From: Shel Gross [mailto:shelgross@tds.net]
Sent: Tuesday, May 26, 2009 1:39 PM
To: EBSA, E-OHPSCA - EBSA
Subject: Comments on Mental Health Parity and Addiction Equity Act.

Attached are comments on the Request for Information related to the Domenici-Wellstone Mental Health Parity and Addiction Equity Act of 2008.

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May is Mental Health Awareness month! Visit our web site at www.mhawisconsin.org to learn more about the *Live Your Life Well* campaign and the 10 tools that can help combat stress and promote health and well being.

May 26, 2009

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653
U.S Department of Labor
200 Constitution
Washington, DC 20210

Attention: MHPAEA Comments

To Whom It May Concern:

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

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 treatment versus medical and surgical benefits. In order to achieve this goal the implementing regulations must reflect the patient/consumer focus and protective intent of this law and ensure access to a meaningful range of evidence-based interventions.

An overly strict reading 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 when the vast majority of employers substituted new restrictions on access to mental health benefits, thereby evading the spirit of the law

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

Questions from the Request for Information:

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, co-payments, 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 should not be interpreted as the only treatment limitations and financial requirements to which parity applies under the new law. Other examples of treatment limitations that 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;

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- Medical necessity and appropriateness criteria that fail to take into account the degree to which maintaining social, vocational and daily life skills functioning is an important goal of treatment;
- Exclusion of certain specialized services like collaborative care, assertive community treatment, residential treatment, and partial hospitalization which are critical components of the continuum of care;
- Limitations on covering specific types of providers and more restrictive provider licensure requirements;
- Higher standards for demonstrating the evidence-base or cost effectiveness for treatments in order for them to be covered;
- More frequent restrictions on treatments due to experimental status;
- Requirements to prove current threat of harm to self or others as the justification for inpatient care and continuing stay requirements that limit the ability to allow consumers to become sufficiently stabilized prior to discharge;
- With regard to medications, "fail first" or “step therapy” policies that require consumers to suffer adverse outcomes from a preferred medication before the medication recommended by their providers—or one that has been successfully used by them in the past—will be covered; and
- Separate deductibles or lifetime limits in addition to those required for all other services..

The MHPAEA regulations should clarify that the parity standard applies to these other types of treatment limitations as well. Plans that manage their mental health and substance use benefits using these techniques must do so in a nondiscriminatory way.

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 copays, deductibles, and other cost-sharing requirements as well as restricting the number of outpatient visits and inpatient days covered. But 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 take into account evidence indicating mental health and substance use benefits have thus far been much more strictly managed than medical and surgical benefit. States with preexisting parity laws have not seen large increases in mental health and substance use care utilization, presumably due to strict medical management. 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.(1)

Thus, it is critical that the regulations make clear that utilization management techniques 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.

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2. Terms/Provisions in the MHEAPA

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

The following terms and provisions should be clarified in the regulations:

- Parity—The regulations should emphasize that financial requirements or 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.
- Impact on state parity laws—Clarification is needed to emphasize the continued applicability of state laws that provide for greater protection of mental health and substance use benefits.
- Application of the MHPAEA to Medicaid managed care plans—Since the 1996 parity law applied to to Medicaid managed care plans the regulations should make clear that the new parity law applies to these plans as well.
- Application of the MHPAEA to CHIP—Since the 1996 parity law applied to the Children's Health Insurance Program, the new parity which amends the old, should also apply to CHIP.
- The MHPAEA prohibits separate cost sharing and treatment limits—The statute clearly prohibits separate deductibles and other cost sharing and treatment limits but this is not well understood.

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?

Because of the items noted under #1 above, it is critical to implement the requirement for transparency of the medical necessity determination process contained in MHPAEA. Most medical necessity standards used by the health plans seem to focus on the following criteria:

- whether the treatment accords with professional standards of practice;
- whether there is sufficient evidence to demonstrate effectiveness;
- whether the treatment is considered medical as opposed to social or custodial; and
- whether the treatment is considered cost-effective by the insurer.

The following additional clarifications would make this criteria better:

- Evidence from national experts should be considered if peer-reviewed literature is not available;
- Services must be available to maintain or restore function and to prevent or ameliorate medical conditions in addition to treating injuries or illnesses; and

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- Cost effectiveness does not necessarily mean lowest cost—a treatment that is less expensive but is not as effective or is not provided by a provider qualified to deliver that treatment may be less cost effective because the best outcomes will not be achieved..

The regulations should require 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 the criteria for medical necessity (e.g., standard of practice, strength of the evidence base, and definition of medical conditions) with regard to mental health and substance use treatments; and
- Make available to beneficiaries, upon request, the standards used to assess whether the medical necessity criteria have been met 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

- specify that consumers may request 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?

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

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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 or actuarial projections. Such projections have notoriously overstated the impact of parity on costs when compared to actual implementation in states that have enacted parity laws up to this point.

7. Other issues

The agencies have also stated that they will accept comments on any 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 addressed is whether only covering mental health medications constitutes providing a mental health benefit such that the parity requirements in the MHPAEA are triggered. To exclude medications from consideration as mental health benefits would imply that the new parity requirements do not apply to this essential form of mental health treatment that is one of the therapies most analogous to medical and surgical benefits. This result would be inconsistent with the intent of the MHPAEA to ensure equity between mental health/substance use benefits and medical/surgical benefits."

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