AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

May 28, 2009

Internal Revenue Service
Department of the Treasury

Employee Benefits Security Administration
Department of Labor

Centers for Medicare & Medicaid Services
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 American Psychological Association ("APA" or "we"), the professional organization representing more than 150,000 members and affiliates engaged in the practice, research and teaching of psychology, appreciates the opportunity to respond to the departments' request for information ("RFI") regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The APA was actively involved for several months in assisting Congress in its consideration that led to passage of this milestone legislation. This involvement was built upon our extensive participation in the passage and regulatory implementation of the Mental Health Parity Act of 1996 ("MHPA"), and our experience with employer compliance efforts with that law. We hope that the departments find our knowledge of both mental health parity laws to be useful in implementing the MHPAEA.

In our comments, we first address a coverage consideration that we understand has been raised by the employer and insurer community regarding whether a group health plan may have separate but equal financial requirements for mental health/substance use benefits. We then respond to each of the six questions raised by the departments in the RFI. Ronald E. Bachman, FSA, MAAA, President and CEO of Healthcare Visions, Inc., assisted in our responses to all questions in the RFI, except for the second question and the preemption analysis, and has joined in signing onto our comments. We conclude our response with a

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short discussion of our view regarding the relationship between federal and state law with regard to the requirements of MHPAEA. This discussion is based on a legal preemption analysis provided by Robert Belfort, Esq., and Lisa Horwitz, Esq., of Manatt, Phelps & Phillips, LLP, during Congressional consideration of the new law.

MHPAEA represents the culmination of the efforts of the APA and many other mental health and substance use consumer and provider organizations—not to mention many members of Congress—to finally end inequity between mental health and substance use and medical and surgical benefits for larger group health plans (with more than 50 employees). This inequity had been historical and without financial basis, and benefits inequity has meant that health plans could discriminate against persons with mental health and substance use disorders, much to their detriment, by applying financial requirements and treatment limitations not applied to physical health conditions. Congress intends that the MHPAEA will end this benefits discrimination.

MHPAEA is an amendment to the MHPA. As such, it simply states that financial requirements and treatment limitations applied to mental health/substance use benefits shall be no more restrictive than those applied to medical/surgical benefits. This language requires parity for all aspects of benefits coverage and adds on to the current MHPA requirement of equity benefits coverage for annual and lifetime dollar limits.

MHPA was a critically important law, because it ensured that the most seriously mentally ill persons, using a substantial amount of services over the course of a year or a lifetime, would not face arbitrary annual and lifetime dollar limits on their coverage. The law greatly helped those persons with serious mental illness and their families. Yet, the law was limited. It allowed employers to reduce other aspects of benefits coverage, and it excluded parity for substance use benefits.

Indeed, most employers did comply with the MHPA but found ways to avoid the spirit of the law by reducing other aspects of mental health benefits coverage. In 2000 the General Accounting Office ("GAO") reported to Congress that:

> Although most employers' plans now have parity in dollar limits for mental health coverage, 87 percent of those that comply contain at least one other plan design feature that is more restrictive for mental health benefits than for medical and surgical benefits . . . . [M]any employers may have adopted newly restrictive mental health benefit design features since 1996 specifically to offset the more generous dollar limits they adopted as a result of the federal law. About two-thirds of these newly compliant employers changed at least one other mental health benefit design feature to a more restrictive one compared with only about one-forth of the employers that did not change their dollar limits. (GAO/HEHS-00-95, *Implementation of the Mental Health Parity Act of 1996,* p. 5)

Ultimately, the GAO determined that the law had "little effect on employees' access to mental health services." (GAO/HEHS-00-95 at 5.)

The APA believes that the statutory language of the MHPAEA does not allow an employer to avoid the spirit of its parity requirement by restricting mental health/substance use benefits in a manner that is isolated from its coverage for medical/surgical benefits, since the law requires parity in all aspects of benefits coverage. We urge that a central consideration in regulatory implementation is a straightforward assessment of Congressional intent to require group health plans with more than 50 employees to provide benefits coverage for mental health and substance use services that is no more restrictive than medical and surgical benefits coverage. With this in mind, we first raise a concern regarding "separate but equal" requirements before addressing the departments' questions.

May a group health plan impose financial requirements (i.e. deductibles, out-of-pocket maximums, copayments, etc.) on mental health/substance use benefits that are separate from but not more restrictive than those imposed on medical/surgical benefits?

A group health plan may not impose financial requirements or treatment limitations on mental health/substance use benefits that are separate from, even if no more restrictive than, those imposed on medical/surgical benefits. Specifically, MHPAEA states that there shall be "no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits." This same condition is provided with respect to treatment limitations. (Section 712(a)(3)(A)(i) and (ii) of the Employee Retirement Income Security Act, section 2705(a)(3)(A)(i) and (ii) of the Public Health Service Act, and section 9812(a)(3)(A)(i) and (ii) of the Internal Revenue Code, as added by section 512(a), (b) and (c) of the Emergency Economic Stabilization Act of 2008.)

Separate, even if equal, financial requirements, for example, would place a greater financial burden on plan enrollees who require mental health or substance use services, by requiring them to essentially pay twice to meet plan financial requirements when receiving these services. As such, "separate but equal" would violate the parity law.

For example, consider a deductible requirement. If a group health plan were permitted to charge a $500 deductible for medical/surgical benefits *and* a separate $500 deductible for mental health/substance use benefits, an enrollee needing mental health/substance use services has an additional financial burden when accessing those services. The enrollee must meet an additional deductible requirement with regards to his or her mental health or substance use benefits available in the plan, and therefore the intent of MHPAEA—to provide parity benefits coverage for those needing mental health/substance use services—would be thwarted if a group health plan could require a separate deductible to access those services. Health plans do not require separate deductibles for cancer treatment, for example, and they should not be permitted to isolate mental health and substance use benefits for such treatment.

Mental health/substance use benefits typically represent 3-6% of the total benefits covered by a group health plan. (Finch R.A., Phillips K., Center for Prevention and Health Services. *An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating, Designing, and Implementing Behavioral Health Services.* Washington, DC: National Business Group on Health, 2005.) In addition, as Congress was considering passage of the MHPAEA, the Congressional Budget Office consistently estimated that the new law

would increase premiums for group health insurance by an average of about 0.4%, before accounting for the responses of health plans, employers, and workers. (See, for example: *CBO Cost Estimate, H.R. 1424, Paul Wellstone Mental Health and Addiction Equity Act of 2007, November 21, 2007, p. 4)* Considering that mental health/substance use benefits make up a very small portion of the overall plan benefit and the extremely low average cost increase associated with MHPAEA (which will generally be shared between employer and enrollee), it is clear that, even if the new law were to allow them, group health plans which impose separate financial requirements on plan enrollees to access mental health/substance use benefits, would be greatly overreacting to the costs associated with the law. Rather, a more appropriate group health plan response to the 0.4% average cost increase associated with MHPAEA, and one which does not thwart the intent of the law, would be to spread this very low increase over the entire medical/surgical and mental health/substance use benefit, which would have a very low impact on the overall financial requirements and treatment limitations of the plan.

Congress clearly intended to end benefits discrimination against mental health and substance use services with enactment of MHPAEA, and this is demonstrated by several floor statements from the legislation's sponsors, leaders of health committees and other members of Congress. While no statements made on the House or Senate floor address the specific issue of "separate but equal" financial requirements or treatment limitations, the record is clear that the new law is intended to completely end benefits coverage discrimination against mental health and substance use benefits. To this point the floor statements of the legislation's sponsors are most helpful:

> Access to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered discriminatory treatment at all levels of society. They have been forced to pay more for the services they need and to worry about their job security if their employer finds out about their condition . . . . [M]ore steps are clearly needed to guarantee that Americans suffering from mental illness are not forced to pay more for the services they need, do not face harsher limitations on treatment, and are not denied access to care . . . . [This bill] guarantees co-payments, deductibles, coinsurance, out of pocket expenses and annual and lifetime limits that apply to mental health benefits are no different than those applied to medical and surgical benefits. It guarantees that the frequency of treatment, number of visits, days of coverage and other limits on scope and duration of treatment for mental health services are no different than those applied to medical and surgical benefits. *153 Cong. Rec. S1864-5 (daily ed. February 12, 2007) (statement of Sen. Kennedy)*

> [The bill] ensures that health plans do not place more restrictive conditions on mental health coverage than on medical and surgical coverage; parity for financial requirements, such as deductibles, copayments, and annual and lifetime limits; parity for treatment limitations, and the number of covered hospital days and visits . . . . Simply put, our legislation will ensure that individuals with a mental illness have parity between mental health coverage and medical and

surgical coverage. No longer will people with mental illness have their mental health coverage treated differently than their coverage for other illnesses. That means there will be parity between the coverage of mental illness and other medical conditions such as cancer, heart disease, and diabetes . . . . Parity means fairness. We have been unfair to the mentally ill since we started medical insurance coverage for people with illnesses. Somehow we got off the track. We said, of course, we will treat everything that has to do with the heart, but, for instance, we won't do anything having to do with illnesses that affect the brain . . . . Today this bill says all of the group insurance policies in the United States of America, no matter who wrote them, no matter where they were written, no matter which company they were written by or for, will have to provide for the mentally ill who are covered. If they are going to have any mental health coverage, those insurance companies must cover them with the exact same coverage they give to others who suffer from other diseases as I have described . . . . *154 Cong. Rec. S9244 (daily ed. September 23, 2008) (statement of Sen. Domenici)*

For far too long, health insurance companies have used the stigma of mental illness and substance abuse as an excuse to deny coverage for those biological disorders. That ends today. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 will finally outlaw the discrimination that is embedded in our laws and our policies. *154 Cong. Rec. H10776 (daily ed. October 3, 2008) (statement of Rep. Kennedy)*

A major barrier for thousands of Americans is insurance discrimination, plain and simple, against people in health plans who need treatment for mental illness or chemical addiction. [The bill] before us today, would end this discrimination by prohibiting health insurers from placing discriminatory restrictions on treatment for people with mental illness or addiction. No more inflated deductibles or copayments that don't exist for physical diseases. No more limited treatment stays that don't apply to physical ailments, no more discrimination against people with mental illness or chemical addiction . . . . It's time to end the discrimination against people who need treatment for mental illness and addiction. It's time to prohibit health insurers from placing discriminatory barriers on treatment. *154 Cong. Rec. H8619 (daily ed. September 23, 2008) (statement of Rep. Ramstad)*

As stated above, "separate but equal" is not an end to discrimination, but a separation out of mental health/substance use benefits for discriminatory treatment through the imposition of additional cost requirements or treatment limitations. As such, if the departments permitted health plans to apply "separate but equal" financial requirements or treatment limitations, the clear purpose of Congress to end benefits discrimination against enrollees with mental health or substance use disorders would be defeated.

The APA turns now to offering responses to the specific questions raised by the departments in the RFI. Due to the breadth of the first question, we separated it into parts for purposes of our response.

Do plans currently impose other types of financial requirements or treatment limitations on benefits beyond those provided in the new law?

Regarding financial requirements, in MHPAEA financial requirements include deductibles, copayments, coinsurance, and out-of-pocket expenses, in addition to the aggregate lifetime and annual dollar limits already covered under MHPA. These requirements, of course, are those that are applied to covered plan members. As such, any other plan requirement that is a financial burden placed on plan members using mental health/substance use benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan. Examples of some types of plan member financial requirements that are of the same nature and that if applied on a more restrictive basis would violate the MHPAEA are:

Episodic Cost-Sharing – An episode of care can be defined as a period of time for which treatment of an illness is covered and ends after a period of time during which no active medical/clinical care is provided (e.g. 180 days without care). Rather than using a typical calendar year limit, a group health plan might implement cost sharing for the episodic limit of the condition or illness. The episodic limit could include a separate benefit deductible, coinsurance, daily co-payment, and aggregate episodic annual or lifetime limits. Again, this would be a violation of MHPAEA, if applied only to mental health and substance use benefits.

Premium Differentials – A group health plan may have different options (e.g. one with mental health parity and one without) whereby the premium contributions required from the covered employee vary depending upon which option is chosen. If mental health parity is a factor in the differential premium contribution levels, this would be a violation of MHPAEA.

Separate But Equal Cost-Sharing – An important aspect of financial parity is the requirement that "...there are no separate cost-sharing requirements that are applicable only with respect to mental health or substance use disorder benefits." For mental health and substance use benefits to be at financial parity, claim submittals should not be "sorted into two piles" for different plan benefit considerations and payment practices. This means that plan benefits for parity are covered with common cost-sharing features. While some group health plans engage in this practice, "separate but equal" cost sharing would violate MHPAEA, as our discussion above explains.

Out-of-Network ("OON") Usual & Reasonable ("UR") Charges – Another type of financial requirement imposed on mental health and substance use is generated by a plan's determination of OON provider UR charges. UR

determinations drive a plan's and the patient's level of financial responsibility. If a plan is allowed to use an unequal formula and process between medical/surgical and mental health/substance use benefits when establishing UR charges it can then create an unequal and greater financial requirement on the use of OON mental health/substance use benefits. Medical/surgical OON UR is based usually on a percentile of an industry database developed from billed charges for the same services in the geographic area. Mental health OON UR is, under some plans, determined using a different methodology that typically lowers the mental health OON UR. This generates an unequal and greater cost sharing burden on the mental health patient's use of OON providers, and as such, would violate MHPAEA.

Regarding treatment limitations, in MHPAEA these include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment, which are group health plan benefit design limits on coverage for provider services. Treatment limitations in MHPAEA are defined as numeric time limitations and are not all inclusive or comprehensive. However, MHPAEA includes language in the definition of "treatment limitations" that applies to "other similar limits on the scope or duration of treatment" thus capturing other limitations. Examples of these include:

Episodic Limits - An episode of care can be defined as a period of time for which treatment of an illness is covered and ends after a period of time during which no active medical/clinical care is provided (e.g. 180 days without care). Rather than using a typical treatment of days or visits, a group health plan might implement a time limit for the episodic treatment of the condition or illness. An episode of care could be limited to a period of time not related to the treatment needs of the patient. If applied to mental health and substance use benefits solely, this would violate MHPAEA.

Hourly/Minutes Limits, Periodic or Other Limits – A group health plan might restrict covered benefits to a limited number of office hours, minutes or some time restriction other than by days or visits. A group health plan might also impose periodic limits, such as treatments no more frequently than a specified number per week, per month or per year. A group health plan that places any limit on diagnosis-specific, generally accepted medically necessary services would violate the MHPAEA, if such a limit is not also applied to medical and surgical 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?

Currently, group health plans commonly apply different financial requirements and treatment limitations to medical/surgical benefits and to mental health/substance use benefits, with greater financial requirements and treatment limitations generally being applied to mental health/substance use benefits. As discussed, MHPAEA identifies specific financial

requirements and treatment limitations for which parity treatment is required, but any of the additional above requirements or limitations could be used by plans in an attempt to evade MHPAEA. Some of the above may never have been used by plans, but the restrictions in MHPAEA may cause plan designers to think anew for perceived loopholes to "back-door" financial restrictions and treatment limits. Regulations that include clarifications on these additional items and others will prevent plan benefit design gambits intended to subvert the parity purposes of MHPAEA.

Do plans currently vary coverage levels within each class of benefits?

Group health plans can and do vary coverage levels and benefit limits by class of benefits. The term "class of benefits" is not a common term of art in the insurance industry. The more usual benefit variation description is by "type of service." Examples of type of service categories include doctor office visits, preventive care, outpatient diagnostic laboratory and x-ray services, maternity care, emergency room care, mental health, substance use, physical therapy (including speech and occupational therapy), chiropractic care, prescription drugs, urgent care, infertility treatment, home health care, hospice care, durable medical equipment, and dental care (accident-related only).

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

The APA focuses on three areas regarding language or provisions in MHPAEA that may need clarification: the first concerns the parity standard itself and the second and third concern technical issues around the meaning of the term "mental health *or* substance use" and "qualified and *licensed* actuary" (emphasis added).

New terms associated with the parity standard. MHPAEA requires that the financial requirements and treatment limitations applied to mental health/substance use benefits are "no more restrictive than the predominant" financial requirements and treatment limitations "applied to substantially all" medical/surgical benefits covered by a health plan (or coverage). This is a different standard than that presently in the law and applied to lifetime and annual dollar limits. In this new standard the term "substantially all" is retained to apply to financial requirements in addition to lifetime and annual dollar limits, and new terms—"no more restrictive than" and "predominant"—are also applied to these additional financial requirements, as well as the treatment limitations provided in the new law.

Having actively participated in the consideration and drafting of MHPAEA, we believe that the new parity standard "no more restrictive than" as well as the new qualifier "predominant" and retention of the original qualifier "substantially all" will operate to ensure parity for all financial requirements and treatment limitations. The Mental Health Parity Act of 1996 only addressed parity for lifetime and annual dollar limits, which are relatively simple financial requirements imposed by a plan or coverage; a plan or coverage either does not apply a lifetime or annual dollar limit or has a single limit for each for the entire benefit. This new parity standard and the additional qualifier "predominant" are necessary to address the greater

complexity associated with a range of financial requirements and treatment limitations associated with the benefit.

Therefore, the parity standard "no more restrictive than" means that the financial requirements or treatment limitations imposed on mental health or substance use benefits can be no greater than those applied to medical and surgical benefits. In other words, any financial requirement or treatment limitation imposed on the enrollee or participant for mental health or substance use benefits must be equal to or less than that applied to medical/surgical benefits. Some states, Colorado, Oregon, and Virginia, for example, have used the term "no more restrictive than" to ensure parity coverage for health plan enrollees and participants.

With regard to the term "substantially all," MHPA required that if a plan or coverage includes a lifetime or annual dollar limit on "substantially all" medical and surgical benefits, then it may impose either the same or a lesser limit on mental health benefits. The departments' implementing rule (62 Fed. Reg. 66932 et seq., December 22, 1997) essentially defined "substantially all" to mean that if a plan or coverage includes a lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it may either impose the same or a lesser limit on mental health benefits. It is our understanding that the vast majority of plans that did impose a lifetime or annual limit met this "two-thirds" test. However, if a plan or coverage applies a different lifetime or annual dollar limit on different benefit categories of more than one-third of all medical/surgical benefits, it may impose a limit on mental health benefits equal to the weighted average of these different categories.

As mentioned, the term "substantially all" is relatively easily applied to plan or coverage lifetime or annual dollar limits, where a plan or coverage generally has only one limit or a few limits. The term "predominant" has been included in the MHPAEA to address those financial requirements or treatment limitations for which there may be number of limits or categories of coverage. The term "predominant" therefore has been included to indicate that the mental health or substance use benefit should be compared to the prevailing or most common financial requirement or treatment limitation imposed by the plan or coverage.

Therefore, under MHPAEA the financial requirement or treatment limitation that is applied to "substantially all" the medical/surgical benefit shall be that requirement or limitation that is applied to the mental health/substance use benefit. Of course, a plan or coverage may apply a lesser requirement or limit, since the MHPAEA provides that such requirement or limit shall be "no more restrictive than" the limit imposed on medical and surgical benefits.

The term "predominant" is an additional qualifier and meant to prevent mental health or substance use benefits financial requirements or treatment limitations from being compared to outliers in the medical/surgical benefit. This could occur if a plan provides for a number of limits or categories of coverage with regard to a financial requirement or treatment limitation. The mental health and substance use benefit should not be compared to outlier limits or categories of medical and surgical benefit coverage.

For example, consider parity with regard to a limit on outpatient psychotherapy visits. To apply the MHPAEA standard, all outpatient medical/surgical visits of a plan should be

considered. If there is no limit on substantially all outpatient medical/surgical visits, for example, then there shall be no limit on outpatient psychotherapy visits. However, if a plan has several types of outpatient medical/surgical visit limits (i.e. for primary physician, specialty, chiropractic, physical therapy, and various other services) so that no one (or a lack of a) limit represents substantially all of the limit on outpatient medical/surgical visits, then the predominant qualifier applies. This means that outpatient psychotherapy visits should be compared to the prevailing or most common outpatient medical/surgical visit limit. For most plans we assume that this would be the primary physician office visit. Therefore, if the plan does not impose a limit on primary physician office visits, then the plan shall not impose a limit on outpatient psychotherapy visits.

For example, consider parity with regard to a copayment requirement for outpatient psychotherapy visits. To apply the MHPAEA standard, all outpatient medical/surgical visits of a plan should be considered. If the copayment requirement for substantially all outpatient medical/surgical visits is $10, for example, then the copayment requirement for outpatient psychotherapy visits shall be $10. However, if a plan has several types of outpatient medical/surgical visit copayment requirements, so that no one copayment represents substantially all of the limit on outpatient medical/surgical visits, then the predominant qualifier applies. This means that outpatient psychotherapy visits should be compared to the prevailing or most common outpatient medical/surgical visit limit. For most plans, we assume that this would be the primary physician office visit. Therefore, if the plan imposes a $10 copayment for a primary physician office visit, then the plan shall impose a $10 copayment requirement for an outpatient psychotherapy visit.

It seems acceptable to us to compare inpatient-to-inpatient and outpatient-to-outpatient medical/surgical benefits with mental health/substance use benefits for purposes of applying the MHPAEA parity standard to financial requirements and treatment limitations in a plan or coverage. Within the inpatient and outpatient benefits provided by a plan, the MHPAEA parity standard is meant to address the subtleties that may be involved in the various financial requirements and treatment limitations applied to various categories of coverage. As described above, the parity standard is designed in the new law to prevent a plan or coverage from "gaming" the requirement by comparing mental health or substance use benefits to outliers in the medical/surgical benefits that it provides.

Mental health or substance use. MHPAEA uses the term "mental health or substance use benefits" for the purposes of applying parity and comparing those benefits with medical and surgical benefits. It is our understanding the word "or" in this term is causing some confusion. Of course, the word "or" is meant to capture all plans which provide mental health benefits or substance use benefits or both. In other words, if a plan or coverage provides any of these benefits, then MHPAEA would apply to its coverage (provided that the plan or coverage was not otherwise exempt). It may be helpful for the departments to clarify this meaning in rulemaking.

Qualified and licensed actuary. Actuaries are not licensed by state or federal agencies. Actuaries are certified through education and experience requirements for membership in the American Academy of Actuaries. We request that the departments clarify that the term

"qualified and licensed" actuary means a member in good standing of the American Academy of Actuaries, and therefore is an individual qualified to provide the cost exemption determinations required by the new law.

What information, if any, regarding the criteria for medical necessity determinations made under the plan (or coverage) with respect to mental health or substance use disorder benefit 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?

Group health plans do not always disclose in writing the specifics for their interpretation and use of medical necessity criteria, and there is no specific mental health/substance use definition for medical necessity. Most coverage contracts and summary plan descriptions state the general outline and process for claims submittals. In some respects, the application of medical necessity and decisions on coverage is shrouded in health plan determinations that are rarely transparent or fully disclosed to patients or providers.

Regarding industry standards or best practices, the definition of "medical necessity" varies by group health plan (or coverage) and is set forth in each plan member's benefit plan. There is no standard language or industry norm regarding this information or how it is communicated. Sometimes only general principles may be found in various health plan descriptions. Below is a composite definition of "medical necessity." The information is drawn from various employer summary plan descriptions and provides a potential template for best practices and greater industry transparency on medical necessity:

> "Medical necessity" means appropriate and clinically necessary services, as determined by a health plan's medical director (or designee), according to generally accepted principles of good medical practice. To be "medically necessary," services and supplies must meet the following requirements—that they—
>
> 1. Are not solely for the convenience of the participant, his/her family or the provider of services or supplies;
> 2. Are the most appropriate level of service or supply which can be safely provided to the plan member;
> 3. Are for the diagnosis or treatment of an actual or existing medical condition unless being provided for plan scheduled preventive services;
> 4. Are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions;
> 5. Are appropriate and consistent with the diagnosis and are in accordance with accepted medical standards;
> 6. Could not have been omitted without adversely affecting the patient's condition or the quality of health services rendered;
> 7. As to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the patient's condition or quality of health services rendered;
> 8. Are not primarily for research and data collection; and

9. Are not experimental or investigational.

Ultimately, of course, the importance of the medical necessity definition is the power it affords an insurer or health plan to select from among professionally accepted treatments that it elects to cover. The insurer or the plan is empowered to determine the quality of the evidence pointing to some treatments as preferable to any others. The power to select on the basis of subjective factors can result in the rejection of treatment approaches that are beneficial.

Regarding to whom this information is made available, if published at all, a definition of medical necessity may be found in the in a group plan member summary plan description. Alternatively, the information on medical necessity may be written into the group policy or administrative contract.

What information, if any, regarding the reasons for any denial under the plan (or coverage) or reimbursement or payment for services with respect to mental health or substance use disorder benefits is 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?

Below is a composite description of an appeals process. The information is drawn from various employer summary plan descriptions and provides a potential template for best practices. A plan should provide the following information on any denial to allow a patient fair resolution of a disputed claim, denied service, or a declined request for coverage:

1. The reasons for denial;
2. The plan provisions on which the denial is based;
3. A contact point through which the plan member may review or receive copies of any documents, records, or other information relevant to his/her claim for benefits;
4. An explanation of the procedure for second appeals and the applicable time limits, along with a statement of his/her right to bring a civil action under ERISA 502(a) (if applicable), following as adverse benefit determination upon criterion of his/her second appeal;
5. A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination; and
6. If the denial is based on a medical necessity or experimental or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination.

To gather more information on the scope of out-of-network coverage, the Departments are interested in finding out whether plans currently provide out-of-network coverage for mental health and substance use disorder benefits. If so, how is such coverage the same as or different than out-of-network coverage provided for medical and surgical benefits?

Other than closed panel HMOs and limited PPO plans (sometimes referred to as "exclusive provider organizations" or EPOs), group health plans generally allow for OON mental health benefits. Based on an unpublished industry survey, approximately 15% of plan claims are for mental health services with out-of-network (OON) providers. As with in-network benefits,

OON mental health/substance use benefits generally include financial requirements and treatment limitations greater than for OON medical/surgical benefits.

MHPAEA states that if a group health plan provides OON coverage for medical/surgical benefits, it must provide coverage for mental health/substance use benefits through OON providers "in a manner that is consistent with" the requirements of the parity law. This means that if a group health plan provides out-of-network ("OON") medical/surgical benefits, then it must provide OON mental health/substance use benefits, at parity, with those medical/surgical benefits.

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?

MHPAEA provides simple legislative language regarding the cost exemption, which may mask some complexity if a group health plan were to seek an exemption. The law is clear in one aspect: an election of a cost exemption must be based on historical claims experience—retrospective data—and not on an analysis using only projections—prospective data. Beyond the required use of retrospective data, the following may be helpful in understanding the complexity of the MHPAEA cost exemption and the key areas and definitions that might be clarified in regulations.

The general cost exemption requirement states that (we paraphrase here), with respect to a group health plan (or coverage), if the application of the parity law results in an increase for the "plan year involved" of the "actual total costs of coverage" for medical/surgical and mental health/substance use benefits under the plan by an amount that exceeds 2% in the first plan year to which the law applies and 1% thereafter of the "actual" total plan costs, then the law does not apply to such plan (or coverage) during the following plan year, and such exemption will apply for one plan year.

Most importantly in this standard is that the election of a cost exemption by a group health plan extends for only one year (a 12-month period). An election is therefore not permanent, and at the end of the election year, a plan must again comply with MHPAEA. Beyond this central consideration, we focus on two key concepts of the general cost requirement—"plan year" and "actual total costs of coverage"—

Plan Year—"Plan year" is presumably a 12 month period from a specifically designated policy/contract determination that establishes the beginning of a plan year. A "plan year" should not be less than or more than 12 months. The 12 month period need not be from January 1 to December 31, but it would need to extend through a 12 month period of time, as determined and defined under a health plan policy or contract. Clarifications may be needed to establish any differences between a plan year, anniversary year, renewal year, contract year, or other language that may be used.

Actual Total Costs of Coverage— Actual total costs of coverage could have several meanings, but for purposes of MHPAEA it should mean incurred claim costs during the plan year for medical and surgical benefits and for mental health/substance use benefits. Medical and surgical references should be to all coverage provided under a medical/surgical plan (including prescription drug costs and any carve out program costs for mental health and substance abuse). Presumably, coverage costs including, but not limited to, employee assistance programs, dental, vision, legal, short term disability or long term disability, and separate specific disease coverage costs would be excluded from the calculation. All comparisons are on actual claim costs—mental health/substance use to total plan costs. Other administrative costs, profit, taxes, etc. would not be included.

The word "actual" should not be taken in "layman's" language but rather with an actuarial perspective of incurred claims. The determination of actual total claim costs should not require a delay in any calculation awaiting runoff claims over an extended period of time. Given the plan year (assuming 12 months), actual total costs of coverage would include a determination of those Incurred But Not Reported ("IBNR") at the beginning and end of the 12 month paid claims period. Actual total costs should mean an actuarial determination of the conversion of paid claims during the period to incurred claim costs by making appropriate adjustments for IBNR and (if applicable) other claim reserves. Any method of determining IBNR to covert paid to incurred claims would be acceptable that meet the Actuarial Standard of Practice No. 5 as published by the Actuarial Standards Board.

Both the total claim costs for the plan year and the mental health claim costs would need to be developed on an incurred basis using similar methods. Both in-network and out-of-network (and out-of-area) claim costs should be included in the calculation. A determination of incurred per member per month ("PMPM") costs is needed to make the final analysis of the cost exemption. PMPM costs are determined by taking the incurred claims and dividing by the number of covered member months during the period.
Considering this as a formula:

$$\frac{\text{(Incurred PMPM MHSA CY)} - \text{(Incurred PMPM MHSA PY x MHSA Trend Factor)}}{\text{(Incurred PMPM Total Plan Claim Costs PY)}}$$

PMPM = Per Member Per Month
CY = Current Plan Year
PY = Prior Plan Year
MHSA = mental health and substance use

The comparison of PMPM MHSA CY should be based on the same coverage provided in the prior year. If a plan voluntarily expands coverage for new conditions/treatments from the PY those costs should be excluded in the calculation in the CY, since they were not required by the legislation. Any comparison of CY and PY MHSA PMPM costs should also account for any differences in cost-sharing levels (e.g., deductibles, co-pays, coinsurance and out-of-pocket limits).

The use of PMPM in the calculation is needed to avoid a determination of an increase that might result for factors such as membership growth. Other factors such as demographic mix (age, sex, dependents, geographic distribution, etc.) should be accounted for to properly measure the impact of the parity benefit and not the impact of other factors that may have affected the plan costs.

The prior year PMPM MHSA claim costs need to be increased by a reasonable trend assumption to determine if the parity benefit design resulted in an increase for the plan year of more than the percentage that would qualify the health plan to claim the cost exemption.

Six-Month Determinations—MHPAEA requires a group health plan seeking an exemption to have complied with the law for the first six months of the year involved. To use the 6-month determination in lieu of the plan year, the calculation rules and formulas would be the same as provided above, with the exception that only six months (rather than 12 months) of paid claims would be used and converted to incurred claims using the Actuarial Standard of Practice No. 5. However, in this case a projection for the full plan year should also be required since it is needed to provide trend assumptions made for both MHSA PMPM and the total plan PMPM so as to reflect an increase for a full plan year.

Notification—An election to modify coverage based upon the cost exemption analysis requires a notification to members of a material modification with applicable notice requirements. We agree that model notices would be helpful to facilitate disclosure to federal and state agencies and to health plan beneficiaries and participants regarding a plan or issuer election to implement the cost exemption.

How will the MHPAEA impact state parity and other laws?

While the departments are not requesting comments regarding the relationship between MHPAEA and state parity and other laws, during our efforts to bring about passage of the law, the APA had considered this issue extensively. From our perspective this aspect of the new law was and remains critically important, since at the time of passage, 43 states had enacted parity laws, and additionally, many states had enacted a range of mandated benefits and other consumer laws to protect individuals seeking and receiving mental health benefits coverage. We view MHPAEA to be extremely protective of state law, since the Health Insurance Portability and Accountability Act ("HIPAA") preemption standard will apply to the new law, just as it has applied to the Mental Health Parity Act of 1996.

Under this standard only a state law that "prevents the application" of the federal law is preempted. This means that if a provision of a state parity law (for example) provides for less protection than the federal law, it is preempted. If a state law provides for more protection than the federal law, it is not preempted. In essence, the HIPAA preemption standard provides a "floor" from which states may provide greater protection.

During Congressional consideration of this issue, the APA had requested an analysis of the HIPAA preemption provision by the legal firm of Manatt, Phelps & Phillips, LLP. This analysis both considered the HIPAA standard and the relationship between the standard and

specific types of state laws, including parity, benefit management and quality assurance, and mental health benefits definitional laws. We attach this analysis for your information (Attachment A).

From House and Senate floor statements and consideration, it is also apparent that members of Congress also were carefully considering the relationship between MHPAEA and state laws. One of these issues, a discussion of Pennsylvania Act 106, as a state law that mandates certain coverage based on provider certification, garnered extensive floor discussion between Senators Edward M. Kennedy and Pete Domenici, as parity legislation sponsors, and Pennsylvania Senators Arlen Specter and Robert P. Casey. We also attach this colloquy for purposes of your information (Attachment B).

Thank you for considering our comments. The APA would appreciate the opportunity to assist the departments with these and any other aspects of implementation of MHPAEA. We are hopeful that the departments will propose rulemaking in the near future and give our organization, as well as other interested parties, the opportunity to provide comments and input before final implementation of the law. If you have further questions or seek further information, please contact Doug Walter, Legislative & Regulatory Counsel, Government Relations, American Psychological Association Practice Organization at (202) 336-5889 or dwalter@apa.org.

Sincerely,

Katherine C. Nordal, Ph.D.
Executive Director

Ronald E. Bachman FSA, MAAA
President & CEO
Healthcare Visions, Inc.

manatt
manatt | phelps | Phillips

Attachment A

To:	Marilyn Richmond and Doug Walter
From:	Robert Belfort and Lisa Horwitz
Date:	September 10, 2007 File No.: 29767-030
Subject:	Preemption of State Laws by Mental Health Parity Act

You have asked us to analyze the extent to which state laws establishing mental health parity and related standards are likely to be preempted by the current version of S. 558, the Federal Mental Health Parity Act of 2007 (the "Act"). Our analysis is set forth below.

I. The HIPAA portability preemption provisions provide the relevant preemption standard for the Act.

The Act adds a new Section 712A of ERISA and Section 2705A of the Public Health Service Act (PHSA). The Act does not contain its own preemption standard.[1] Instead, these new sections of ERISA and the PHSA will become subject to the preemption standard enacted as part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which is set forth in 29 U.S.C. § 1191 and 42 U.S.C. § 300gg-23.

29 U.S.C. § 1191 provides that, subject to certain exceptions not relevant here, the federal standards:

> [S]hall 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 this part (emphasis added).

Virtually identical language is contained in 42 U.S.C. § 300gg-23. Thus, the Act will not preempt state laws unless such laws "prevent the application" of a provision of the Act.

[1] The one exception is that subsection (d)(2) of Section 712A and Section 2705A states that the Act's exemption of group health plans sponsored by small employers shall not be construed as preempting state laws governing such plans.

II. The "prevents the application" preemption standard provides for the continued applicability of state laws that afford a higher level of protection than the Act.

In enacting Sections 1191 and 300gg-23, Congress made clear that it intended "the narrowest preemption." H.R. Rep. 104-736, 1996 U.S.C.A.N.N. 1990, 1996 WL 579893. "State laws which are broader than federal requirements would not prevent the application of federal requirements." *Id.* Courts have honored this congressional intent in their interpretation of these sections. *See Plumb v. Fluid Pump Svc., Inc.*, 124 F.3d 849, 862, n. 10 (7th Cir. 1997) (interpreting 29 U.S.C. 1191 as having no preemptive effect on "state laws that are, generally speaking, more favorable to the insured"); *O'Donnell v. Blue Cross Blue Shield of Wyoming*, 173 F. Supp.2d 1176, 1184 (D. Wyoming 2001) (interpreting virtually identical preemption language of 42 U.S.C. 300gg-62 as meaning that "[c]ongress has made it clear that provisions of HIPAA regarding individual market reforms were not intended to completely preempt state authority in the field").

The Act's sponsors, Pete V. Domenici and Edward M. Kennedy, recently confirmed this interpretation of Sections 1191 and 300gg-23 as it applies to the Act. In response to questions from Senators Arlen Specter and Robert P. Casey, of Pennsylvania, Senator Kennedy stated:

> It is our intention to establish a Federal floor and not a Federal standard or Federal caps. Thus, we decided to use the already-existing language and standard found within part 7 of ERISA, which is where the current mental health parity law already resides, and where S. 558 will be codified. The law contains the narrowest possible preemption language, and is meant to preempt only those state laws that are less beneficial to consumers and insured, from the standpoint of the consumer and insured, than this new Federal law.

Congressional Record, Senate Page: S10883. Accordingly, a state law that is more protective than the Act should not be preempted.

III. State laws mandating coverage of mental health benefits, regulating the manner in which benefits are delivered or establishing parity standards for the small group market should not be preempted by the Act.

A. *"Mandated Parity" Laws*

Certain state parity laws mandate the coverage of a defined set of mental health benefits in connection with imposing a parity requirement. These laws are referred to as "mandated parity" laws. The Act does not impose such a mandate. Instead, in subsection (a) of Section 712A and Section 2705A, the Act states only that, if a health plan covers both medical and mental health benefits, it must do so at parity.

A state mandated parity law does not prevent the application of subsection (a). Such a law imposes a mandate that goes beyond the parity obligation set forth in the Act and is more favorable to the insured. As a result, state mandated parity laws should not be preempted by the Act.

B. ***Benefit Management and Quality Assurance Laws***

Certain states have adopted laws that regulate the manner in which medical and/or mental health benefits are delivered by health insurers. These laws address, among other things, the time periods for making utilization review decisions, the qualifications of the personnel determining medical necessity, the information that must be disclosed to enrollees, the type of quality oversight that must be carried out by the plan and plan reporting obligations to government agencies. In some cases, these laws have been enacted in connection with a mental health parity statute; in other cases, they have been adopted separately.

The Act's parity provisions, which are set forth in subsection (a) of Section 712A and 2705A, make no reference to the benefit management and quality assurance rules governing the delivery of mental health services. Accordingly, state laws establishing benefit management or quality assurance standards do not prevent the application of these federal parity provisions.

The only provisions in the Act that address benefit management or quality assurance at all are the "clarifications" contained in subsection (b) of Section 712A and 2705A. These clarifications state only that a plan "shall not be prohibited from ... managing the provision of mental health benefits in order to provide medically necessary services for covered benefits, including through the use of any utilization review, authorization or management practices, the application of medical necessity and appropriateness criteria applicable to behavioral health, and the contracting with and user of a network of providers."

The clarifying provisions of the Act should not preempt state benefit management and quality assurance laws applicable to the delivery of mental health benefits. These are mere "clarifications" that are most reasonably interpreted as intended to make clear that the Act's parity provisions do not bar health plans from applying benefit management techniques otherwise permitted under applicable law. It seems unlikely that Congress would establish a new federal benefit management standard through a "clarification," especially given the absence of any substantive benefit management provisions in the Act that would govern a health plan's activities.

This view was confirmed recently by Senator Domenici, who, in a Senate colloquy in response to questions from Senator Specter and Senator Casey, stated:

> Section 712A(b) says that managed care plans "shall not be prohibited from" carrying out certain activities. It does not require them to do so, and this is not a "requirement of this part." This section recognizes that plans have flexibility. It

> is not our intention to preempt any State laws that regulate, limit or even prohibit entirely the medical management of benefits. That is one of the reasons we are using the preemption standard -- the existing HIPAA standard that so clearly does not preempt such a law.

Congressional Record, Senate Page: S10883. Senators Specter and Casey asked these questions with specific regard to Pennsylvania Act 106, a State law that mandates certain coverage based on a treating provider's certification. Senators Domenici and Kennedy went on to clarify that, in accordance with this interpretation, state laws mandating coverage based on a treating provider's certification would not be preempted by the Act. This evidence of Congressional intent will be helpful in protecting the Pennsylvania law and similar statutes from preemption.

C. ***Definition of Mental Health Benefits***

Section 712A and Section 2705A both include a subsection (f) that, for purposes of applying the Act's parity obligation, defines the term "mental health benefits" to include any such benefits "as may be defined under State law when applicable to health insurance coverage offered in connection with a group health plan." Thus, to the extent a state has established its own definition of mental health benefits as part of a parity or other insurance law, that definition continues to be applicable when applying the Act's parity standards to state-licensed insurers.

D. ***Small Group Market***

As indicated above, although the Act does not apply to the small group market, the Act expressly states that it does not preempt any state insurance law relating to group health plans sponsored by small employers. As a result, state parity laws applicable to the small group market should not be preempted by the Act.

years ago, FMLA declared the principle that workers should never be forced to choose between the jobs they need and the families they love. In the years since its passage, more than 50 million Americans have taken advantage of its provisions to care for a sick love one, or recover from illness themselves, or welcome a new baby into the family.

Mr. President, if ordinary Americans deserve those rights, how much more do they apply to those who risk their lives in the service of our country? Soldiers who have been wounded in our service deserve everything America can give to speed their recoveries—but most of all, they deserve the care of their closest loved ones. Given the severity of their injuries, and our debt of gratitude, our servicemembers need more. That is exactly what is offered in the Support for Injured Servicemembers Act.

Senator Bob Dole and former Secretary of Health and Human Services Donna Shalala have been instrumental in this effort as well, through their thoughtfulness and work on the President's Commission on Care for America's Returning Wounded Warriors. It's not surprising that the Commission found that family members play a critical role in the recovery of our wounded servicemembers. The commitment shown by the families and friends of our troops is truly inspiring. According to the Commission's report, 33 percent of active duty servicemembers report that a family member or close friend relocated for extended periods of time to help their recoveries. It also points out that 21 percent of active duty servicemembers say that their friends or family members gave up jobs to find the time.

I am pleased that Senator CLINTON is the lead co-sponsor of my amendment. FMLA was the very first bill that President Clinton signed into law, and I am grateful that his wife, Senator CLINTON, continues to support the principles that I have been fighting for over 20 years. I am pleased that Senators DOLE, GRAHAM, KENNEDY, CHAMBLISS, REED, MIKULSKI, MURRAY, SALAZAR, LIEBERMAN, MENENDEZ, BROWN, NELSON of Nebraska, and CRAPO are co-sponsoring this amendment. I thank Senator BAUCUS and Senator GRASSLEY for accepting this important amendment and appreciate the support of all of my colleagues in this effort.

Mr. President, I am troubled by the comments from the Bush administration about this bill. It is a bill to help children and an overwhelming majority of members on both sides of the aisle have voted to support that goal. The CHIP Program is a model of success and this bill provides sustainable and predictable health care coverage for low income children regardless of their health status. One day soon, the President will make a decision on whether to sign CHIP reauthorization into law. At that moment, all Americans will know whether the President stands for children or would rather stand in the way of children's access to critically needed health care.

BRITISH PETROLEUM REFINERY

Mr. DURBIN. Mr. President, today I rise to speak about the proposed expansion of a British Petroleum refinery in Whiting, IN. BP Amoco has requested, and received, a permit to increase the pollution it dumps into Lake Michigan.

Under this new permit, BP's expanded facility will release 54 percent more ammonia and 85 percent more suspended solids which contain heavy metals, including mercury, into Lake Michigan. Expanding refinery capacity is an important goal and a project with many benefits, but we shouldn't do this at the expense of one of our most precious natural resources.

Congress passed the Clean Water Act to restore and maintain the integrity of our Nation's waters. The express goal of the law is to reduce the amount of pollutants entering the Nation's waterways. The Clean Water Act went so far as to set a very specific target of reaching zero pollutants going into the waters by 1985. Zero discharges. We certainly have not met that target.

But we have been trying to move toward it. Now, BP wants to increase its pollution into Lake Michigan. BP has spent millions and millions of dollars to "green" its image. This company has effectively changed its name from "British Petroleum" to "Beyond Petroleum."

Yet with this "green" image, BP turns around and asks for a permit to dramatically increase the amount of pollutants it dumps into Lake Michigan. BP has worked very hard to make the American public think that the company is an environmental steward, that it is a responsible and sustainable company. And it does have some very good initiatives, but BP stands to lose this image by insisting on dumping more pollution into Lake Michigan.

A Chicago Sun Times article this week referred to BP as "Big Polluters." I don't think that is what the company wants.

The CEO of BP met with me last week. I asked him to take another look at the technology that is currently available to decrease the amount of ammonia and total suspended solids that will be introduced into Lake Michigan. I encouraged BP to find a better solution.

I am calling on BP to live up the standard it has set for itself as a corporate steward of the environment and to stop any additional pollution from being discharged into Lake Michigan.

The Great Lakes are a tremendous and valuable resource. The lakes are a largely closed ecosystem that has a very long water retention time. It takes 106 years for water to be completely flushed through Lake Michigan. Pollutants that are introduced into the lake are likely to stay there for a long time.

The Great Lakes contain more than 20 percent of the Earth's surface fresh water and are a necessary drinking water source for nearly 40 million Americans. Increasing pollution going into the Lakes should worry us all. Twenty-five percent of the U.S. and Canadian populations are within the watershed of the Great Lakes.

Congress appreciates the value of this resource. More than 30 Federal laws have been enacted that specifically focused on restoring the Great Lakes basin.

Government at all levels is working to prevent industrial pollution, sewage discharges, invasive species and water diversion. These efforts are to ensure that future generations will enjoy the beauty of our magnificent Great Lakes.

Dumping more pollution into one of our most important sources of fresh water is a bad idea. The people in my State recognize that. They are willing to forgo the modest increase in refinery expansion to protect Lake Michigan.

At a time when fresh water sources are threatened here and around the globe, we should demand more especially from corporate leaders who flash public relations campaigns about moving "beyond petroleum." BP is not a struggling small business. In the past three years, BP Corporation has earned net profits of over $6 billion. If anyone has the resources to find alternatives, it is BP Amoco.

We respectfully ask BP to live up to the image it has worked so hard to create and use some of the resources they have to prevent additional pollution from entering our drinking water. Please protect our natural resource, don't degrade it.

MENTAL HEALTH PARITY ACT

Mr. CASEY. Mr. President, I rise today to clarify my support for S. 558, the Mental Health Parity Act of 2007. This bipartisan legislation introduced by Senators DOMENICI and KENNEDY, seeks to provide parity between health insurance coverage of mental health benefits and benefits for medical and surgical services. I join my colleague, the senior Senator from Pennsylvania, Mr. SPECTER, in establishing for the record today the reasons for our joint support for this bill. I also thank Chairman KENNEDY and Senator DOMENICI for joining us in this discussion.

Mr. SPECTER. I thank my colleague Senator CASEY. Mr. President, as a cosponsor of S. 558, I am pleased that the Senate is taking up this important legislation. I thank Health, Education, Labor, and Pensions, HELP, Committee Chairman KENNEDY, Senator DOMENICI, who along with HELP Committee Ranking Member ENZI and others, have worked to establish mental health parity for millions of American citizens.

Mr. KENNEDY. I thank my colleagues from Pennsylvania and appreciate their dedication to and support for the cause of mental health parity. I

welcome this opportunity to discuss this critical legislation.

Mr. DOMENICI. I concur with Senator KENNEDY and look forward to Senate action on S. 558.

Mr. CASEY. Mr. President, the Mental Health Parity Act of 2007 amends the Employee Retirement Income Security Act, ERISA, and the Public Health Service Act to require a group health plan that provides both medical and surgical benefits and mental health benefits to ensure that: (1) the financial requirements applicable to such mental health benefits are no more restrictive than those of substantially all medical and surgical benefits covered by the plan, including deductibles and copayments; and (2) the treatment limitations applicable to such mental health benefits are no more restrictive than those applied to substantially all medical and surgical benefits covered by the plan, including limits on the frequency of treatments or similar limits on the scope or duration of treatment.

Mr. SPECTER. In 1989, in the Commonwealth of Pennsylvania, the State legislature passed a bill, Pennsylvania Act 106, which requires all commercial group health insurance plans and health maintenance organization's to provide a full continuum of addiction treatment including detoxification, residential rehabilitation, and outpatient/partial hospitalization. The only lawful prerequisite to this treatment and to coverage is certification to need and referral from a licensed physician or psychologist. Such certifications and referrals in all instances control the nature and duration of treatment. I support existing Pennsylvania law and, before agreeing to support S. 558, assured myself that S. 558 will not serve to supplant greater Pennsylvania protections for those seeking treatment for substance abuse.

Mr. CASEY. I join my esteemed colleague in having assured myself that S. 558 will not serve to preempt in any way the services and benefits provided to the citizens of Pennsylvania by Pennsylvania Act 106. I know that our offices have collaborated extensively in this analysis and have consulted with HELP Committee staff and Senator DOMENICI's staff, and that our views are borne out by extensive legal and scholarly analysis of the preemptive provisions of S. 558.

Mr. KENNEDY. I can assure the Senators from Pennsylvania that we have labored to ensure that S. 558 will serve only to benefit States and the coverage that citizens receive.

Mr. CASEY. I thank Chairman KENNEDY and Senator DOMENICI, and I note in particular that Professor Mila Kofman, Associate Research Professor, Health Policy Institute, Georgetown University, wrote to Senator SPECTER and myself on August 2, 2007, extolling the benefits of S. 558. I ask unanimous consent to print in the RECORD Professor Kofman's letter.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

GEORGETOWN UNIVERSITY
HEALTH POLICY INSTITUTE,
August 3, 2007.

Hon. ROBERT P. CASEY, Jr.,
U.S. Senate, Russell Senate Office Building, Washington DC.

Hon. ARLEN SPECTER,
U.S. Senate, Hart Senate Office Building, Washington, DC.

DEAR SENATOR CASEY AND SENATOR SPECTER: This is a response to a request for an analysis of the preemption provisions in the Mental Health Parity Act of 2007 (S. 558 as amended 8/3/07 Managers' Amendment).

The changes made to the preemption section in S. 558 mean that the current HIPAA federal floor standard would apply to the new Mental Health Parity law (just like it applies to the current law passed in 1996).

This would mean that more protective (of consumers) state insurance laws would apply to insurers that sell coverage to employers. This bill would also mean new federal protections for people in self-insured ERISA plans.

This would be a tremendous victory for patients who need coverage for mental health services. This approach continues the public policy established in 1996 in HIPAA—an approach that allows states to be more protective of consumers while setting a federal minimum set of protections for workers and their families.

While not every word or phrase is perfect (meaning not 100% litigation proof), using the current HIPAA preemption standard would certainly make it difficult to win a case that seeks to challenge more protective state insurance law.

If enacted, this bill would provide much needed minimum protections for people in self-insured ERISA plans who currently are not protected by states because of ERISA preemption. It also raises the bar for insured products.

If you have additional questions, please contact me at 202–784–4580.

Very truly yours,

MILA KOFMAN, J.D.,
Associate Research Professor.

Mr. CASEY. In the letter, Professor Kofman writes:

The changes made to the preemption section in S. 558 mean that the current HIPAA federal floor standard would apply to the new Mental Health Parity law (just like it applies to the current law passed in 1996).

This would mean that more protective (of consumers) state insurance laws would apply to insurers that sell coverage to employers. This bill would also mean new federal protections for people in self-insured ERISA plans.

This would be a tremendous victory for patients who need coverage for mental health services. This approach continues the public policy established in 1996 in HIPAA—an approach that allows states to be more protective of consumers while setting a federal minimum set of protections for workers and their families.

If enacted, this bill would provide much needed minimum protections for people in self-insured ERISA plans who currently are not protected by states because of ERISA preemption. It also raises the bar for insured products.

Mr. SPECTER For the purpose of further clarifying congressional intent of S. 558 and its application to state law and specifically Pennsylvania Act 106, will the senior Senator from Massachusetts and the senior Senator from New Mexico yield for questions from Senator CASEY and myself?

Mr. KENNEDY I will be happy to do so.

Mr. DOMENICI As will I.

Mr. SPECTER I thank Chairman KENNEDY and Senator DOMENICI. Why doesn't the Mental Health Parity Act have its own preemption provision?

Mr. KENNEDY It is our intention to establish a Federal floor and not a Federal standard or Federal caps. Thus, we decided to use the already-existing language and standard found within part 7 of ERISA, which is where the current mental health parity law already resides, and where S. 558 will be codified. This law contains the narrowest possible preemption language, and is meant to preempt only those state laws that are less beneficial to consumers and insured, from the standpoint of the consumer and insured, than this new Federal law.

Mr. CASEY The Health Insurance and Portability Accountability Act, HIPAA, preemption standard that will apply prevents State laws that "prevent the application of requirements of this part," which refers to part 7 of ERISA. Do the medical management provisions of section 712A(b) constitute "requirements of this part" that might preempt State laws under this standard?

Mr. DOMENICI No. Section 712A(b) says that managed care plans "shall not be prohibited from" carrying out certain activities. It does not require them to do so, and this is not a "requirement of this part." This section recognizes that plans have flexibility. It is not our intention to preempt any State laws that regulate, limit, or even prohibit entirely the medical management of benefits. That is one of the reasons we are using a preemption standard—the existing HIPAA standard that so clearly does not preempt such a law.

Mr. SPECTER Would a State law that establishes a physician or psychologist's certification, as the only lawful prerequisite to managed care coverage of a particular treatment, be preempted?

Mr. KENNEDY Such a law is not preempted, and it is not our intention to preempt any such law.

Mr. CASEY What about a State law requiring insurers or managed care companies to cover an entire continuum of care?

Mr. DOMENICI Mr. President, it is my understanding that such a law would not be preempted. S. 558 is a Federal floor, and nothing in such a State law Senator CASEY describes would prevent the application of any requirements of part 7 of ERISA.

Mr. SPECTER Would State laws that place coverage decisions squarely in the hands of treating clinicians be preempted?

Mr. KENNEDY Absolutely not.

Mr. CASEY Focusing specifically on Pennsylvania, as you may be aware, the citizens of Pennsylvania just received a significant court victory from the Commonwealth Court, upholding a Pennsylvania law that was previously mentioned here, Pennsylvania Act 106.

That State law and the recent decision in The Insurance Federation of Pennsylvania, Inc. v. Commonwealth of Pennsylvania Insurance Department, removes managed care barriers to addiction treatment. What effect will S. 558 have on that State law, or on State efforts to enforce that law or to find remedies for violations of that law?

Mr. KENNEDY This bill would have no effect upon that law.

Mr. CASEY Would any State laws be preempted?

Mr. DOMENICI Yes, State law requirements that would prevent the application of a requirement of S. 558 by, for example, endorsing a less consumer-friendly level of coverage or benefits. For example, a State law that prohibited an insurance company from selling policies providing for full parity in coverage for mental health services and medical/surgical services would be preempted.

Mr. CASEY Would the current legislation, S. 558, have any effect on any provisions of Pennsylvania Act 106, or on any State efforts to enforce provisions of that law or to find remedies for violations of any provisions of that law?

Mr. KENNEDY It would have no effect. Pennsylvania's Act 106 is an example of the kind of consumer protection law that is not preempted by the federal floor created in S. 558.

Mr. SPECTER I appreciate this discussion with my colleague from Pennsylvania, Chairman KENNEDY and Senator DOMENICI. I thank Chairman KENNEDY, Ranking Member ENZI, Senator DOMENICI and others on the HELP Committee who have worked so hard to establish these critical benefits for citizens across our great country. And I thank them for this discussion to clarify our support for S. 558.

Mr. CASEY I also want to express my deepest thanks to HELP Committee Chairman KENNEDY, Senator DOMENICI, HELP Committee Ranking Member Enzi, and all members and staff who have worked so hard to make this long time dream a reality. I greatly appreciate this discussion and our establishment of intent regarding S. 558.

AMERICA COMPETES ACT

Mr. INOUYE. Mr. President, America's strength has always been in the innovation, technical skill, and education of its workforce. The economic growth and well-being of the nation relies on the technological innovations achieved by our workforce. To realize growth and success, the United States must continue to support the two critical components vital to the innovation process: education and basic research. Today, Congress takes a significant step toward this commitment.

The National Academy of Sciences and the Council on Competitiveness have identified science and innovation as key drivers of economic growth. The United States has seen a sharp palpable decline in its scientific prowess. The United States is losing the educational battle with Germany, China, and Japan. In the United States, only 32 percent of graduates hold a degree in science and engineering, while Germany boasts 36 percent of graduates with degrees in science and engineering. Outpacing both the United States and Germany is China, with 59 percent of graduates with degrees in math and science, and Japan with 66 percent.

The America COMPETES Act embodies bipartisan, bicameral multicommittee efforts in responding to the Nation's defining economic challenge of how to remain strong and competitive in the face of emerging challenges from India, China, and the rest of the world.

The America COMPETES Act addresses programs within several scientific agencies of which the Senate Committee on Commerce, Science, and Transportation has jurisdiction. Within the Department of Commerce, the National Institutes of Standards and Technology, NIST, promotes U.S. innovation and industrial competitiveness by advancing measurement science, standards, and technology. The legislation before us would double the agency's funding over the next 10 years. We also create a new program, the Technology Innovation Program, which will support high-risk, high-reward research. This was one of the major recommendations of the National Academies report, "Rising Above the Gathering Storm."

Also within the Department of Commerce, the National Oceanic and Atmospheric Administration, NOAA, conducts significant basic atmospheric and oceanographic research, including climate change research. Some have argued that the ocean truly is the last frontier on Earth, and ocean research and technology may have broad impacts on improving health and understanding our environment. Toward this end, Congress included provisions on NOAA research and education, as well as, NOAA's continued participation in interagency innovation and competitiveness efforts.

The bill also includes the National Aeronautics and Space Administration, NASA, in the competitiveness agenda. Like the oceans, space serves to inspire young students and attract them to studies in science, technology, engineering, and mathematics.

The need for additional research through the National Science Foundation, NSF, also is addressed in this bill with authorization for appropriations through fiscal year 2010. This bill places NSF on track to double in 7 years. While this is not as aggressive an approach as the Senate sought, it is clear that Congress is united in our belief that the NSF is indeed the Nation's premier scientific research enterprise. We need to support this enterprise to the best of our abilities, so that it can enable our scientists to continue their discovery. Within the NSF, I am proud that the conferees supported the creation of a mentoring program designed to recruit and train science, technology, and engineering professionals to mentor women, and other underrepresented minorities, in these fields. We need to ensure that we do not neglect a segment of the U.S. population, but rather maximize all of this country's great human resource.

A strong national investment in science, education, and technology provides opportunities for Americans to succeed in a whole array of disciplines and professions. Technology and innovation influence many policy problems such as a changing telecommunications landscape, potential improvements to our transportation infrastructure, and the need for advanced technologies to increase our energy independence. The America COMPETES Act directs the Nation on the path to preserve and improve its workforce. This bill demonstrates that Americans are not taking their traditional technological and economic dominance for granted but are continually working to improve and lead

Mr. CARDIN. Mr. President, I am pleased that last night the Senate passed the conference report that accompanies H.R. 2272, the America COMPETES Act of 2007. Innovation resulting from Americans' genius and gift for innovation has revolutionized the global economy and workplace as well as all our everyday lives.

Unfortunately, our education system has failed to keep pace; now, many of our Nation's schools are unable to provide their students with the scientific, technological, engineering, and mathematical knowledge and skills the 21st century economy demands. Without well-trained people and the scientific and technical innovations they produce, this Nation risks losing its place as the epicenter for innovative enterprise that has been one of our proudest traditions.

I applaud Senators BINGAMAN and ALEXANDER and the other leading sponsors of the bill for their action to ensure that this Nation remains a technological leader. I was proud to join them as a cosponsor of the bill and was proud to join them to vote for its final passage.

I am grateful to the academic and business leaders, including Nancy Grasmick, the Maryland State superintendent of schools, and Dr. C.D. Mote, Jr., president of the University of Maryland, who produced both the National Academies' ''Rising Above the Gathering Storm'' and the Council on Competitiveness's ''Innovative America'' reports and recommendations that serve as the foundation for this critical legislation.

This legislation is critical for it addresses the growing gap in this country between what is taught in elementary and secondary schools and the skills necessary to succeed in college, graduate school, and today's workforce. This gap threatens the implicit promise we have each made to our own children and those whom we represent: get