medicare & Medicaid Services
45 CFR Parts 146
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Department of the Treasury, Internal Revenue Service
26 CFR Part 54
[TD 9479]
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Families USA, a nonprofit, nonpartisan consumer advocacy organization dedicated to the achievement of high-quality, affordable health care for all Americans, appreciates the opportunity to comment on the interim final rules for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Families USA strongly supports the interim final rules published by the Department of Labor, Department of Health and Human Services, and Department of Treasury. Effective implementation of the rules will prevent unequal, restrictive access to mental health and substance use disorder services that makes it harder for consumers in large group health plans to obtain necessary and appropriate care. This is especially critical for consumers with moderate to severe conditions who require regular contact with mental health or substance use disorder professionals and medication management. MHPAEA and the interim final rules will make it easier for such individuals to obtain timely, appropriate care so that they can be healthy and productive members of society. Improved access to care will also prevent conditions from escalating into more severe problems, avoiding the development of costly acute conditions. As evidenced by experience in the Federal Employees Health Benefits Program (FEHBP) and certain states, all of this can be achieved at a negligible cost.

MHPAEA and the interim final rules build upon the Mental Health Parity Act of 1996 (MHPA 1996) and the existing patchwork of state mental health parity laws, which vary greatly in the protection they provide. MHPAEA and the interim final rules will set a strong foundation to protect consumers in large group plans in every state from unequal, discriminatory limits on mental health and substance use disorder services, while allowing states to provide additional protections to consumers as they see fit.

Families USA strongly supports the application of MHPAEA's parity requirements as outlined in the interim final rules. The separate application of the parity requirements to each coverage unit will provide equity to every covered individual in a large group plan. The separate

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application of the parity requirements to each type of financial requirement or treatment limitation is essential to achieving true equity in access to services. This is also true of the application of the parity requirements to each benefit package option or combination of medical/surgical and mental health/substance use disorder benefits offered by an employer. Families USA believes the interim final rules' explicit prohibition of administering mental health and substance use disorder benefits through a separate plan, without medical/surgical benefits, in order to evade the parity requirements will also provide important protection to consumers in large group plans.

Defining Benefit Classifications

Families USA strongly supports the requirement that health plans that offer mental health/substance use disorder benefits must provide them for all covered conditions in each of the listed classifications for which medical/surgical benefits are provided. This requirement will help to ensure that evidence-based, medically appropriate mental health and substance use disorder care is accessible to patients who need it. The interim final rules apply this requirement to out-of-network care as well as to in-network care, which is critical since many consumers receive mental health and substance use disorder services out-of-network. Families USA recommends that the Departments specify in the rules that the application of this requirement to out-of-network services includes parity for any protections against high out-of-network costs that plans may provide for enrollees, such as an exception from higher costs for out-of-network emergency care.

Determining Applicable Financial Requirements and Quantitative Treatment Limitations

Families USA supports the interim final rules' prohibition of the application of financial requirements or quantitative treatment limitations to mental health/substance use disorder services unless they apply to at least two-thirds of medical/surgical benefits in a given classification. This definition of when requirements or limits apply to "substantially all" medical/surgical benefits in a classification will ensure that such restrictions are fairly applied to mental health/substance use disorder services. Families USA also supports the interim final rules' requirement that plans apply the "predominant" level of financial requirements or treatment limitations placed on medical/surgical services to mental health/substance use disorder benefits. This is essential for true parity in access to mental health/substance use disorder services.

However, when no single level of a financial requirement or treatment limitation applies to more than one-half of medical/surgical benefits subject to that restriction, the process of determining the predominant level is cumbersome and may not result in the most consumer friendly outcome. Families USA would prefer that the alternative, simpler option that plans may use, in which they treat the least restrictive level of a financial requirement or quantitative treatment limit as the predominant level, always be required in these situations. Or, could the Departments consider requiring that plans combine the levels of a requirement in the order that they are most prevalent, instead of allowing plans to start with the most restrictive level? In this case, a plan's calculation would start with the most common level of a requirement and work from there until the combination exceeds one-half of the benefits subject to a restriction. The predominant level would then be the least restrictive level in the combination. This process might better achieve the intent of MHPAEA to eliminate barriers to mental health/substance use disorder services.

In addition, commentary to the interim final rules states that plans may not distinguish between specialists and generalists when determining the predominant level of a financial requirement in order to comply with MHPAEA. Families USA supports this position and urges the Departments to restate this prohibition in the contents of the regulations in addition to its inclusion in the commentary.

Application of Cumulative Financial Requirements and Quantitative Treatment Limitations

Families USA strongly supports the interpretation of MHPAEA in the interim final rules that plans may only apply one combined deductible (or other cumulative financial requirement or quantitative treatment limitation) for mental health/substance use disorder and medical/surgical services. Allowing two “separate but equal” deductibles would not be consistent with the intent of MHPAEA to “eliminate barriers that impede access to and utilization of mental health and substance use disorder benefits.” If deductibles were not combined for mental health/substance use disorder and medical/surgical services, individuals who required care for mental health or substance use disorders would be subject to two deductibles, while plan enrollees who did not require such services would only have to satisfy one deductible. In this case, even if plans applied a lesser deductible to mental health/substance use disorder services than to medical/surgical services, parity still would not be achieved. Separate deductibles would result in inequitable restrictions on mental health/substance use disorder benefits that would pose a large and unequal burden on consumers who need them, impeding their ability to obtain timely, appropriate care.

We are aware that some health plans are concerned about the costs of converting their systems to accommodate a combined deductible for mental health/substance use disorder and medical/surgical benefits. While some plans may face a one-time cost for implementing this change, which the Departments found to be as low as \$35,000 (with a small maintenance cost in years thereafter), without a combined deductible, consumers who need mental health/substance use disorder services would incur a disparate cost burden not just once, but year after year. The disparate cost burden of two separate deductibles for mental health/substance use disorder and medical/surgical services each year could make necessary care unaffordable for consumers. This could lead them to delay or forgo the services they need, leaving their conditions untreated, only to worsen and eventually become more expensive to treat. Such a result runs contrary to the intent of MHPAEA to eliminate barriers to necessary mental health and substance use disorder services. Therefore, we strongly support the Departments’ interpretation that separate cumulative financial restrictions and quantitative treatment limitations for mental health/substance use disorder and medical/surgical services violate MHPAEA.

If, when implementing a combined deductible for mental health/substance use disorder and medical/surgical benefits, the exchange of information between administrators for each type of benefit does not occur in real-time, safeguards will be necessary to ensure that health plan enrollees are not overcharged for services. For example, if plan enrollees receive both mental health and medical services on the same day, they may end up paying more out-of-pocket than is required by their deductible because cost information from the mental health and medical benefits administrators may not have been combined yet. Therefore, a process to retroactively refund overpayments by enrollees must be in place if the exchange of information between benefits administrators does not occur in real-time. To ensure that this process is effective and that consumers are not overcharged, the Departments should require that patients receive notice of their right to a single, combined deductible and contact information of whom in their health

plan and in the enforcing departments to contact if they believe they have been overcharged through a cumulative financial requirement in violation of MHPAEA.

Application of Aggregate Lifetime and Annual Dollar Limits

Families USA supports the interim final rules' requirements regarding annual and lifetime limits, which mirror those for MHPA 1996. Due to the passage of the Patient Protection and Affordable Care Act (PPACA), lifetime limits on mental health/substance use disorder benefits will soon be prohibited and annual limits will be restricted, providing important new protections to consumers. The Departments will need to modify the MHPAEA regulations to reflect these changes. In addition, it will be necessary to ensure that after the restriction on annual limits takes effect, plans maintain parity as they modify the annual limits that apply to medical/surgical benefits, until PPACA outright prohibits annual limits in 2014.

Application of Nonquantitative Treatment Limitations

The interim final rules outline MHPAEA's parity requirements for nonquantitative treatment limitations. Families USA supports that included among these are standards for provider admission into a network and reimbursement rates, including methods for determining usual, customary, and reasonable charges. The application of parity to these factors is critical, as access to providers can be a large barrier to care for consumers needing mental health and substance use disorder services, even when they have insurance. MHPAEA and the interim final rules will ameliorate this problem, making it easier for consumers to obtain mental health and substance use disorder care from appropriate providers.

The interim final rules state that plan enrollees cannot be required to exhaust employee assistance program (EAP) benefits before they are eligible for covered mental health or substance use disorder benefits if they do not face the same EAP requirements for medical or surgical benefits. This will make appropriate care more accessible to consumers by eliminating a barrier to obtaining necessary services from mental health and substance use disorder providers.

In addition, the interim final rules specify that the processes, strategies, evidentiary standards, or other factors used in applying nonquantitative treatment limitations must be comparable for medical/surgical and mental health/substance use disorder benefits, both in the plans' policies as written and in the way they are applied in operation. Families USA supports this requirement and believes it is critical to ensuring that the application of nonquantitative limitations does not become a loophole to the parity requirements.

As the interim final rules recognize, the settings where evidence-based, medically appropriate mental health and substance use disorder services are delivered and the types of services that are necessary may differ from those for medical or surgical conditions. Therefore, the delivery settings and types of treatment included in the benefit classifications (such as outpatient, inpatient, and emergency) for mental health and substance use disorders to which the parity requirements apply should be somewhat different and/or broader than the settings and treatments included in the classifications for medical/surgical benefits. Families USA believes that limiting mental health and substance use disorder parity requirements only to settings and treatments that apply to medical and surgical benefits would not match MHPAEA's intent of eliminating barriers to mental health and substance use disorder services. Therefore, we recommend that the Departments clarify that MHPAEA requires that a full scope of mental health/substance use disorder benefits be included in each covered benefit classification. This will ensure that

consumers can access necessary and appropriate services such as counseling and non-hospital residential treatment.

Exemptions from Parity Requirements

MHPAEA exempts small employers from complying with parity requirements. The interim final rules refer to small employers as those with no more than 50 workers. Families USA has some concerns regarding the interaction of PPACA with the small employer exemption in MHPAEA. PPACA modifies the Public Health Services Act (PHSA), and thereby the Employee Retirement Income Security Act (ERISA) and the IRS Code of 1986, to define small employers as those with no more than 100 workers. In general, this change is beneficial to consumers. However, in the case of the parity requirements, it may result in the negative consequence of exempting more employers from the requirements if MHPAEA is interpreted as incorporating the definition of a small employer from ERISA, PHSA, or the IRS Code of 1986. Families USA believes that this impact on the parity requirements is an unintended effect of PPACA and may even be a drafting error. Therefore, we recommend that the MHPAEA final rules clarify that the change in the definition of small businesses made by PPACA does not affect the parity requirements of MHPAEA, and that businesses remain subject to the requirements unless they have 50 or fewer employees.

Businesses can also receive a cost exemption from the parity requirements. MHPAEA allows plans to receive such exemptions for no more than one year at a time. This will limit longstanding negative effects on consumers' access to mental health and substance use disorder services. However, it may be slightly confusing for plan enrollees whose mental health and substance use disorder benefits could change from year to year. Therefore, Families USA recommends that plans be required to provide a one-page notice each year of any changes in coverage due to this exemption. In addition, to ensure transparency, the certification a plan receives for a cost exemption, as well as the documents a plan files in order to receive the exemption, should be available to plan enrollees.

Disclosures and Notices to Consumers

MHPAEA includes disclosure requirements that will help consumers understand their health plans' benefits and policies. These requirements will help ensure that consumers' rights are upheld by providing them information about medical necessity criteria and denials of claims, facilitating their ability to file appeals when they see fit.

In addition to the medical necessity and claim denial disclosure requirements included in the MHPAEA statute, Families USA recommends that plans also be required to provide notice to consumers of their general rights to parity under MHPAEA. Plans should be required to include this notice both in general plan materials and in any notice of a denied claim for mental health/substance use disorder services (along with the other notices that are required in cases of claims denials). The notice should state that, by law, health plans may not subject mental health and substance use disorder services to more restrictive financial requirements or treatment limitations than those that apply to medical and surgical services. In order to ensure that this right is upheld, plans should be required to provide notice of who enrollees can contact in the responsible departments if they suspect violations of the parity requirements. The notice should describe specific potential violations including:

- Failure to reasonably define mental health/substance use disorder and

- medical/surgical benefits,
- Failure to comply with parity requirements when applying financial requirements or quantitative treatment limitations,
- Failure to comply with parity requirements when classifying prescription drugs into tiers,
- Failure to comply with parity requirements when applying cumulative financial requirements and treatment limitations, including failure to apply only one combined deductible or other cumulative requirement to both mental health/substance use disorder and medical/surgical benefits,
- Failure to comply with parity requirements when applying aggregate lifetime and annual dollar limits, and
- Failure to comply with parity requirements when applying nonquantitative limitations.

Interaction with State Laws

Families USA strongly supports the interim final rules' interpretation of MHPAEA that the federal parity requirements do not preempt any state laws mandating a minimum level of mental health or substance use disorder coverage in insurance plans, as long as MHPAEA can be applied as required by federal law. The interim final rules recognize that state laws may require some fully insured plans to provide mental health and/or substance use disorder services, even though MHPAEA does not require them to do so. In addition, Families USA recommends that the rules clarify that states can continue to enact laws regarding coverage of mental health and substance use disorder services that require greater consumer protection in insurance plans than MHPAEA as long as the laws allow for the application of MHPAEA.

MHPAEA Enforcement

Proper enforcement of MHPAEA and the interim final rules will be essential to ensuring that the implementation of MHPAEA matches the intent of Congress that consumers have parity in their mental health/substance use disorder and medical/surgical benefits. Families USA is concerned that the interim final rules include no specific process through which the responsible federal departments will ensure compliance with the law. We believe that a formal mechanism must be in place so that the federal departments are aware of plans that fail to comply with the parity requirements.

Therefore, we suggest that the Departments require health plans and issuers to submit reports with data on how they comply with the parity requirements. Plans and issuers should be required to submit annual reports to the agencies tasked with enforcing MHPAEA that include:

- The standards the plan used to define mental health/substance use disorder and medical/surgical services,
- The calculations the plan used to determine whether financial requirements or treatment limitations apply to "substantially all" medical/surgical benefits and the calculations the plan used to determine the predominant levels of the restrictions,
- The factors the plan used to classify drugs into specific tiers,
- The calculations the plan used to determine the share of medical/surgical benefits to which lifetime or annual limits apply and calculations the plan used to determine the applicable limits, including calculations of "weighted averages" where applicable,

- and
- The clinical criteria the plan used when applying nonquantitative limits that result in different restrictions placed on mental health/substance use disorder services and medical/surgical services.

In addition, Families USA recommends that the Departments conduct periodic audits and other reviews, both randomly and in response to consumer complaints, to ensure that plans comply with the parity requirements. Some of the potential violations that audits should examine are listed in the above section, "Disclosures and Notices to Consumers."

All departments with MHPAEA oversight and enforcement responsibilities should prominently display individuals' rights under MHPAEA and contact information for the department responsible for responding if a consumer believes his or her MHPAEA rights are being violated on their websites. The departments should also conduct outreach, such as through the media, in order to publicize individuals' rights under MHPAEA.

Thank you for considering our comments on the interim final rules for MHPAEA, which will have a profound effect on consumers' access to critical mental health and substance use disorder services.

If you have any questions, please contact Claire McAndrew at cmcandrew@familiesusa.org or by telephone at 202-628-3030.

Sincerely,

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