RICHARD BLUMENTHAL		KEVIN LEMBO
ATTORNEY GENERAL		HEALTHCARE ADVOCATE
State of Connecticut		**State of Connecticut**

By Electronic Mail

May 28, 2009

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW.
Washington, D C 20210
Attention: MHPAEA

Re: Joint comments on Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

To Whom it May Concern:

We write to comment jointly on the April 28, 2009 Request for Information regarding the MHPAEA issued by the Departments of Labor and Health and Human Services.

First, we commend the preservation of strong state mental health parity laws in the passage of the MHPAEA. Through the work of dedicated advocates, attorneys general and congressional delegations, we were able to prevent preemption of Connecticut's (and other states') stronger state laws.

Despite the request for information, we would be remiss if we did not express our concern that the MHPAEA allows employers who offer group medical plans to not offer mental health services if the cost of doing so reaches an increased cost of two percent. We hope that Congress, and DOL and HHS through its analysis of the impact of the MHPAEA, will address this issue in recommendations for future legislation since the cost exemption can only work to prevent access to medically necessary mental health care. Under the cost exemption as written, an increase in cost from legitimate utilization of mental health treatment or diagnostic services may actually lead to the elimination of the benefit. The long overdue inclusion of a substantive provision to federal mental health parity should not be

permissive. If an employer offers a group plan that includes medical benefits, it should also include mandatory coverage of mental health services without regard to cost-exemptions. We do not permit such cost-exemptions on the medical side of these group plans. Including a cost exemption seems on its face to be an example of not treating mental illness the same as medical illnesses are treated under ERISA.

Treatment Limitations

We view the phrase "treatment limitations" broadly to include required lengths of stay before being allowed access to another service, prior authorization requirements and limited and narrow medical criteria that are not applied with consideration to individual circumstances. Our experience shows that treatment limitations are not handled consistently across medical/surgical and mental health services. These prior authorization and concurrent reviews are treatment limitations at the most basic level.

For instance, many plans have pass through mental health visits, a number of visits for which access to care is unimpeded by insurers. After that time, however, insurers often impose burdensome prior authorization requirements or concurrent review requirements, the likes of which are not seen in any but only the most severe medical cases, such as severe illnesses requiring prolonged hospitalizations. It is unheard of to limit visits to a primary care provider or a specialist, even though a referral may be required prior to the specialist visit.[1]

The natural subjectivity of the diagnostic activities of a psychiatrist, psychologist or APRN requires that there not be artificially imposed limitations on the number of visits before treatment limitations kick in. The complications of mental health militate that the diagnostician's considered medical opinion as to diagnosis, treatment design, including level of care, pharmaceutical interventions and length of stay be granted deference. Mental illness diagnosis and treatment rest upon clinically based activities that should require plans to grant the mental health provider's decisions the presumption of medical necessity with the burden of proving that a treatment is not medically necessary placed on the plans.

Second guessing considered medical judgments in the evaluation and treatment of mental health care is an intolerable treatment limitation that can only be truly remedied by the shift in the burden in the medical necessity determination to the insurers or administrators, where it belongs. Not only is this the logical and proper solution, but it is the only solution that can ensure that there is not only mental health parity on paper, but also in reality.

Without this shift, providers have been subject to repeated paperwork to justify continued treatment for their patients. Since many mental illnesses are chronic with varying periods of exacerbation, ongoing treatment is most often medically necessary. These burdens on providers, accompanied by antiquated reimbursement structures and the second guessing of treatment options, has led to the wholesale defection in Connecticut of all but only a few accessible mental health providers. Covered access is essentially limited to the limited number of social workers, APRNs, marriage and family therapists who accept

[1] A referral is not a determination of medical necessity as is prior authorization.

insurance or other health plan coverage. While these providers are qualified to deliver services within their scope of practice, there are not enough of them accepting new patients to take on the demand for mental health treatment and/or diagnosis. There are few psychologists and virtually no psychiatrists that participate in insurance plans in our state, further impeding access to care. Eliminating these types of treatment limitations and burdens is the only way to ensure the return of mental health providers to health plan participation in sufficient numbers to allow consumers affordable and accessible critical mental health care.

Medical Necessity Criteria

Use of Criteria in determining medical necessity

While access to medically necessary mental health treatment should not be subject to limitations that exceed those of medical health, we still need to recognize that mental illness diagnosis and treatment are not the same as medical illnesses. The uniqueness of mental health treatment has resulted in financial limitations that while equal in absolute dollars are unequal in actual adequacy in treatment. Insurers continue to use absolute criteria in making determinations of medical necessity despite the requirement that medical necessity be determined on an individual basis.

Insurers have effectively mined mental health claims to such an intricate level as to create very narrow medical necessity criteria that they often incorrectly use as the sole determinant for making a decision on medical necessity. In many cases, plans do not follow their own criteria. For instance, in many cases criteria require that if co-morbidities are present, that there must be more review, but the plans do not do it. As stated above, mental health treatment is particularly individualized in nature. For instance, it is commonly know that certain prescription drugs may help one individual while psychologically damaging another. The same holds true for different forms of therapy and level of care determinations.

Relying flatly on medical necessity criteria is a dangerous game. When one considers that many health plans use reviewers who may be medical reviewers or mental health professionals who have not met the consumer and/or whose credentials do not match those of the treating provider, the use of criteria as the determinant of medical necessity is inadequate.

We recommend that any regulations issued by either DOL or DHHS include a provision requiring that : 1) a health plan reviewer's credentials must match those of a treating provider; and 2) plans shall not use solely medical necessity criteria to determine medical necessity and shall consider the consumer's individual circumstances as the overriding determinant of medical necessity.

Sharing of Medical Necessity Criteria

In Connecticut, medical necessity criteria are required to be made available to enrollees only upon request. Many do not know that such information can be requested when challenging a denial. Though many insurers post their criteria online, those criteria are not easy to access and are most often located under provider sections of the websites. We

suggest that medical necessity criteria be included in any correspondence that communicates either a denial or a partial denial of care. This will allow fair preparation for an appeal.

Reasons for Denial Not Adequately Shared

We proposed legislation in Connecticut's current legislative session to address this very issue. Denial letters are mostly very general in nature and make a statement such as the following, "[W]e have denied your claim as not medically necessary. Your claim does not meet our medical necessity criteria."

Such a notice does not fairly indicate a true reason for denial and does not permit adequate preparation for an appeal. We recommend that in promulgating regulations, you consider language that requires: health plans to provide a clear, easy to read, detailed explanation for the denial or partial denial, tied not only to criteria used as a guideline, but to the individual's circumstances; the name of the reviewer on whose recommendation the denial or partial denial was based; and information on how to appeal. We also recommend that in the communication of a denial or partial denial, the health plan include the any medical necessity criteria used to evaluate coverage for the requested treatment.

Conclusion

We greatly appreciate the issuance of a request for information by the Departments of Labor and of Health and Human Services before promulgating regulations for the MHPAEA. As advocates who participated in the negotiations on a portion of the Act, and as parties who handle hundreds of mental health treatment denials every year, across all health plans, our comments are based on a wealth of experience. Thank you for your consideration of our comments.

Sincerely,

Richard Blumenthal
Attorney General

Kevin Lembo
Healthcare Advocate