

United States Senate

WASHINGTON, DC 20510-2309

May 3, 2010

The Honorable Hilda Solis
Secretary
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

The Honorable Timothy Geithner
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Ave, NW
Washington, DC 20220

Dear Secretaries Solis, Sebelius, and Geithner:

Thank you for your work in promulgating regulations for the Wellstone-Domenici Mental Health Parity Addiction and Equity Act (MHPAEA). This law is an historic step forward for our country, and we are pleased that the regulatory process thus far seems to accurately reflect the intent of the law.

We appreciate that your departments share our view that discrimination against mental health and substance use benefits (regarding treatment limitations) may take a form beyond those limitations specifically described in the MHPAEA. Insurers have often found other ways to inappropriately limit mental health and substance use disorder benefits – beyond those that are imposed on medical/surgical benefits – through processes such as medical management, use of usual and customary charges, and restrictions on access to psychotherapy. We would like to highlight the fact that while the strategy of intensely managing care and limiting services has lowered short-term costs, it has also created unintended consequences. Both patients and providers have reported problems with access, quality of care, and unequal benefits including higher deductibles and co-payments compared to general healthcare services.

We are pleased that your departments address non-quantitative treatment limitations in the Interim Final Rule with the list of limitations that would violate the MHPAEA. However, we note that the regulators provide no examples for several of the non-quantitative treatment limitations in the illustrative list. While the examples in the rule regarding the use of medical management are useful, we believe that more examples are needed because mental health and substance use disorder benefits are so intensely managed. As your departments have indicated, additional descriptions and examples will provide useful information regarding unacceptable non-quantitative treatment limitations by health plans, particularly regarding medical management. We appreciate your attention in addressing these inequities in the final regulation, and further examples of plan management would be helpful to this end.

One of the non-quantitative treatment limitations listed in the Interim Final Rule describes health plan methods for determining usual, customary, and reasonable charges. The process by which a plan determines these charges can be complex and, if applied on a more restrictive basis, would violate the MHPAEA. Usual, customary, and reasonable charges are typically applied to out-of-network coverage and these charges determine the level of financial responsibility for the health plan and the patient. If a plan is allowed to use an unequal formula and process for determining charges for medical/surgical versus mental health/substance use benefits, it may create a greater financial requirement on out-of-network mental health/substance use benefits. It is this type of disincentive for mental health services that MHPAEA is meant to end, and an example of this practice in the rule would be helpful in clarifying what constitutes a violation of the MHPAEA.

Like health plan use of usual, customary, and reasonable charges, the other non-quantitative limitations listed in the Interim Final Rule involve concepts that may not be readily understandable to the average plan enrollee. These include use of fail-first policies or step therapy protocols, prescription drug formulary design, provider network participation, and exclusions based on a failure to complete a course of treatment. We believe these concepts deserve examples in the final regulation to provide a general understanding of compliance with the law.

Finally, we recommend a clarification on how the MHPAEA applies parity for scope of services – namely how a plan enrollee needing mental health or substance use disorder services is covered for scope of services and the duration of benefits compared to services for medical/surgical conditions. Your departments describe parity for non-quantitative treatment limitations, and we believe it is also important that the regulation addresses parity for scope of services. To fully address the spirit of the MHPAEA, the final rule should clarify this important aspect of parity for patients and providers.

Thank you for your careful consideration of these comments. We appreciate your efforts to ensure Americans have access to the mental health and substance abuse services they are entitled to under the MHPAEA.

Sincerely,



Tom Harkin
United States Senator



Christopher Dodd
United States Senator



Al Franken
United States Senator