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May 27, 2009

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue, NW
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:

The Mental Health Association in California (MHAC) is pleased to provide comments to the six questions listed in the *Federal Register* (April 28, 2009, Pages 19155 et al) on the rulemaking and regulations concerning the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

1. Financial Requirements and Treatment Limitations

The statute provides that the term ''financial requirement'' include deductibles, co-payments, coinsurance, and out-of-pocket expenses. But it excludes an aggregate lifetime and annual limit. These should be included.

The statute further provides that the term ''treatment limitation'' include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

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?

In terms of how these requirements are applied differently between medical/surgical and mental health/substance use, yes, there are differences.

The most obvious is that plans routinely have different requirements for out-of-network care. For example, there is limiting the number of visits or excluding all together for mental health while allowing unlimited visits for medical/surgical. Also, we see different co-insurance requirements for out of network care between medical and mental health.

Mental health and substance use treatments are often placed under greater utilization scrutiny than are medical/surgical treatments. A plan may not require prior authorization and ongoing review for many medical/surgical interventions while always requiring it for mental health/substance use care. This, then, operates as if there is a limit on the number of mental health visits when none exist in the contract.

Provider access to plan information may vary between mental health/substance use and medical/surgical plans.

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

The federal parity statute allows plans (and purchasers) to choose which mental health and substance use "disorders" will be covered. It will be critical to require specificity of diagnoses and interventions for all covered conditions.

Also, requirements for dealing with provisional diagnoses must also be very clear, as diagnoses in mental health/substance use treatment often change during the initial assessment phase, which could last a few months or more.

For example, in California, the initial caregiver's provisional diagnosis is supposed to hold until the plan or another caregiver declares otherwise. All care up to that point is supposed to be covered "as if" the person had a parity diagnosis, based on the initial caregiver's diagnosis.

3. What information, if any, regarding the criteria for medical necessity determinations made under the plan (or coverage) 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?

Most mental health plans do not make their medical necessity criteria known even to their own providers. They should be required to do it on their websites. This requirement should be required across the board for all behavioral health plans, be made available to members as well, and be provided through multiple vehicles besides the Internet, e.g., in benefit books/SPDs.

In addition, requirements for coverage when and if those criteria change should be spelled out. The criteria needs to be specific and measurable, and requirements spelled out as to coverage available while the determination is being made.

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?

Plans (because of the California Department of Managed Health Care audits) have gotten better about putting the required information in their formal denial letters that go to the provider and consumer - if they are denying based on medical necessity.

An area of concern is the way in which care is terminated or transitioned once the plan has determined that medical necessity no longer is met. This juncture can become a morass of phone calls, documents, debates, etc., between providers and the UR staff, resulting in a great deal of uncertainty and disruption for the client.

In addition, if the provider determines that the client still needs care, and the plan terminates the benefit, the provider is left potentially unreimbursed. Clear requirements to address this situation should be considered.

Provisions for coverage when treatment is denied for reasons other than medical necessity (usually an administrative problem) should be spelled out and should not penalize a client for the omission or error of the provider.

5. 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?

Out-of-network coverage for mental health and substance use disorder benefits is spotty across plans; however, this should be available if it is for medical/surgical treatment.

The level of benefit for out-of-network coverage for mental health is usually lower than that for medical/surgical. It is common for plans to limit the number of visits and have much larger co-pays or coinsurance, etc., for out-of-network mental health and substance use disorder treatment than for out-of-network medical/surgical treatments.

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?

Whatever evidence a plan puts forward to support an application for the increased cost exemption must be made public. Consumer advocacy groups should be able to appeal or rebut an application for exemption if they can provide evidence that the plan's data is flawed, incorrect, etc.

MHAC appreciates the opportunity to provide comments on these regulations. We will be happy to provide more information upon request.

Sincerely,

Peter Schroeder

Peter Schroeder
President of the Board of Directors