American Medical Student Association/Foundation

- Quality, Affordable Healthcare for All
- Global Health Equity
- Enriching Medicine through Diversity
- Professional Integrity, Development, and Student Well-Being

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

ATTN: MHPAEA COMMENTS

Dear Sirs/Madams:

On behalf of the American Medical Student Association, which represents over 67,000 physicians-in-training, I thank you for allowing us the opportunity to submit our comments on implementing the Domenici-Wellstone Mental Health and Addiction Equality Act of 2008. As longtime supporters of parity legislation, we are pleased with its passage, which we consider an important step toward the goal of providing affordable, high-quality health care in the United States. We also recognize that close attention must be paid to its implementation in order to preserve the intent of the Act: to facilitate the financing and delivery of individualized, patient-centered mental health and substance abuse services.

In theory, the reason parity has been found not to significantly increase total cost is that less intensive treatment options, used early, reduce the need for costly hospitalizations. More generally speaking, this is the rationale behind the concept of managed care. However, care must be taken that insurers apply best practices for efficient delivery of health care, rather than more damaging cost-reduction measures that impose additional barriers to obtaining care. Furthermore, we believe that best practices, as disseminated by federal agencies, should be weighted toward patient-centered criteria such as efficacy and patient satisfaction, rather than toward purely financial considerations. We favor regulations that ensure access to a wide range of evidence-based treatment options, and would like to present several issues that may affect access to care.

One of our primary concerns is the way the term "treatment limitations" will be construed. It is our position that plans currently impose treatment limitations not explicitly mentioned in your solicitation of comments, and we fear that discriminatory application of such limitations as a response to parity legislation may undo the progress that parity represents.

In particular, administrative burdens on providers represent a significant barrier to treatment. Here, the experience of Federal Employees' Health Benefit (FEHB) plans in Washington, D.C. is instructive. Although President Clinton's Executive Order mandating parity for federal employees was successful in reducing deductibles and co-payments, the reaction of managed care companies administering the benefit plans hurt the same people that the order was intended to help. Within the first year,

many local providers left FEHB plan networks. Psychiatrists surveyed by the Washington Psychiatric Society in 2001 cited increased pre-authorization requirements and more frequent and time-consuming utilization reviews as reasons for leaving the plans, along with insufficient reimbursement. The increase in administrative requirements may have been in anticipation of greatly increased numbers of claims. Four years later, only a small minority of psychiatrists, social workers, and clinical psychologists in the D.C. area were in FEHB networks and accepting new patients. Accordingly, a new patient might expect to have some difficulty obtaining in-network treatment. Also, passing the insurance paperwork itself on to patients is becoming an increasingly common practice among mental health care providers; this also increases the difficulty of obtaining care.

Therefore, we support a broad construction of the term "treatment limitations," covering pre-authorization requirements as well as limits on frequency of treatment, days of coverage, and similar. In addition to imposing extra administrative burdens on providers and patients with the detrimental effects we have already noted, pre-authorization effectively limits the flexibility of treatment, particularly in mental health crisis situations. Regulation should ensure that it is not used in a discriminatory manner.

Our second concern is the range of services to be covered at parity. Because mental healthcare spans a wide range of treatment and enabling services, parity should apply to coverage of a wide range of evidence-based treatment options, including those not traditionally covered by private insurance. The definitions of mental health benefits and substance use disorder benefits should be clarified such that they include all treatment modalities strongly supported by scientific evidence. It may be useful to refer to the American Psychological Association's listing of empirically validated treatments for guidance. Mental health services that have no analogous medical/surgical services, such as residential treatment or partial hospitalization, may require specific regulation; certainly the percentage of cost borne by the patient should not exceed that for medical/surgical services of similar cost. In addition, we encourage the Departments to study the costs and benefits of reimbursement at parity for enabling services, which might allow greater access to mental health as well as medical/surgical services.

Finally, we are concerned with discriminatory use of utilization management. The clause of the Act mandating availability of plan information is a major step forward. While medical necessity criteria for many plans are already available to the public, evidence suggests that medically unjustified denials of claims occur on a regular basis. Multiple studies have suggested that utilization management "democratizes" mental health services to detrimental effect by limiting utilization based on diagnosis while failing to consider severity of illness. This amounts to denial of needed care. It fails to provide adequate

care to the most severely ill patients, and takes treatment decisions out of the hands of the clinicians best able to make them.

The next logical step, then, is to establish, along with other quality assurance programs, a process for resolving parity-related disputes by which patients and healthcare providers can challenge insurance decisions. Certain categories of disputes are easily foreseeable, such as those concerning whether a treatment modality is covered by the parity law, or those concerning whether a type of treatment limit is discriminatory with respect to analogous medical/surgical limits. The system must be able to examine decisions on a case-by-case basis in order to ensure appropriate care. Already a number of states mandate availability of third-party review of denied claims. These may provide guidance on implementing a fair and cost-effective process for procedural justice.

In summary, we urge you to: define "treatment limitations" broadly, to include pre-authorization requirements and other administrative burdens on providers and patients as well as frequency of treatment, days of coverage, and similar parameters; protect parity coverage of a broad range of evidence-based treatments for mental health and substance use disorders, whether traditionally covered or not; ensure that utilization management is used in a fair and non-discriminatory manner and in a way that does not endanger the most severely ill individuals; establish a process by which patients, healthcare providers, and other stakeholders may challenge parity-related insurance decisions.

Again, as future physicians, we appreciate the opportunity to offer our opinion on implementing the MHPAEA and will be pleased to discuss any of our concerns in further detail. We hope that our comments may be of assistance in crafting fair and effective rules that increase the public's access to mental health and substance abuse treatment.

Sincerely,

Ms. Farheen A. Qurashi
Jack Rutledge Legislative Director

Cc: Internal Revenue Service, Department of the Treasury
Employee Benefits Security Administration, Department of Labor

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