PUBLIC SUBMISSION

As of: May 26, 2009
Received: May 26, 2009
Status: Pending_Post
Tracking No. 809b6625
Comments Due: May 28, 2009
Submission Type: Web

Docket: EBSA-2009-0010
Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: EBSA-2009-0010-0001
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Document: EBSA-2009-0010-DRAFT-0108
Comment on FR Doc # E9-9629

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General Comment

• Medical management of mental health and substance use treatment benefits and medical necessity criteria.

The Act does not provide specific guidance on whether plans can apply different medical management processes for their medical/surgical and their mental health and substance use treatment benefit. Nor does it provide specific guidance about whether plans are free to apply different medical necessity criteria. The Act clearly recognizes that plans will be employing medical necessity criteria for behavioral health benefits: “the criteria for medical necessity determinations made under the plan” shall be made available to plan beneficiaries.

Medical management and application of medical necessity criteria for determining coverage would fall into the treatment limitations section of the law. The treatment limitations definition provides a list of limits that are subject to parity, including “other similar limits on the scope and duration of treatment.” Medical management and medical necessity are mechanisms for limiting coverage. Therefore, they fit within the treatment limitations definition and are subject to the parity requirements. Allowing more stringent medical management or medical necessity criteria would be inconsistent with the purpose of the Act. The purpose

of the Act is to ensure “parity” between mental health and substance use benefits and medical/surgical benefits. Medical necessity criteria that are more stringent than medical/surgical criteria are not at “parity.” Medical management or medical necessity criteria that are the same in form but more restrictive in effect would also be prohibited.

The legislation was enacted to remedy a specific problem – namely, “the discrimination that exists under many group health plans with respect to mental health and substance related disorder benefits.” Unequal and more stringent medical necessity criteria or the application of more stringent medical necessity criteria for mental health and substance use services than for medical/surgical services would undermine the solution that Congress put in place with the Act.

• How can plans and employers that provide multiple health plans with multiple and very different benefits, cost-sharing, deductibles and co-pays meet the law's requirements? Can employers offer multiple health plans and a single carve-out behavioral health plan?

Health insurers and employers may offer beneficiaries an array of health plans to choose between. These health plans may have very different coverage of medical/surgical and behavioral health benefits, different financial limitations such as deductibles and co-payments, and different designs of in-network and out-of-network providers (e.g., HMO, POS, PPO, high deductible health plans). Some employers offer employees a choice between multiple health plans but contract with a single behavioral health vendor whose benefits are “carved-out” from the medical/surgical benefit. To what standard are health plans and employers held in these instances?

The Act clearly states that it addresses individual group health plans. It states: “in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan shall ensure….” Throughout the Act, the language refers to a single plan or coverage offered in connection with such a plan. Therefore, health plans or employers that offer multiple plans must comply with the Act’s financial and treatment limitations for each plan or offering. The Act states that financial requirements and treatment limitations can be “no more restrictive than the predominant financial [and treatment limitations] applied to substantially all medical and surgical benefits covered by the plan (or coverage),” which is a clear indication that MH/SU and medical/surgical benefits are to be consistent within a plan, not across multiple plans. It would appear that employers who offer multiple health plans for their employees must assure offer mental health and substance use benefits that are no more restrictive that the financial and treatment limitations applied to each offered health plan. Employers and health plans are free to offer a single mental health and substance use benefit as long as it is not more restrictive than the least restrictive of the health plans offered.

• If the plan covers medical detoxification for alcohol or drug intoxication, is the plan required to cover a full continuum of services for alcohol and drug use disorders, if it covers a full continuum of services for medical conditions under the medical/surgical benefit?

The Act does not mandate coverage of mental health or substance use disorder benefits. Plans may choose what mental health conditions and substance use disorders that they will cover or whether they will cover no mental health or substance use disorders at all. Mental health and substance use benefits are defined as “benefits with respect to services for mental health conditions [and substance use disorders], as defined under the terms of the plan and in accordance with applicable Federal and State law.” Once the decision is made to cover some services for a mental health or substance use condition, then

the “no more restrictive” standard of the Act operates. If a plan covers every level and type of medical/surgical care for substantially all medical and surgical benefits, but only provides for certain levels or types of care for a substance use or mental health disorder, it is likely that the plan has violated the Act’s “no more restrictive” standard.”

A plan may not offer a full continuum of medical/surgical services and limited behavioral health services for mental health conditions or substance use disorders. The Department of Labor has determined that “benefits for treatment of drug and alcohol abuse, stress, anxiety, depression and similar health and medical problems constitute “medical” benefits or “benefits in the event of sickness” within the meaning of section 3(1). The Department does not make a distinction whether behavioral health benefits are provided contractually under a plan’s medical/surgical benefit, a behavioral health carve-out, or an employee assistance program with counseling benefits: benefits for treatment of behavioral health disorders are “medical” benefits or benefits “in the event of sickness.” Mental health and substance use benefits across the array of medical benefits that plans or employers use are subject to the “no more restrictive” requirements of the Act. Plans frequently cover emergency or inpatient medical detoxification for alcohol or drug use disorders within their medical/surgical benefit. Employers may contract with EAPs that provide limited counseling services for “treatment of drug and alcohol abuse, stress, anxiety, depression and similar health and medical problems”. If a plan covers some services for a mental illness or substance use condition, then “to the extent” the plans offers some services, these benefits must be no more restrictive than the preponderance of medical/surgical benefits.

• If the fee schedule is so low that access to in-network or out-of-network care is more restrictive than the treatment limitations for medical conditions, does that violate the intent or letter of the Act? If the network of mental health or substance use treatment providers is more restrictive than the network of medical/surgical providers, does that violate the intent or letter of the Act? If the end result is a reduction in access to services, does this constitute a violation of the “treatment limitations” section of the law?

The broad language of the treatment limitations section of the Act provides a non-exhaustive list of limits on treatment and indicates that “other similar limits on the scope and duration of treatment” come within the definition. To comply with the Act, a plan must ensure that “the treatment limitations applicable to such mental heath or substance abuse disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan.” A strong argument can be made that, in light of the purpose of the Act, as stated in the House Education and Labor and Energy and commerce Committee Reports that the purpose of the legislation is to ensure “fairness” and “equity” for mental health services. Equity and fairness are not achieved when the end result of fee schedules or network provider panels is reduced access to treatment. To end discrimination in form, but not in effect, would stand against the purpose of the Act. Plans should not be able to limit fairness and equity though provider fee schedules or restricted provider networks what they are not permitted through other treatment limitations or financial requirements.

However, the Act’s discussion of treatment and financial limitations appear to be applied to beneficiaries, not to providers. The Act requirements apply to “deductibles, copayments, coinsurance, and out of pocket expenses and other similar limits on the scope and duration of treatment.” It is difficult to argue that fee schedules or extent of provider networks are “other similar limits on the scope and duration of treatment.” Practically, however, fee schedules that are so low that there are few or no providers to provide services, or that provider networks are so restrictive that medically necessary services are many miles distant from

beneficiaries or have wait lists that are disproportionately lengthy create treatment limitations that undermine the goal of parity and equity. If a low fee schedules or restrictive provider panels results in disparities in access to MH/SU benefits compared to substantially all medical/surgical benefits, a strong argument can be made that it is “more restrictive” and thus a violation of the Act.

• Does the Act permit plans or employers to exclude specific services for which there are no directly comparable medical/surgical procedures? Examples might include intensive outpatient programs for addictions, psychosocial rehabilitation services, psychoanalytic psychotherapy, and electroconvulsive therapy?

Can a plan cover some mental health and substance use treatment services, but not others? The Act states that plans must ensure that: “treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage).” The Act prohibits a treatment limitation if it is more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. Under the Act, a treatment limit is considered to be predominant if it is the most common or frequent of such type of limit. The limit in question must also be applied to substantially all medical and surgical benefits under the plan. Applying these concepts, it seems unlikely that a plan that limited services to some types of mental health and substance use treatment services but not others could be justified, unless there were similar limitations in the most common or frequent medical and surgical benefits under the plan. The Act imposes significant hurdles before a plan can impose more restrictive limitations only for MH/SU benefits. The Act states that health plans must ensure that “there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.” If a plan does not cover a particular mental health service or substance use service that does not exist outside of mental health or substance use, it is clear that the treatment limitation applies only to mental heath or substance use disorders. The criteria for inclusion or exclusion of mental health or substance use services must meet the high standard of the Act that these be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits.

The Act very clearly permits health plans to determine which mental health conditions and substance use disorders are “defined under the terms of the plan.” Once the plan decides which conditions or disorders are covered, it is subject to the requirement discussed above concerning treatment limitations. It appears a reasonable interpretation that mental health and substance use services cannot be limited in a more restrictive manner than medical/surgical services. Plans may not subject specific mental health and substance use treatment services to greater categorical restrictions or exclusions than those applied to the predominant medical/surgical services.

• Does the act require plans to cover medications that treat mental health and substance use disorders at the same level as medication coverage for medical/surgical conditions?

Plans are not obligated by the Act to provide MH/SU benefits. The Act only applies to a plan that provides both medial and surgical benefits and mental health or substance use disorder benefits. Assuming that the plan offers both medical/surgical and MHSU benefits, the question can be raised whether the Act applies to medications. The text of the legislation does not specifically address coverage of medications. However, there is some indication that medications for treatment of mental illnesses and substance use disorders in the legislative history. The cost estimate prepared by the Congressional Budget Office includes estimates of the “increased use of prescription drugs that mental health parity would be likely to induce.” This statement was included in the reports from the

Congressional Committees that approved the bill. It appears that Congress intended that medications would fall within the Act, so that treatment limitations and financial requirements respecting medications are subject to the "no more restrictive" standard. There would be no justification for allowing requirements for medications to be more restrictive for MH/SU benefits than for medical/surgical benefits, and would be prohibited under the Act. Similarly the Act could be interpreted to require that drug formularies for MH/SU benefits be nor more restrictive than those for medical/surgical benefits. Drug formulary management would likely fall within the non-exclusive list of benefits included within the treatment limitations section. The list included in the treatment limitations of the Act is clearly not intended to be exhaustive. Formulary management which is concerned with restricting access to medications would fall under the treatment "scope and duration" limitations covered by the Act. Coverage for medications to treat mental health or substance-related disorders, the tiers and co-payments, deductibles, etc. for these medications, and inclusion of at least one medication for each FDA clinical indication are determinations would need to be made at the plan level based on the criteria in the act of no more restrictive financial or treatment limitations. If a plan offered one drug for each FDA clinical indication within the medical/surgical benefit and did not do so in the mental health or substance use disorder benefit, it would likely be in violation of the Act.

• Does the Act permit separate but equal deductibles, cost-sharing and other financial limitations for mental health and substance abuse treatment and for medical/surgical treatment?

The Act clearly states that "no separate cost sharing requirements … are applicable only with respect to mental health or substance use disorder benefits" Separate and equal deductibles, cost-sharing or other financial limitations for mental health or substance use disorder benefits from those of medical/surgical benefits produces a result that would impose financial requirements on mental health and substance use benefits more restrictive than medical/surgical benefits. Mental health and substance use treatment expenditures typically make up between 2% and 5% of health plans' expenditures. Separate and equal deductibles place a 20:1 or even a 50:1 greater financial limitation for persons accessing mental health or substance use benefits compared to persons accessing medical/surgical benefits. Separate and equal financial limitations would not be permitted by the Act.

• Does the Act permit plans or employers to carve out behavioral health services from medical/surgical services, and to provide more limited behavioral health services, for example, through an Employee Assistance Program? Does the Act permit plans or employers to carve out behavioral health benefits to a separate vendor from other health benefits and apply more restrictive financial or treatment limitations on the separately contracted behavioral health benefits from those applied to medical/surgical benefits?

Since at least 1983, the Department of Labor has determined that Employee Assistance Programs fall within the definition of an employee welfare benefit plan within the meaning of section 3(1) of ERISA and subject to the provisions of title I of ERISA. Section 3(1) of ERISA defines the term "employee welfare benefit plan" to include: … any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947(other than pensions on retirement or death, and insurance to provide such pensions)." The definition is broad, encompassing "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability" without

distinction to the type of contractual arrangements that employers or health plans make to provide such medical benefits. In a series of ERISA Opinion Letters, the Department of Labor clearly indicates that EAPs that deliver counseling benefits fall within the definition of a medical benefit. The Department of Labor has consistently determined that “benefits for treatment of drug and alcohol abuse, stress, anxiety, depression and similar health and medical problems constitute “medical” benefits or “benefits in the event of sickness” within the meaning of section 3(1). An ERISA Opinion Letter interpreted the phrase “to the extent” to indicate Employee Assistance Programs that offer counseling by personnel with special training in counseling, psychology, social work, public health or other health disciplines falls within section 3(1) of title I of ERISA. An EAP that provides telephone or in-person counseling by employees of the company, by employees of the EAP or through counselors or other health professionals contracted by the EAP are delivering “medical” benefits or benefits “in the event of sickness.” An EAP that provides only telephone referrals and does not provide any benefits which are in the nature of “medical” benefits or benefits “in the event of sickness” and is not staffed by employees with special medical or counseling training, is not considered an employee welfare benefit plan.

Employers that choose to offer an Employee Assistance Plan or other “benefits for treatment of drug and alcohol abuse, stress, anxiety, depression and similar health and medical problems constitute “medical” benefits or “benefits in the event of sickness” within the meaning of section 3(1) would be subject to the Parity Act’s requirement that financial and treatment limitations for mental and substance use benefits be no more restrictive than the medical/surgical benefits. Employers or health plans may contract for Employee Assistance Services or carve-out behavioral health benefits from their medical/surgical benefits. They are not permitted by the Act to impose treatment limitations or financial restrictions more stringent than those applied to medical/surgical benefits.

• Does the Act require that Medicaid managed care plans provide mental health and substance use treatment services that are comparable to medical/surgical services, even when the full range of services are not reimbursable under the States' CMS approved state Medicaid plans? Must States reimburse Medicaid managed care plans for mental health and substance use treatment services that are not included in state Medicaid plans or CMS approved waivers?

The Act does not mandate Medicaid managed care plans cover mental health or substance use disorders. State Medicaid agencies or the health plans that they contract with may choose what mental health conditions and substance use disorders that they will cover. They may choose to cover no mental health or substance use disorders. The State Medicaid agency may choose to cover certain diagnoses within their Medicaid managed care plans and others remain in Medicaid fee-for-service or in a separately contracted managed behavioral health plan. Mental health and substance use benefits are defined as “benefits with respect to services for mental health conditions [and substance use disorders], as defined under the terms of the plan and in accordance with applicable Federal and State law.” Once the State Medicaid agency or its Medicaid managed care plan contractor decides to cover some services for a mental health or substance use condition, then the “no more restrictive” standard of the Act operates. If a plan covers every level and type of medical/surgical care for substantially all medical and surgical benefits, but only provides for certain levels or types of care for a substance use or mental health disorder, it is likely that the plan has violated the Act’s “no more restrictive” standard.”

State Medicaid agencies use a variety of contractual models for managing medical benefits. The Department of Labor has determined that for ERISA, “benefits for treatment of drug and alcohol abuse, stress, anxiety, depression and similar health and medical problems constitute “medical” benefits or “benefits in the event of sickness” within the meaning of section 3(1). There is

no distinction whether behavioral health benefits are provided contractually through a medical/surgical benefit, a behavioral health carve-out, or a disease management program: benefits for treatment of behavioral health disorders are “medical” benefits or benefits “in the event of sickness.” If State Medicaid agencies choose to include some services for a mental illness or substance use condition, then it must be subject to the “no more restrictive” requirements of the Act. A State that chooses to cover emergency or inpatient medical detoxification for alcohol or drug use disorders within their medical/surgical benefit would have to expand coverage to match the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. If a plan covers every level and type of medical/surgical care for substantially all medical and surgical benefits, but only provides for certain levels or types of care for a substance use or mental health disorder, it is likely that the plan has violated the Act’s “no more restrictive” standard.”