American Psychiatric Association

1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209
Telephone 703.907.7300
Fax 703.907.1085
E-mail apa@psych.org
Internet www.psych.org

May 28, 2009

The Honorable Hilda L. Solis
Secretary of the Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Kathleen Sebelius
Secretary of the Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Timothy Geithner
Secretary of the Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Docket No. CMS-4140-NC; [RIN 0938-AP65]; 74 Federal Register 19155 (April 28, 2009).

Dear Secretaries Solis, Sebelius, and Geithner:

The American Psychiatric Association (APA), the national medical specialty society representing more than 38,000 psychiatric physicians, appreciates the opportunity to submit these comments on the Departments of Labor, Health and Human Services, and the Treasury (The Departments) request for information (RFI) on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Sections 511 and 512 of PL 110-343, October 3, 2008) (MHPAEA08).[1] Enactment of the MHPAEA08 will improve coverage for over 113 million people, including 82 million individuals covered by employer sponsored plans which were not subject to state regulations. The law will ensure that mental health or substance use disorder coverage will now be treated the same as all other forms of healthcare coverage.

[1] Pub. L. 110-343

Background

While the MHPAEA08 is a landmark piece of legislation, it is not the first legislation to address the inequities of coverage between mental health benefits and medical/surgical benefits. The Mental Health Parity Act of 1996 (MHPA96) required that there be parity in the aggregate lifetime and annual dollar limits for mental health benefits and medical and surgical benefits.[2] The MHPAEA08 goes beyond MHPA96 by including substance use disorder treatment and adds the following new requirements:

> (1) the financial requirements (including deductibles, copayments, coinsurance, and out-of-pocket expenses, but excluding aggregate lifetime limits and annual limits (which are subject to MHPA 1996's existing 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;
> (2) there are no separate cost-sharing requirements that are applicable only with respect to mental health or substance use disorder benefits;
> (3) the treatment limitations (including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment) 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; and
> (4) there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. A financial limit or treatment limit is considered to be predominant under MHPAEA if it is the most common or frequent of such type of limit or requirement.[3]

The MHPAEA08 also states that plans offering out-of-network benefits to beneficiaries for medical and surgical coverage, must also provide out-of-network coverage for treatment of mental illness or substance use disorders in a manner consistent with the other sections of the law.

The MHPAEA08 picks up where the MHPA96 left off and closes many of the loopholes which led to continuing discriminatory practices by insurance companies to perpetuate the stigma associated with mental illness or substance use disorders and to deny coverage for those individuals who desperately need it. While we are very pleased that the legislation includes a requirement that the Government Accountability Office (GAO) conduct a study of the implementation of the law, we believe that there is a strong need for real-time monitoring of insurance coverage and management practices. Based on our members experience APA has concerns that some insurers may utilize overly aggressive management techniques in response to the statute and that careful oversight by the Departments, particularly DoL and HHS, is necessary. APA believes that this is within

[2] 74 Federal Register 19155, 19156.
[3] 74 Fed. Reg. at 19156.

the authority given to the Departments through the audit sections of the MHPAEA08 and the Departments should not hesitate to take advantage of this power when it is indicated the law's intent is being circumvented.

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

While there is no perfect model for comparison of cost analysis, the integration of parity in the FEHBP and several of the state laws requiring parity of mental health benefits can serve as examples of how the statute might affect costs. In general, it is well documented that imposing parity on a plan might increase costs somewhat, but that these costs tend to be less than expected and are often offset by tangible cost reductions through increased worker productivity, reduced absenteeism, and disability costs.

Under the MHPAEA08, insurance plans that offer mental health and substance use disorder coverage would be required to change several common policies and procedures. These policies and procedures would include: cost-sharing policies, day and visit limitations, maximum out-of-pocket limits, and deductibles. It is very common for insurers to have separate requirements for mental health or substance use disorder benefits as compared to medical and surgical benefits and would be required under the statute to make them equivalent. These changes may result in both direct and indirect costs for insurers, employers, physicians and beneficiaries. However, these costs could be offset by a number of different changes. The MHPAEA08 allows insurers to continue to manage their benefit as they see fit, which in turn could control costs. Although employers may see an increase in the costs of providing such insurance, they will also likely see a rise in work productivity and a reduction in absenteeism as employees take advantage of newly available mental health or substance use disorder treatment benefits. In addition, ready access to continuous high quality mental health care will reduce disability costs as patients remain under the care of a professional and remain stabilized. Lastly, although insurance premiums may rise, employees will be able to take advantage of equal cost-sharing and likely lower out-of-pocket maximums. All of these effects can be appropriately balanced and result in a benefit for consumers with proper oversight and management.

Physicians will likely see an increase in uncompensated time from additional requirements from the new management techniques. The health services research literature has documented the magnitude of the time burden (uncompensated time) on physicians to comply with the administrative requirements imposed by insurers. The literature has also demonstrated conclusively that parity implementation increases the use of utilization management protocol by insurers. There are definitive cost consequences for physicians which will be associated with the law's implementation. We urge the Departments to factor in these costs as part of their overall analysis.

For a comparison of costs, APA encourages the Departments to examine the example of mental health parity as implemented in the federal workforce health system. In 1999, under a directive from President William Clinton, the Office of Personnel Management (OPM) moved to ensure parity in the FEHBP for mental health and substance use disorders.[4] While the results from the parity implementation for FEHBP are pertinent, a key difference between the implementation of parity for FEHBP and the MHPAEA, is the fact that FEHBP only covered in-network benefits and did not require parity for out-of-network benefits. However, given the large scale of the FEHBP, which covers 8.5 million enrollees including the federal workforce, retirees and spouses and dependents, this example is perhaps the most analogous to the current implementation scenario.

During the implementation, OPM encouraged health plans to use managed care techniques to control expected cost increases associated with the expanded coverage.[5] A study performed by HHS in 2002 showed that the implementation of parity resulted in "little or no significant adverse effect on access, spending, or quality"[6] of services and care provided. An analysis of spending in nine large FEHBP plans revealed that the policy resulted in out-of-pocket spending decreases for beneficiaries in six of the nine programs.[7] While there was an overall increase in spending on mental health services over the years examined, it was commensurate with the growth for these services in non-FEHBP plans.[8] In fact, in seven of the nine plans examined, spending on behavioral health services actually declined.[9]

While the federal government took steps to ensure that FEHBP plans implemented parity for in-network services before the MHPAEA08 was passed, numerous states also passed parity laws which are more protective than the new federal standard. While implementation of full parity varies from state to state, the experiences are valuable examples of how to implement the current statute. Studies of the implementation of parity in Texas and North Carolina actually showed decreased costs for mental health beneficiaries between 30 and 50 percent when combined with managed care.[10] In addition to these lower costs, the population able to access mental health care rose by one to two percent.[11] In addition to the positive examples in Texas and North Carolina, Maryland has had success moving forward with their own parity law. Since mental health care was

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[4] Goldman, H., et al., *Behavioral Health Insurance Parity for Federal Employees*, N Engl J Med 2006; 354:1378-86 at 1379.
[5] Goldman at 1379.
[6] Sethi, R., Jee, J., Chimento, L., & Mauery, D.R. *Designing Employer-Sponsored Mental Health Benefits.* (2006) DHHS Pub. No. SMA-06-4177. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration at page 24. (*hereinafter* Designing Employer-Sponsored Mental Health Benefits).
[7] Ibid at 24 (While the study showed decreases for six of the nine programs, only 5 of those decreases were statistically significant.).
[8] Id. at 24.
[9] Id. at 24 (Of those seven, decreases were statistically significant in five of the programs.).
[10] Id. at 24. *See also* Testimony of Darrel A. Regier, M.D., M.P.H., on "Insurance Coverage of Mental Health Benefits" to the House Committee on Energy and Commerce, Subcommittee on Health; July 23, 2002.
[11] Designing Employer-Sponsored Mental Health Benefits at 24.

already offered through managed care, costs increased by less than 1 percent in 1994 when the law was implemented.[12]

While these state experiences reveal that costs rarely increase after the implementation of mental health parity and result in better access to care for patients, the state statutes vary and may not be as broad as the MHPAEA08. A better example might be that of Vermont, which instituted the most comprehensive mental health parity law in 1998.[13] In studies examining the impact of the law for the first two to three years, which went into effect at the same time as the MPHA96, it was demonstrated that parity decreased total spending for covered mental health services.[14] Despite the breadth of the law, employers did not drop mental health coverage or switch to self-insured products as many had feared.[15] While there were concerns that lack of awareness of the statute complicated the implementation, consumers reported improved access to outpatient mental health services and total spending on mental health services decreased.[16] Effective managed care was an important factor in controlling these costs, but this example shows that broad implementation of mental health parity can positively affect consumers and not be costly to employers and may well be cost neutral.

The Congressional Budget Office (CBO) conducted a cost estimate of H.R. 1424 as ordered by the House Committee on Education and Labor[17] and estimated that the statute would increase premiums for group health insurance plans by an average of 0.4%[18] before accounting for any responses on the part of employers and insurers. CBO estimated that those responses would offset approximately 60% of the potential impact of the legislation.[19] CBO estimated that the other 40% of the potential increases, which accounts for less than 0.2% of group health insurance premiums, would occur through higher spending for health insurance. Overall, CBO stated that the cost of the legislation would be $1.3 billion in 2008 (the first year of compliance) and would rise to $3.0 billion in 2012.[20] These increases will be mitigated by the cost savings in indirect costs, since mental illness and substance use disorders cost employers an estimated $80 to $100 billion dollars in indirect costs annually.

While there is no perfect way to assess exactly how the MHPAEA08 might impact costs for the government, physicians, employers and consumers, the examples set by the

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[12] Id. at 24.
[13] Id. at 24. For a full analysis of the implementation of the mental health parity law in Vermont, *see* Rosenbach, M., Lake, T., Young, C., et al. (2003). *Effects of the Vermont Mental Health and Substance Abuse Parity Law*. DHHS Pub. No. (SMA) 03-3822. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. (Available at: *http://mentalhealth.samhsa.gov/publications/allpubs/sma03-3822/default.asp*).
[14] Designing Employer-Sponsored Mental Health Benefits at 25.
[15] Id. at 25.
[16] Id. at 25.
[17] Cost Estimate for H.R. 1424: Paul Wellstone Mental Health and Addiction Equity Act of 2007 as ordered reported by the House Committee on Education and Labor on July 18, 2007, Congressional Budget Office, September 7, 2007. (*hereinafter* CBO Report)
[18] Id. at 4.
[19] Id. at 4.
[20] Id. at 7.

implementation of the MHPA96, states which have already imposed broader mental health parity laws, and the estimates from CBO provide a positive picture. In many of these cases, parity has been less costly for insurers and employers than expected and very beneficial for employees and their dependents. However, there is always the potential for overzealous management to minimize the benefits for patients. The APA urges the Departments to conduct outreach and careful oversight to ensure that the law is implemented as intended.

Comments Regarding Regulatory Guidance

Financial and Treatment Limitations

Recent data shows that nearly all workers who had health insurance were also provided mental health benefits.[21] However, for many of those individuals, this does not mean that they are afforded a mental health benefit that is comparable to their medical and surgical coverage. While most plans cover a wide range of services, such as inpatient treatment, outpatient treatment, and prescription drug benefits;[22] financial requirements and treatment limitations are extremely common. As the Departments state in the RFI, financial requirements can include deductibles; cost sharing measures, such as copayments or coinsurance; and other out-of-pocket expenses. While financial requirements limitations vary from plan to plan, typically the out-of-pocket expenses for beneficiaries are higher for mental health services than for medical and surgical services. For a more complete picture of the prevalence of various requirements, limitations and discrepancies, APA would encourage the Departments to consult a database such as MEDSTAT and additional public and private databases that track coverage characteristics.

Before the MHPAEA08, plans would frequently impose separate and even higher annual deductibles for mental health or substance use disorder treatment than for medical and surgical benefits. In the recently issued carrier letter for the FEHBP, OPM recognizes that plans are permitted to offer separate, but equal deductibles under the MHPAEA08. However, OPM states that they "strong encourage FEHB plans to offer combined deductibles and catastrophic limits which include expenses for both medical and surgical and mental health and substance use disorder services."[23] OPM is also asking that plans that decide not to have a combined deductible to provide "a reasonable explanation and justification" for the choice.[24] APA would ask the Departments to encourage plans to move to system where they have a combined deductible for all covered healthcare costs.

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[21] Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2008 Annual Survey*, Henry J. Kaiser Family Foundation, Menlo Park, California, and Health Research & Educational Trust, Chicago, Illinois at page 141. (Available at *http://ehbs.kff.org/pdf/7790.pdf*) (*Hereinafter* 2008 Kaiser/HRET Employer Health Benefits Survey).

[22] Designing Employer-Sponsored Mental Health Benefits at 40.

[23] FEHB Program Carrier Letter: Letter 2009-08, Insurance Services Program, U.S. Office of Personnel Management, April 20, 2009 at page 5 (Available at http://www.opm.gov/carrier/carrier_letters/2009/2009-08.pdf)

[24] Id.

Additionally, plans typically impose higher cost sharing measures on mental health services. In 1997, the median in-network cost sharing was a $15 copayment or a 20% coinsurance for inpatient services and a $20 copayment or 20% coinsurance for intermediate services.[25] While plans vary, the cost sharing is generally lower on the medical and surgical benefit for similar services. Also, some insurers will structure their cost sharing in a tiered manner whereby patients would pay less for initial visits and more as treatment continues or the tiers are designed to encourage use of less costly services, which may or may not be the best form of treatment for a particular patient.[26]

In addition to many of the financial requirements that are imposed on the mental illness and/or substance use disorders plans also impose treatment limitations that are not applied to medical-surgical benefits. These treatment limitations often include visit and day limits, coverage for only certain diagnoses or treatments, and limited reimbursement for physicians. Only 18% of covered employees had coverage for unlimited outpatient visits and 22% had coverage for unlimited inpatient days for mental illness.[27] While there is some variation across plans, the most common treatment limitations are 20 outpatient visits and 30 inpatient days annually.[28] These types of limitations are very popular; however they are not that effective in controlling costs and serve only to limit the type of treatments that patients can receive.[29] On the other hand, these same limitations do not exist on the medical and surgical side of the benefit.

While most insurers currently apply the direct limitations on treatment for mental illness and/or substance use disorders noted above, they also apply less straightforward methods of limiting the types and duration of such treatments that are covered for patients. APA has concerns that, after the implementation of parity, insurers will employ less visible means of restricting access to treatment for mental illness and/or substance use disorders, that will perpetuate the discriminatory coverage schemes that the MHPAEA08 sought to eliminate. We think that certain forms of aggressive benefit management can become de facto treatment limitations and should be prohibited under the law.

For example, many insurance companies will use reimbursement to physicians as a method of limiting the type of services that a patient can receive. It is not uncommon for an insurer to only reimburse psychiatrists for a narrow range of Current Procedural Terminology (CPT) codes which are specific to psychiatric care. However, there are a number of codes, particularly the "Evaluation and Management (E&M)" codes, which the insurer will reimburse to all other physicians. These E&M codes cover physician services that are essential to the care of patients, including coordinating care management, talking with patients' families, and discussing treatment options. As healthcare moves to a system where physicians are encouraged to spend time coordinating care of their patients, especially those with multiple chronic illnesses, this type of policy can become a serious

[25] Designing Employer-Sponsored Mental Health Benefits at 45.
[26] Id. at 45-46.
[27] 2008 Kaiser/HRET Employer Health Benefits Survey at 141.
[28] Designing Employer-Sponsored Mental Health Benefits at 43.
[29] Id.

limitation on the type of care a patient receives and on who is administering this care. This practice seems particularly discriminatory since CPT codes are open for all qualified physicians under Medicare and similar reimbursement restrictions are rare to nonexistent for any other medical specialty. APA would encourage the Departments to instruct insurers that limiting physician reimbursement to certain codes in an unequal manner is a violation of the MHPAEA08 and will not be permitted.

Other examples of management techniques that morph into de facto treatment limitations include the use of prior authorization as a barrier to care and other perquisites to accessing care. While many insurers use prior authorization as a legitimate benefit management tool, it can also be used as a roadblock for patients seeking certain treatment. It increases the amount of time and effort required by both the physician and the patient to access the appropriate treatment and can be used solely to discourage use of these services. When benefit management protocols are used in this manner, they become, in effect, treatment limitations and APA would object to the use of prior authorization to access mental health care or substance use disorder treatment where there is no such similar requirement on the medical and surgical benefit.

In addition to requiring prior authorization, some benefits require that a patient access the employer's employee assistance programs (EAP) before they are able to seek mental health care through the mental health benefit. As mentioned above, APA would strenuously object to application of this type of restriction, since it functions as a treatment limitation and there is no analogous restriction for accessing the medical and surgical benefit. Given the possibility that plans may use the parity requirements to simply shift treatment limitations to more opaque methods, such as the use of differential reimbursement for physicians, prior authorization and similar barriers, APA urges the Departments to monitor for this activity and instruct the GAO to consider these scenarios when conducting their review of plan adherence.

In sum, benefits for psychiatric services should be indistinguishable from benefits for other medical services. This applies to financial limits, co-payments and particularly to utilization review. Utilization review for psychiatric services should be indistinguishable from utilization review for all other medical services with respect to timing (when it is required), intensity, and denial rates.

Clarifications

APA appreciates that the Departments are seeking input on what areas of the law might require greater clarification. While the law is relatively straightforward, the implementation of it may not be. We have identified several areas which clarification and guidance from the Departments would be welcome.

Predominant Limits

APA believes that the terms in the statute which state that a financial requirement or treatment limitation can be "no more restrictive than the predominant requirements/limitations which are applied to substantially all"[30] medical and surgical benefits needs definitional certainty through regulation. For the regulations under the MHPA96, the Departments previously held that they would employ a "one-third/two-thirds" test in defining the "predominant" limitation. The regulations state that plans that did not impose aggregate or lifetime limits on less than one-third of the medical and surgical benefits could not impose a similar limit on the mental health benefit.[31] Similarly, if the plan does impose aggregate or lifetime limits on the medical and surgical benefit, the mental health benefit can be no more restrictive than the features which apply to two thirds of the medical and surgical limits.[32] APA believes that this is a clear and logical standard which has been held by the Departments since the enactment of the MHPA96 and we would recommend the Departments to apply the same standard here.

Also, to ensure that there is a fair and accurate determination of the predominant limitation, we would ask that the Departments state that plans should compare the predominant limits within categories. For example, the plan should compare the predominant limitation for inpatient services on the medical and surgical benefit to the limitation for inpatient services on the mental health, and likewise, outpatient services should be compared to outpatient services. The Departments should clarify, as OPM did in the 2009 FEHB Program Carrier Letter, that it is inappropriate to equate limitations on treatment for mental illness or substance use disorders to limitations for other therapy services such as speech, physical or occupational therapy.[33] As with prior regulations, we would greatly appreciate it if the Departments would provide examples and further guidance on how to apply this standard in the forthcoming rules. We anticipate that state insurance commissioners will set additional guidance for the plans, but a clear statement from the Departments is necessary in this area. We urge the Departments to carefully review how states with parity laws have in fact operationalized equivalency respecting financial requirements and treatment limitations for mental health and substance use disorders.

In addition to further guidance about the standard for determining what the "predominant limitation" of a plan is, APA believes that the statutory language of the MHPAEA08 is clear that the term "no more restrictive than" means that the mental health benefit must be equal to or better than the predominant limitation for the medical and surgical benefit. Therefore if a plan determines that predominant limitation on the medical and surgical benefit is actually more restrictive than the limitation on the mental health benefit, they do

[30] Pub. L. 110-343 (October 3, 2008)
[31] 62 Federal Register 66931, 66935 (December 22, 1997).
[32] 62 Fed. Reg. at 66935.
[33] FEHB Program Carrier Letter at 5.

not need to adjust the benefits to be equal. Plans which offer very generous mental health benefits should not be penalized and required to lower the mental health coverage that they provide for their beneficiaries. APA urges the Departments to make a clear statement in the final regulations to eliminate any possible confusion.

Applicability of MHPAEA08 to Some Smaller Employers

APA would urge the Departments to offer a clear statement of exactly to whom the law applies. While the statutory language exempts employers with 50 or fewer employees, there are a number of other options for which the application of the law is not quite as clear. For example, if there are three main employers, each with 25 employees who decide to pool their risk and resources to purchase health insurance, are they above the 50 employee threshold? Or, if an employer with 30 employees also extends lifetime healthcare for 30 retirees? In addition to these examples, there have been questions raised about whether the law applies to student health plans, frequently offered by colleges, universities and graduate programs. While the answers to many of these questions may already exist elsewhere in statute and regulation, providing guidance and information to plans who may be concerned about whether or not they must comply in the regulations would be greatly appreciated. Additionally, to clear up any confusion, APA would ask that the Departments issue a clear statement that Medicaid managed care plans fall under the purview of the law and must comply.

Employee Assistance Programs

Another area of concern is whether Employee Assistance Programs (EAPs) and wellness programs fall under the scope of the law. These programs are increasingly popular among employers as a benefit for their employees, but currently most also offer mental health coverage. Since EAP and wellness programs often provide some counseling and 'mental health' services, there is considerable confusion as to whether EAPs fall under the MHPAEA08. However, since these types of plans also often offer additional assistance programs (e.g. financial planning and conflict resolution) and do not offer a medical or surgical benefit, among other reasons, we do not believe that EAPs should be considered group health plans. APA understands that DoL has issued some advisory letters to employers as to whether specific EAPs should be covered by ERISA and therefore would be subject to the requirements in MHPAEA08, but that these letters have been issued on an ad hoc basis. APA encourages the Departments, particularly DoL, to issue clear parameters defining when an EAP would fall under the requirements of the statute and when they would not. It would also be helpful for the Departments to articulate whether it is permissible under the MHPAEA08 for an employer to offer a medical and surgical health benefit and an EAP, but not provide mental health or substance use disorder coverage.

Medicaid Managed Care

While it is clear that the requirements of the MHPAEA08 apply to managed care under Medicaid (MMC), there are many complex issues as to how MMC plans to comply with the Act's requirements due in large part to the various kinds of management the states have established. In as much as nearly two-thirds of Medicaid enrollees are in MMC plans, it is critical that the Departments provide authoritative guidance on this issue.

Indirect and Direct Coverage

As the Departments are aware, the majority of treatment for psychiatric disorders occurs outside the specialty sector for mental health services. More than 80% of patients with mental health or substance use disorders are treated in the general medical sector. So, for example, individuals are often treated for depression by primary care physicians with medications whose primary FDA-approved indication is for depression. This can and often occurs outside an individual's specific coverage for mental health conditions. It would be inappropriate for a plan to choose not to directly provide coverage for mental health conditions, but to allow indirect coverage for the type of scenario described above. This would be a circumvention of the MHPAEA08s requirements. In our view, indirect coverage under such circumstances is equivalent to offering direct coverage. We strongly recommend that the Departments address this issue to clarify that indirect coverage is the same as direct coverage and that the Act's requirements apply.

Preemption

Since the passage of the MHPA96, the majority of states have enacted their own mental health parity statutes.[34] Some of these statutes include mandates to cover mental health or substance use disorders, while others simply require parity of benefits. There is a great deal of variation among state laws and few of the state statutes are as sweeping as the MHPAEA08. The codified MHPAEA08 amends the Public Health Service Act which states that the law "shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of

[34] As of December of 2008, 42 states have enacted legislation parity laws with varying approaches to prohibit discrimination in insurance and managed care coverage of mental illnesses: Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and West Virginia.

this part."[35] Therefore, while the language is clear that it will only preempt state laws that are more restrictive than the federal law, the application of this standard could become extremely complex in practice. APA believes that implementation of the federal law, given current state laws, may well cause preemption concerns pending the issuance of regulations.

Given the wide variation in state parity statutes, we anticipate that state insurance commissioners and attorneys general will be responsible for ensuring state compliance. Since the MHPAEA08 was passed and in the absence of guidance from the federal government, several states that have parity laws have issued opinion letters about how their laws wrap around the federal law. We would refer the Departments to these letters, particularly to that of Maryland,[36] as a model for how states should proceed in how to evaluate their own laws. Specifically, we also would request that The Departments issue a letter to the state insurance commissioners to issue advice and guidance on how to evaluate the possibility of any conflicts. This clear direction from the Departments would alleviate a great deal of confusion and possible undue conflicts which will impede and delay the implementation of the law.

Medical Necessity and Denials

The MHPAEA08 contains a statutory requirement that "the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits […] shall be made available by the plan administrator."[37] The law also states that "[t]he reason for any denial under the plan"[38] also be made available to the provider or beneficiary. APA is pleased that this requirement is contained within the statutory information and also that the Departments are inquiring as to the current practice with regard to medical necessity and denials.

APA has concerns that insurers use an opaque and complex formula for determining medical necessity for mental health and substance use disorder treatment. Over half the states have a statutory definition of "medical necessity" currently in effect, which serves to enhance patient protections.[39] Many health insurance plans do indeed publish their stated medical necessity criteria on their plan's website or distribute the information to the plan participants. Much of the same information is frequently contained in the provider "handbooks" or "manuals" given to physicians and other healthcare providers who participate in the plan. However, this information is not usually the whole universe of the plan's medical necessity criteria. Much of the actual data and information used to

[35] 42 United States Code §300gg-23(a)(1).
[36] *See* Impact on Maryland Law of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Parity Act") February 23, 2009 (available at: *http://www.oag.state.md.us/Opinions/2009/94oag3.pdf*).
[37] Section 512(a)(1)(4) of Pub. L. 110-343.
[38] Section 512(4).
[39] Buckley IV, J.F., Prysby, N.D., *State by State Guide to Managed Care Law, 2009 Edition*, Aspen Publishers, 2009 at §5.02.

determine necessity and issue denials is deemed proprietary and therefore confidential by insurers. APA objects to this practice and would encourage the Departments to issue strong regulations addressing the need for greater transparency in the process.

We understand the right of companies to maintain confidentiality with regard to their proprietary information, but we also have serious concerns about the use of this confidentiality as a shield to circumvent the law. As an example, 44 states have enacted procedures for independent external review processes for coverage denials.[40] These review processes vary among states, but can often be initiated by the insured party or their designee or the physician acting on the insured's behalf.[41] APA would recommend that the Departments enact or require a similar external independent review process. This could be accomplished at the federal level or through a delegation of authority to the state insurance commissioners.

National accreditation organizations such as the Utilization Review Accreditation Commission (URAC) provide an industry standard for the process of communicating reasons for denial. Despite these national standards, physician providers experience rigid and aggressive utilization review sometimes related to particular reviewers. This can selectively limit access to mental health and substance abuse services. There needs to be prompt and accessible appeals that can be initiated by the provider of services, not just by the patient. Reviews must be done by physicians subject to the oversight of state physician licensing agencies. Appeals should be done by physicians certified in the specialty area related to the treatment under review. The reviewer must be familiar with the service network in the patient's area. Should providing physicians be subject to unprofessional treatment by physician reviewers, they should be able to report this behavior to state licensing agencies.

Out of Network Treatment

One feature of the MHPAEA08 which APA considers extremely important is the extension of parity to out-of-network (OON) services. Approximately 70 percent of consumers with employer sponsored health insurance have the option of access to OON services, frequently subject to increased cost sharing as compared to in-network coverage.[42] Patient choice is extremely important to the physician-patient relationship, particularly with respect to mental health and substance use disorder treatment where instability and change can be very detrimental to a patient's care. During the implementation of parity in the FEHBP, OPM did allow plans to offer higher cost sharing

[40] Id. at §5.03.
[41] Id.
[42] *See* Testimony of Nancy H. Nielsen, M.D., Ph.D. before the Senate Committee on Commerce, Science and Transportation on "Deceptive Health Insurance Industry Practices - Are Consumers Getting What They Paid For?," March 26, 2009. (Available at: *http://commerce.senate.gov/public/_files/NielsonTestimonyonDeceptiveHealthInsurancePractices32609.pdf*).

and day and visit limits for OON options.[43] Before implementation of parity, the plans did not distinguish between in-network and out-of-network mental health benefits, but after implementation, studies showed that the out-of-network benefit mirrored the pre-parity in-network benefit.[44] While all of the plans in the FEHBP complied with the in-network parity requirements, none of the plans extended parity to the OON benefit.[45] Recent studies have shown that adequacy of in-network participation and access to out-of-network services is extremely important to the health of the patients.[46] Therefore, APA is extremely pleased that the law extends parity to these services, as it would likely not occur in the absence of a federal requirement.

There is also concern that differential reimbursement to physicians could affect the adequacy of an insurer's network. While insurance companies typically have higher cost sharing measures when patients go out-of-network to encourage in-network visits, this practice could go too far. If reimbursement is drastically lower for out-of-network physicians, the out-of-pocket burden on the patient could be unaffected by post-parity implementation. This could have the adverse effect of forcing patients to see in-network providers, as opposed to merely a deterrent. APA regards these measures as a veiled attempt to circumvent the MHPAEA08 and would ask the Departments to inquire about the reimbursement practices of insurers as a part of the GAO study.

Cost Exemption

Like the MHPA96, the MHPAEA08 contains an exemption process for employers who experience a significant increase in costs through the implementation of parity. Few employers opted to go through the cost exemption process under the earlier law and APA does not anticipate that costs will increase dramatically to extent that many employers will need to undergo the process. However, APA believes that guidance about the cost exemption would be very helpful and would encourage the Departments to publish such guidance.

There are a few areas of the cost exemption that APA urges the Departments to include in any guidance that is put forth. We would expect a clear restatement of the statutory language indicating that the cost exemption is retrospective, meaning that any employer who wishes to file of the exemption must comply with the MHPAEA08 for at least one year. Also, while the statute states that the determination of increases in actual costs must be performed by a "qualified and licensed actuary who is a member in good standing with

[43] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Evaluation of Parity in the Federal Employees Health Benefits (FEHB) Program: Final Report*, December 2004, at 47. (Available at: http://aspe.hhs.gov/daltcp/reports/parity.pdf) (*Hereinafter* Evaluation of Parity in the FEHB Program).
[44] Id.
[45] Evaluation of Parity in the FEHB Program at 203.
[46] Regier, D., et al., *Parity and the Use of Out-of-Network Mental Health Benefits in the FEHB Program*, Health Affairs 27, no. 1 (2008): w70-w83 (published online 18 December 2007; 10.1377/hlthaff.27.1.w70).

the American Academy of Actuaries."[47], in practice, an actuary who is a member in good standing of the American Academy of Actuaries (AAA) is considered to be "certified" as opposed to "licensed" by AAA. A clarification from the Departments in the forthcoming regulations on this matter would eliminate any possible confusion that could arise from the conflicting terminology.

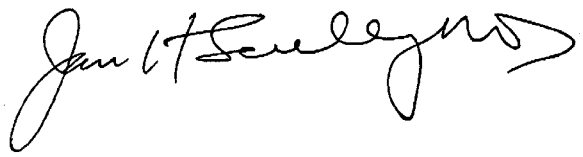
Additionally, as with the regulations issued after implementation of the 1996 law, examples of how companies are required to collect data regarding the cost exemption would be very helpful. APA would greatly appreciate any model notices the Departments could provide to ease disclosure of the plans which have elected to file for the cost exemption. We would encourage the Departments to take vigorous action in this area to ensure transparency and disclosure throughout this process.

Conclusion

Passage and enactment of the MHPAEA08 is the culmination of a decade-long effort to increase the protections of the MHPA96 and ensure that the discriminatory insurance schemes for mental health and substance use disorder treatment are eliminated. The law will have wide-reaching positive health effects and hopefully begin to erase the stigma of seeking treatment for mental illness. APA greatly appreciates the efforts of the Departments to try to gather as much information as possible to create clear and effective regulations. We believe that implementation will go smoothly with the proper guidance and oversight from the federal government. APA also believes that cost increases will be minimal and vastly outweighed by the benefits afforded by appropriate access to mental health care. We are happy to serve as a resource whenever the Departments may need it and would be pleased to offer any additional information should it be requested.

Thank you for your consideration of these comments on this request for information. We look forward to working with you in the future to develop and implement any policy change. If you have any further questions, please contact Nicholas Meyers, Director, Department of Government Relations, at nmeyers@psych.org or Jennifer Tassler, Deputy Director, Regulatory Affairs, at jtassler@psych.org or at (703) 907-7800.

Sincerely,



James H. Scully Jr., MD
CEO and Medical Director

[47] Section 512(a)(3)(B) of Pub. L. 110-343.