Defending Liberty
Pursuing Justice

AMERICAN BAR ASSOCIATION

Governmental Affairs Office
740 Fifteenth Street, NW
Washington, DC 20005-1022
(202) 662-1760
FAX: (202) 662-1762

May 28, 2009

Alan D. Lebowitz
Deputy Assistant Secretary for Program Operations
U.S. Department of Labor
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
200 Constitution Avenue, N.W.
Washington, DC 20210

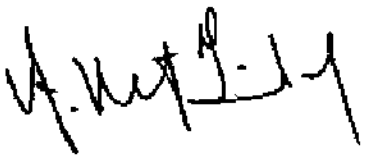
RE: MHPAEA Comments

Dear Mr. Lebowitz:

On behalf of the American Bar Association (ABA) and its more than 400,000 members, I am pleased to present our enclosed comments in response to the Request for Information regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 [*See* Notice of Request for Information, 74 Fed. Reg. 19155 (Apr. 28, 2009)].

Thank you for considering our views on this important matter.

Sincerely,



H. Robert Fiebach
Chair, ABA Standing Committee on Substance Abuse

/Enclosures

cc: Thomas Susman, Director, ABA Governmental Affairs Office
Lillian Gaskin, Senior Legislative Counsel, ABA Governmental Affairs Office
Jared Hess, Legislative Assistant, ABA Governmental Affairs Office

Comments on Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")

Comment 1: Both Inpatient and Outpatient benefits are to be provided in parity

1. Statutory Provisions

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that 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, the treatment limitations applicable to 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, and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. "The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, *or other similar limits on the scope or duration of treatment*." (Emphasis supplied.)

2. Suggestion

It is requested that the implementing regulations clarify that an insured plan that provides both an inpatient and outpatient benefit on the medical/surgical side; and provides however, only an outpatient benefit on the mental health/substance use disorder side, would be prohibited under MHPAEA as containing a predominant treatment limitation on the scope or duration of mental health/substance use disorder benefits.

3. Explanation

Some have suggested that a plan providing an inpatient and outpatient benefit on the medical/surgical side; and, only an outpatient benefit on the mental health/substance use disorder side, and excluding an inpatient benefit, would be in compliance with MHPAEA. This is contrary to the language and intent of MHPAEA. While MHPAEA does not mandate group health plans to provide a mental health and/or substance use disorder benefit, if a plan does provide such a benefit, that benefit must be on par with substantially all benefits provided on the medical/surgical side. The legislative history for Emergency Economic Stabilization, Pub.L.No. 110-343, House Report 110-374 (Part 1), III. Summary of the Bill, p. 24, speaks to the intent of MHPAEA:

> The bill [H.R.1424] does not mandate group health plans to provide any mental health coverage; however, if the group health plan does offer mental health coverage then there

> must be equity between mental health coverage and all comparable medical and surgical benefits that the plan covers. H.R. 1424 makes clear that equity in financial requirements, treatment limitations, and out of network coverage is essential to a strong federal mental health parity law.

MHPAEA does not separately address inpatient benefits versus outpatient benefits, nor were they intended to be addressed or treated separately. MHPAEA addresses *substantially all* medical/surgical benefits on the one hand, and *substantially all* mental health/substance use disorder benefits on the other hand. To permit plans to contain a significant limitation on the number of visits, days of coverage and scope and duration of treatment, such as an *outpatient only* benefit on the mental health/substance use disorder side, while providing an *inpatient and outpatient* benefit on the medical/surgical side, under the guise that MHPAEA does not mandate a mental health/substance use disorder benefit, would be contrary to the plain language and intent of MHPAEA.

Comment 2: Inpatient to Inpatient/Outpatient to Outpatient comparison required

1. Statutory Provisions

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that 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, the treatment limitations applicable to 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, and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. "The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, *or other similar limits on the scope or duration of treatment*." (Emphasis supplied.)

2. Suggestion

It is requested that the implementing regulations clarify that, in applying the parity provisions of MHPAEA, inpatient benefits on the medical/surgical side are to be compared with inpatient benefits on the mental health/substance use disorder side. Likewise, outpatient benefits on the medical/surgical side are to be compared with outpatient benefits on the mental health/substance use disorder side.

3. Explanation

For example, limits on number of visits under the medical/surgical benefit for outpatient physical or occupational therapy visits, should *not* be compared with limits on number of visits under the mental health/substance use disorder benefit for inpatient psychotherapy, group therapy or other therapy-related sessions. MHPAEA was intended to ensure parity in terms of treatment limitations with respect to the comparable benefit. To permit outpatient treatment limitations to be applied to components of inpatient care would violate the purpose and intent of MHPAEA.

Comment 3: Facility type and Clinician type restrictions not permitted

1. Statutory Provision

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that 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, the treatment limitations applicable to 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, and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. "The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, *or other similar limits on the scope or duration of treatment*." (Emphasis supplied.)

2. Suggestion

It is requested that the implementing regulations clarify that MHPAEA does not permit plans to limit covered treatment services for mental health/substance use disorder benefits to those services rendered *only* by hospitals or facilities affiliated with hospitals, as opposed to free-standing residential treatment facilities that are duly licensed and accredited. Similarly, MHPAEA does not permit plans to limit covered treatment services for mental health/substance use disorder benefits to those services rendered by licensed psychologists, mental health counselors, social workers and certified addiction professionals.

3. Explanation

Many insured plans, (and several state law mandates), providing for mental health/ substance use disorder benefits, restrict benefits to services rendered only by hospitals or facilities affiliated with hospitals, as defined by the plan. Many insured plans do not include appropriately licensed and accredited free-standing residential treatment

facilities in their definition of "hospital" or "qualified treatment facility." Substance abuse treatment facilities that are properly licensed for each level of care they provide are the equivalent of properly licensed hospitals on the medical/surgical side. This treatment limitation, as contained in many insured plans, deprives members of the ability to obtain covered treatment from those healthcare providers that specialize in, and are specifically licensed to, render those services the member requires.

Similarly, some group health plans provide coverage for medical services rendered by substantially all types of licensed professional clinicians such as physicians, nurses, and physical rehabilitation therapists under the medical/surgical benefit. However, the same plan might exclude coverage for substance use disorder services rendered by substantially all types of licensed professional mental health/substance use disorder providers such as psychiatrists, psychologists, mental health counselors, social workers and certified addiction professionals under the mental health/substance use disorder benefit. An insured plan should be required to eliminate such treatment limitations in order to be in compliance with MHPAEA.

Comment 4: Non par Level of Care exclusions not permitted

1. Statutory Provision

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that 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, the treatment limitations applicable to 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, and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. "The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, *or other similar limits on the scope or duration of treatment*." (Emphasis supplied.) ERISA §712(e)(5) was added to define substance use disorder benefits as "benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law."

2. Suggestion

It is requested that the implementing regulations clarify that MHPAEA does not permit plans to contain treatment limitations on mental health/substance use disorder benefits that exclude coverage for state licensed levels of care, or licensable components, when such equivalent or analogous healthcare services are not excluded under the medical/ surgical benefit. Such exclusions have the effect of limiting both the scope and duration of treatment, creating an impermissible "treatment limitation" in violation of MHPAEA.

3. Explanation

Many insured plans providing both a medical/surgical and a mental health/substance use disorder benefit, exclude from coverage the rehabilitation and/or residential levels of care on the substance use disorder side, requiring patients to go straight from detoxification into an outpatient setting. There exists no such corresponding exclusion on the medical/surgical side. Residential treatment consists of a 24 hour structured live-in environment with rehabilitative treatment services, and is an integral part of the continuum of care for substance abuse treatment. While medical necessity determinations need always be made, *and are not at issue here*, the exclusion from coverage altogether of a state licensed rehabilitation or residential level of care, is a treatment limitation that is more restrictive than predominant treatment limitations placed on the medical/ surgical benefit.

To illustrate, a member obtaining substance abuse treatment may typically be admitted to detoxification level of care, followed by intensive inpatient rehabilitation and monitoring, followed by residential treatment, followed by outpatient day or night treatment, followed by outpatient group therapy. To analogize, a member obtaining medical/surgical care typically will be admitted for surgery, followed by intensive care in a monitoring unit, followed by continued hospitalization in a regular patient room, followed by outpatient therapy. Every such level of medical/surgical care is a covered benefit.

MHPAEA addresses *substantially all* medical/surgical benefits on the one hand, and *substantially all* mental health/substance use disorder benefits on the other hand. To permit plans to contain a significant treatment limitation on the number of visits, days of coverage and scope and duration of treatment, such as *an exclusion for residential level of care* on the mental health/substance use disorder side, while providing *a full continuum of care* on the medical/surgical side, would be contrary to the plain language and intent of MHPAEA.

An insured plan that excludes coverage for a level of care, such as residential treatment, under the mental health/substance use disorder benefit that is not excluded under the medical/surgical benefit, should be deemed in violation of MHPAEA, and the plan should be required to provide corresponding levels of care as offered on the medical/surgical side in order to be in compliance with MHPAEA.

Comment 5: Non Par Pre-authorization Penalties not permitted

1. Statutory Provisions

ERISA §712(a) [29 USC 1185a] (3)(A)(i) and (B)(i) and (ii) were added to require that 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, the *financial requirements applicable to 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, and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. (Emphasis supplied). A financial requirement is considered to be predominant if it is the most common or frequent of such type of requirement. "The term 'financial requirement' *includes* deductibles, copayments, coinsurance, and out-of-pocket expenses." (Emphasis supplied). (Aggregate lifetime limits and annual limits are addressed in §712(a) (1) and (2)).

2. Suggestion

It is requested that the implementing regulations clarify that MHPAEA does not permit plans to impose a financial pre-authorization penalty when a healthcare provider is unable, or otherwise fails, to obtain a pre-authorization for services prior to admission under the mental health/substance use disorder benefit, when there is no such financial pre-authorization penalty under the medical/surgical benefit. Such imposition of pre-authorization penalties constitutes a more restrictive financial requirement on the mental health/substance use disorder side than the predominant financial requirements applied to substantially all medical/surgical benefits, thereby prohibited by MHPAEA.

3. Explanation

Many insured plans contain financial pre-authorization penalty provisions that apply when a healthcare provider of substance use disorder treatment services is unable or otherwise fails to obtain a pre-authorization to render services prior to the member's admission into treatment. Such financial penalties can range from $500 to complete denial of coverage. Financial pre-authorization penalties exist with respect to the mental health/substance use disorder benefit; however, not with respect to the medical/ surgical benefit. These financial penalty provisions result in more restrictive financial requirements on mental health/substance use disorder benefits than are applicable to medical/surgical benefits, thereby violating the plain language and intent of MHPAEA. An insured plan should be required to eliminate financial pre-authorizations penalties that exist on the mental health/substance use disorder side, and that do not exist on the medical/surgical side in order to be in compliance with MHPAEA.

Comment 6: Non par Treatment Completion Requirements not permitted

1. Statutory Provisions

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that 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, the treatment limitations applicable to 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, and that there are *no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.* (Emphasis supplied). A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. "The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." ERISA §712(e)(5) was added to define substance use disorder benefits as "benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law."

2. Suggestion

It is requested that the implementing regulations clarify that MHPAEA does not permit plans to contain a separate treatment limitation under the mental health/substance use disorder benefit that requires a member/patient to complete a particular treatment program, as set forth in the plan, in order for the treatment to be covered, when there is no such treatment program completion requirement for coverage under the medical/surgical benefit.

3. Explanation

Many plans require that a member complete a treatment program as set forth in the plan, (for example, a 28 day program), in order to be covered under their substance use disorder benefit. There exists no such program completion requirement on the medical/surgical side. To illustrate, under such a plan, a member could receive detoxification, intensive inpatient and residential treatment for a total of 16 days, and leave treatment against medical advice. Because the member did not complete a 28 day treatment program, *none* of the treatment would be covered. Conversely, under the medical/surgical benefit, a member could be recovering from knee replacement surgery and be prescribed a series of 28 therapy sessions, yet stop at the 16th session. On the medical/surgical side, the 16 treatment sessions would, of course, be covered. A separate treatment limitation that a member completes a treatment program set forth in the plan, in order for *any* of the treatment services to be covered under the mental health/ substance use disorder benefit is a separate treatment limitation that does not exist under the medical/surgical benefit. An insured plan should be required to eliminate such separate treatment limitations on the mental health/substance use disorder side in order to be in compliance with MHPAEA.

Comment 7: Parity Requirements apply equally to Out-of-Network providers

1. Statutory Provision

ERISA §712(a)(5) was added to require that "if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder

benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section."

2. Suggestion

It is requested that the implementing regulations clarify that the MHPAEA parity be applied equally to benefit coverage for out-of-network providers of mental health or substance use services, as it is applied to benefit coverage for out-of-network providers of medical and surgical services.

3. Explanation

As Congress expressed:

> H.R. 1424 makes clear that equity in financial requirements, treatment limitations, and *out of network coverage* is essential to a strong federal mental health parity law. [Emphasis supplied.]

Economic Stabilization, Pub. L. No. 110-343, House Report 110-374 (Part 1), p.23. Thus, if an insured plan with medical and surgical and mental health or substance use disorder benefits, provides out-of-network coverage on the medical/surgical side, it must also provide on par out-of-network coverage on the mental health/substance use disorder side.

Comment 8: More generous state parity and mandate laws not pre-empted, More restrictive state parity and mandate laws pre-empted

1. Statutory Provision

ERISA §712(a) [29 USC 1185a] (3)(A)(ii) and (B)(ii) and (iii) were added to require that 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, the treatment limitations applicable to 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, and that there are *no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.* (Emphasis supplied). A treatment limitation is considered to be predominant if it is the most common or frequent of such type of limit. "The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment." ERISA §712(e)(5) was added to define substance use disorder benefits as "benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law."

2. Suggestion

It is requested that the implementing regulations clarify that MHPAEA does not preempt state parity and mandate laws to the extent that they do not prevent the application of MHPAEA. Thus, provisions in state parity and mandate laws that are more generous than parity required under MHPAEA are not impacted. However, it is requested that the DOL/IRS clarify that provisions in state parity and mandate laws that are more restrictive than the parity that is required under MHPAEA, are preempted.

3. Explanation

As set forth in the legislative history for Economic Stabilization, Pub. L. No. 110-343, House Report 110-374 (Part 1), pp.21, 23:

> Since 1996, a key principle for Congress has been to incrementally reform private health coverage by establishing a federal floor of protections for workers and their families. Through a federal standard that is a floor, not a ceiling, Congress has recognized that state policymakers may determine that to protect patients in state-regulated plans, a stronger set of standards are necessary than those provided in federal law. In fact, many states now require insurance companies to cover mental health services.
>
> * * *
>
> The bill [H.R. 1424] generally would not preempt state laws that do not "prevent the application" of federal mental health parity standards... The bill also specifically does not intend to preempt state laws containing benefit mandates...

Thus, for example, licensure (hence geographic) and residency restrictions in state law parity and mandate laws, creating treatment limitations that weaken the parity of mental health and/or substance use disorder benefits required under MHPAEA, must be eliminated from group plans in order for such plans to reach the federal parity floor in compliance with MHPAEA.

Comment 9: Both Fully-funded and Self-insured plans are governed

1. Statutory Provisions

MHPAEA governs "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..." ERISA §712(a) [29 USC 1185a](3)(A). MHPAEA exempts from its governance small employer group plans for employers who employed not more than 50 employees on business days during the

preceding year, and plans that qualify for the cost exemption in accordance with the provisions of MHPAEA. Otherwise, both fully-insured and self-funded plans are governed by MHPAEA.

2. Suggestion

It is requested that the implementing regulations clarify that MHPAEA governs both fully-funded plans that are subject to state regulation and self-insured plans that are not subject to state parity and other state laws.

3. Explanation

It is apparent from the clear language of MHPAEA that, as opposed to state regulations that are limited in governance to fully-funded plans, MHPAEA governs both fully-funded and self-insured plans, which do not otherwise fall within its exemption provisions.

Comment 10: Parity Requirements apply equally to the Availability of In-network providers

1. Statutory Provision

ERISA §712(a) [29 USC 1185a] (3)(A)(i) and (B)(i) and (ii) were added to require that in the case of a group health plan (or health insurance coverage afforded in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, the financial requirements applicable to 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, and if there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. A financial requirement is considered to be predominant if it is the most common or frequent of such type of requirement. The term "financial treatment" includes deductibles, co-payments, co-insurance and out of pocket expenses.

2. Suggestion

It is suggested that the implementing regulations clarify that in order to achieve parity, a health insurance plan that contains both medical/surgical benefits as well as mental health or substance use disorder benefits provide an in-network selection of in-patient and out-patient providers that are comparable to the availability of in-network providers for medical and surgical benefits.

3. Explanation

The greatest out-of-pocket expense now incurred by members requiring mental health and/or substance use disorder benefits, is the gap between what is covered and what is not covered, in terms of the expenses incurred when accessing out-of-network providers. Thus, the optimum way for members requiring these services to reduce that out-of-pocket exposure is to utilize an in-network provider. However, under present pre-MHPAEA plans, a great disparity exists between the options available for in-network providers of medical/surgical services and the scarcity of in-network providers of mental health and/or substance use disorder services. This disparity needs to be addressed in the clarifications and regulations to be issued by the Departments.