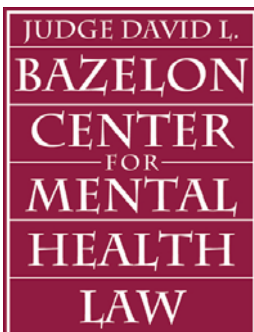

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May 26, 2009

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U.S. Department of Labor

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (published in 74 Fed. Reg.19155 et seq.)

To the Departments:

Thank you for the opportunity to comment on issues surrounding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The attached document represents the comments from the Bazelon Center for Mental Health Law, established in 1972 and the leading national legal advocacy organization for people with mental disabilities.

In the document, we have addressed many of the specific areas for which comments were solicited. We hope you will take our recommendations under careful consideration as regulations are developed.

Thank you again for this opportunity to comment.

Sincerely,

Chris Koyanagi

Chris Koyanagi
Policy Director

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Response to Request for Information:
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Submitted by the Bazelon Center for Mental Health Law

A. Comments Regarding Economic Analysis, Paperwork Reduction Act and Regulatory Flexibility Act

1. *Do plans currently impose other types of financial requirements or treatment limitations on benefits? How do plans currently apply financial requirements or treatment limitations to (1) medical and 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?*

> There has been debate in the field regarding whether or not there should be a single deductible that includes both physical health care services and mental health care services, or "separate but equal" deductibles for these services. Given that the primary goals of parity legislation are to prohibit discriminatory insurance practices and affirm that mental health and substance use disorder treatments are integral components of comprehensive health care, creating discrete but equal deductibles undermines these goals by suggesting that it is necessary to treat physical and mental health services differently. We strongly suggest that one single, inclusive deductible for physical health care and mental health services is necessary to avoid further discrimination.

2. *Are there unique costs and benefits for small entities subject to MHPAEA (that is, employers with greater than 50 employees that maintain plans with fewer than 100 participants)? What special consideration, if any, is needed for these employers or plans? What costs and benefits have issuers and small employers experienced in implementing parity under State insurance laws or otherwise?*

> Currently, there is no provision in the new law that allows for special considerations for small entities. We agree that the law should not permit such special considerations, and that small entities that are subject to MHPAEA should be required to comply in the same manner as other plans subject to MHPAEA.

3. *Are there additional paperwork burdens related to MHPAEA compared to those related to MHPA 1996, and, if so, what estimated hours and costs are associated with those additional burdens?*

> While acknowledging the potential for MHPAEA to create additional paperwork hours and costs is necessary, there should be no consideration given to any additional burden on plans associated with the costs of making a request to the federal government for

exclusion from the parity requirements.

B. Comments Regarding Regulatory Guidance

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

Clarification is needed regarding the application of the parity law to Medicaid managed care plans. Uncertainty in the field continues to exist, despite statutory language or references in Medicaid to the 1996 parity Act. Explanation is also needed to affirm that parity applies to SCHIP plans, as provided by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

Clear explanations indicating how to compare mental health to health with regard to limits on a benefit package and cost-sharing requirements are also necessary. For example, Section 512(a)(3)(A)(i) states that financial requirements for mental health benefits should be "no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan;" there is almost identical language in subsection (ii) with respect to treatment limits. What do these terms mean? The regulations must clarify and explain these terms in order to ensure that any limits on mental health services are appropriate given the overall coverage (including limits and financial obligations of the insured) in a particular plan.

Not all treatments are analogous, and mental health services that are offered on an office outpatient basis, for example, should be treated the same as medical or surgical outpatient visits. This is straightforward for some benefits – medication management, coverage of prescription drugs. It is less clear for some other benefits. However, the term "no more restrictive than" should mean that coverage and cost sharing are equal even when, for example, a mental health service, such as a psychotherapy visit, is not strictly identical to a medical-surgical service, such as a 10-minute office visit. A second example would be if the plan chooses to cover intensive outpatient services or residential treatment. The intensive outpatient treatment should be compared with a standard medical-surgical visit for purposes of out-of-pocket costs or limits on number of visits. The residential treatment service should be considered analogous to inpatient hospital stays.

The regulation should make clear that the plan may also provide for improved coverage of mental health and addictions services. For example, some plans waive cost-sharing for the first few visits in order to encourage individuals into treatment. A plan that chooses to provide residential treatment with lower cost-sharing than hospital care should be free to do so.

Clarification is necessary to assist with the identification of those instances when state laws are to be pre-empted. It is particularly important to provide examples that illustrate how broader mandates that remain in effect in States interact with the new federal law. For example, any mandate to cover mental health services (whether only for people with

certain serious mental disorders or only for a certain number of days) should remain in force. The federal law would then preempt any inappropriate limits on those services, and thus a mandate for 30 days of inpatient care would become a mandate for coverage of inpatient mental health care at parity with other inpatient health services. Additionally, statements that explain how a mandated minimum benefit becomes a parity benefit and how mandated coverage of serious mental illness remains in effect and becomes mandate for parity for serious mental illness are necessary.

4. What information, if any, regarding the reasons for any denial under the plan (or coverage) 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?

Individuals should be provided with more information than is now typically received when a service is denied to them based upon medical necessity. A plain language explanation of why this particular service was not considered appropriate at this time for this person should be required.

6. *Which aspects of the increased cost exemption, 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?*

Regulations that restrict the use of the exemption for a plan based on their documentation of increased costs are needed – the regulation on this matter should be identical to the regulation on the 1996 law. Model notices would indeed be helpful to assist with disclosure to participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption.