Depression and Bipolar Support Alliance

May 28, 2009

Internal Revenue Service
U.S. Department of the Treasury

Employee Benefits Security Administration
U.S. Department of Labor

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (published in 74 Fed. Reg.19155 et seq.)

VIA EMAIL: E-OHPSCA.EBSA@dol.gov

To the Departments:

The Depression and Bipolar Support Alliance (DBSA) welcomes the opportunity to respond to the request for information as the departments begin the rulemaking process on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, also known as MHPAEA.

DBSA feels it is important that the departments keep as their main focus the clear and straightforward assessment of Congressional intent for this law. The clear intent of the law to require group health plans with more than 50 employees to provide benefits coverage for mental health and substance use services on an equal footing with medical surgical benefits, or in simple terms, parity. There will inevitably be differences in interpretation between existing rules and regulations, and disputes over how to implement particular aspects of the law. DBSA feels that by adhering closely to the letter and spirit of the law, as evidenced by Congressional intent, the departments will ensure rules and regulations that satisfied members of the public, and the Congress.

We address several of the questions from the Request for Information below:

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

Some form of parity legislation exists in more than 40 states; limited parity has been in effect in Federal law since 1996, including several "Sunset provision" extensions. DBSA, despite a serious attempt to find instances where any of the laws had a deleterious economic or paperwork

burden impact, on employers (large or small) or health insurers, has been unable to substantiate any such impact. With the current widespread adoption of electronic health records and electronic billing, DBSA anticipates that any economic impact will be minimal, to insurers or employers. We would urge that any claims of excessive cost or paperwork burden be rigorously examined, and that appropriate historical data be provided by those asserting such high burden or cost.

> *Do plans currently impose other types of financial requirements or treatment limitations on benefits? How do plans currently apply financial requirements or treatment limitations to (1) medical and surgical benefits and (2) mental health and substance use disorder benefits? Are these requirements or limitations applied differently to both classes of benefits? Do plans currently vary coverage levels within each class of benefits?*

It was the intent of Congress that separate pools of deductibles for mental health and medical and surgical benefits be construed as financial discrimination. The MHPAEA states that there are to be "no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits." For a plan to require an individual to pay an out of pocket deductible for medical and surgical benefits and then a separate deductible for mental health benefits is not equitable and would tend to pose a significant barrier to treatment for many individuals. Separate but equal deductibles and out of pocket maximums are discriminatory and should be prohibited.

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

Several states, Washington, to name one, have broader mandates than MHPAEA. DBSA believes that the MHPAEA should serve as a floor on benefits, not as a ceiling. States with broader mandates should not have their laws pre-empted by MHPAEA, while MHPAEA requirements should be seen as "mandatory minimums". In no way should MHPAEA become an impediment to improving services for mental health or substance use disorders. We believe the Departments should seek information from the various states as to their individual parity laws, along with states' assessments of the impact of these parity laws, especially their impact on costs. Organizations like the National Association of Insurance Commissioners (NAIC) may also be consulted to help determine the best way to integrate federal and state law in a manner consistent with Congressional intent in MHPAEA.

Network design, and especially "phantom networks" of providers have proven to be significant barriers to individuals attempting to access appropriate services. Serious consideration needs to be given to allowing maximum flexibility for individuals to access out of network providers when insurers are unable to provide access through their own network.

Depression and Bipolar
Support Alliance

Some thought needs to be given to the inclusion of the various mental health specialties as part of the provider network. Having a wider range of provider specialties and levels of service available to persons needing services can lead to improved outcomes as well as reduce dependence on the most expensive services, typically inpatient hospitalization.

> *What information, if any, regarding the reasons for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits is currently made available by the plan? To whom is this information currently made available and how is it made available? Are there industry standards or best practices with respect to this information and communication of this information?*

Service denials are often delivered in cryptic language that even professionals don't always understand. Explanations of service denial should be provided in plain language, with a clear statement as to why a particular service was deemed inappropriate. There should be clear directions, again in plain language, on how individuals may access any appeals process that they are entitled to under their plan coverage.

> *Which aspects of the increased cost exemption, if any, require additional guidance? Would model notices be helpful to facilitate disclosure to Federal agencies, State agencies, and participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption?*

While the potential for increased cost exemption may be required in some instances, the regulations should be based on requiring thorough documentation of such increased costs. The 1996 law provides good guidance to the departments for this part of the regulations. Model notices would be most helpful, and should be standardized.

DBSA appreciates the opportunity to comment on the Departments' Request for Information, and we thank you for considering our views. We stand ready to be of assistance in the next steps of the implementation of the MHPAEA.

Sincerely yours,

Peter Ashenden, President/CEO
Depression and Bipolar Support Alliance