CALIFORNIA COALITION FOR MENTAL HEALTH

American Association for Marriage and Family Therapy California Division
California Alliance of Child and Family Services
California Association of Health Facilities
California Association of Marriage and Family Therapists
California Association of Mental Health Patients Rights Advocates
California Association of Social Rehabilitation Agencies
California Council of Community Mental Health Agencies
California Hospital Association
California Institute for Mental Health
California Mental Health Advocates for Children and Youth
California Mental Health Directors Association
California Mental Health Planning Council
California Network of Mental Health Clients
California Primary Care Association
California Psychiatric Association
California Psychological Association
California Society for Clinical Social Work
California Women's Mental Health Policy Council
Disability Rights California
Mental Health Association in California
Mental Health Association of Santa Barbara
NAMI California
National Association of Social Workers, California Chapter
Occupational Therapy Association of California, Inc.
Orange County Coalition for Mental Health
San Diego Coalition for Mental Health
Service Employees International Union, Local 1021
Suicide Prevention Advocacy Network, California
United Advocates for Children and Families

VIA E-MAIL: E-OHPSCA.EBSA@DOL.GOV

May 27, 2009

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, N.W., Room N-5653
Washington, D.C. 20210

RE: Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equality Act of 2008 (Public Law 110-343)

To Whom It May Concern:

On behalf of the California Coalition for Mental Health (CCMH), we wish to thank you for the opportunity to express our views about the Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equality Act of 2008 ("Act").

CCMH is comprised of over thirty organizations whose membership includes family members and consumers, and professional as well as institutional providers of mental health.

In the text below, CCMH has identified specific responses to the request for information surrounding Public Law 110-343:

<u>1. Treatment Limitation</u>:

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Health care plans and insurers use "utilization review" policies to assess treatment limitations on individual enrollees. Generally speaking, mental health and

substance use treatments are placed under heavier scrutiny than medical/surgical treatments.

Unfortunately, in practice, some insurers/plans will place a limit on the number of mental health visits when none exist in the contract. Clear language must be included in regulation as to the plan's/insurer's responsibility to adhere to the Act and not use utilization review to place treatment limitations on their enrollees' access to medically necessary mental health illness or substance abuse treatment.

2. Term Clarification:

A. Mental Health Illness and Substance Abuse Disorder: Regulation must clarify that the purpose of the Act is to serve both those suffering from mental health illnesses and substance abuse disorders. All three amendment sections: (a) ERISA, (b) Public Health Service Act, and (c) IRS Code at subsection (3) state:

> (3) Financial Requirements and Treatment Limitations.
> (A) IN GENERAL.—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 or coverage shall ensure that—
> (i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate cost sharing requirements

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that are applicable only with respect to mental health or substance use disorder benefits; and,
(ii) the 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) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

A clear statement should be put into regulation advising that Public Law 110-343 is to cover both mental health illness and substance abuse disorders, not either.

B. Preliminary Diagnosis: Through regulation, it must be clear that the initial mental health provider's diagnosis, the preliminary diagnosis, stands until another mental health provider declares otherwise. Plans and/or insurers routinely, and inappropriately, void the initial provider's preliminary diagnosis without provider input with the result in California of depriving the individual of the benefits of California's parity law. Clarity needs to be given that the preliminary provider's diagnosis stands until another provider amends that diagnosis (not the plan or insurer.)

3. Medical Necessity:

Currently, each plan and insurer creates their own medical necessity criteria. For obvious reasons this creates a lack of consistency, as well as a lack of clarity. It is imperative that there be a federal model put forward defining "medical necessity" so that the provider, the enrollee, and the consumer can all comprehend whether "medical necessity" applies to their mental health or substance abuse situation.

In putting forward a model, it is crucial that the definition be created and vetted by all stakeholders, including mental health providers and consumers in addition to health care plans and insurers. Medi-Cal and Medicare have both put forward "medical necessity" criteria definitions which may be useful in developing model language.

Moreover, medical necessity criteria is not generally made readily available to the enrollee, but only to the providers. Putting forth regulation encouraging transparency as to medical necessity criteria would be beneficial to the enrollee and consumer.

Lastly, creating an independent medical review system ("IMRS") to evaluate contested denials of treatment based on "medical necessity" would protect the patient from inappropriate or unlawful plan or insurer denials of coverage based on medical necessity. Sample IMRS guidelines and principals can be further reviewed at California Health and Safety Code Section 1374.30.

4. Denial of Reimbursement or Payment:

Providing to the patient and the health care practitioner the reasoning behind a denial of reimbursement or payment is essential in protecting a patient's right to treatment.

Throughout the California Health & Safety Code and Insurance Code, language is utilized to mandate clear reasoning behind plan or insurer decision making. We would suggest similar language in regulation such as:

If reimbursement or payment is *denied by the health care plan/insurer, the decision shall be in writing, and shall include a clear and concise explanation of the reasons for the decision.*

5. Out-of-Network Coverage:

Allowing the patient to receive services out-of-network may sometimes be necessary based on exigent circumstances. Putting into regulation the following concepts protects the patient, while not creating undue hardship on the health care plan or insurer:

- For continuity of care purposes, if the patient's plan/insurance changes, allow patient to continue with their existing health care practitioner (even if out-of-network), provided that practitioner is willing to accept the new health care plan/insurer's rate of reimbursement;

- To assure timely access to care, if an in-network provider is not available to a patient within a timely manner, the plan/insurer shall reimburse the out-of-network practitioner;

- To assure timely access to care, if an in-network provider is not available to a patient within their geographic area within a timely manner, the plan/insurer shall reimburse the out-of-network practitioner;

- A definition of "timely access to care"; and,

- Plan/insurer to reimburse for any reasonable costs associated with urgent care or emergency services, or other extraordinary and compelling health care services, when the patient's decision to secure

those services outside of the plan network was reasonable under the urgent or emergency circumstances;

6. Cost Exemptions:

Model notices would be helpful in facilitating disclosure to agencies, enrollees, and beneficiaries regarding the plan or insurer's election to implement the cost exemption. In addition, the plan or insurer should notify the enrollees and beneficiaries before they elect to take the cost exemption so that those directly affected by the exemption have the ability to select other coverage which includes their given diagnosis.

Additionally, regulation should mandate strict enforcement of plan/insurer reapplication for cost-exemption so that plans/insurers cannot continue with exemption without cause.

Lastly, whatever evidence a plan/insurer utilizes to support an application for exemption should be available to the consumer so that advocacy groups may appeal or rebut a flawed application.

Thank you for your attention to this matter and please let us know if we can provide you any additional information.

Sincerely,

Mary Riemersma
President