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May 28, 2009

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N–5653
U.S. Department of Labor
200 Constitution Avenue, NW.
Washington, DC 20210

Attention: MHPAEA Comments

To Whom It May Concern:

Thank you for the opportunity to comment on issues surrounding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The attached document represents the comments from Representative Patrick J. Kennedy and other members of Congress. We hope you will take our recommendations under careful consideration as regulations are developed.

Thank you again for this opportunity to comment.

Sincerely,

Patrick J. Kennedy
Member of Congress

Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
Departments of Treasury, Health and Human Services, and Labor
May 27, 2008

The purpose of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Subtitle B of Public Law 110- 343) is to equalize mental health and addiction benefits with other health benefits. The Act seeks to end insurance coverage discrimination for those seeking to access mental health and substance use disorder benefits through their health insurance provider.

Testimony from the Congressional hearings on mental health parity, as well as the fourteen nationwide field hearings, confirm that individuals with mental illness and substance abuse disorders experience discriminatory financial requirements and treatment limitations when seeking treatment. This discrimination can result in the denial of needed medical attention, increased use of emergency rooms, increased health care costs for co-occurring disorders, and premature death. Ending discrimination entails ensuring that every offered mental health benefit is offered in equity with medical and surgical benefits. Since comparing medical and surgical benefits to mental health benefits is not always straight forward, it is essential that the regulations are clear as to how this determinant will be made, ensuring that the Congressional intent of equivalency is met.

In an effort to ensure that the regulations developed for mental health parity are consistent with the intent of the law, a number of key recommendations are made.

1. It is essential that plans are held publically accountable as to how that determination is made, and that this criterion clearly and transparently be equitable to medical and surgical benefits. It should be clear what criteria will be used by health plans to make health coverage determinations, and how medical necessity is defined, in order to ensure that the same criterion are used to determine coverage for both physical and mental health conditions. The application of medical management tools or medical necessity determinations must be no more restrictive in mental health and substance use disorder benefits than as in medical and surgical benefits.

2. The intent of this legislation is to ensure that patients have access to the full scope of services required for their condition. For example, if a doctor prescribes an anti-

depressant for a patient, the associated psychotherapy for this condition may be recommended by a medical professional, despite the fact that a comparable medical benefit does not exist. It is also intended that prescription drugs necessary to treat mental health conditions are considered as a part of covered services. The definitions in these regulations should be clarified in a way which provides for this, since not all treatment modalities for mental health conditions are analogous enough to that for medical and surgical conditions to make this comparison clear.

Therefore, clarification may be necessary to some key terms, including "financial requirement," "predominant," and "treatment limitation," in order to eliminate loopholes due to ambiguity. Specifically, clarity on the criteria on which determinations of "predominant treatment" and "treatment limitations" are based is needed. It may be useful to create categories of care in which comparisons will be made. For instance, in-patient, in network services for medical and surgical benefits could be compared to in-patient, in network services for mental health benefits. Other categories of comparison could be outpatient/in-network; inpatient/out-of-network; and outpatient/out-of-network.

3. In order to offer equitable coverage, it is essential to be clear as to how that equity will be evaluated. Insurers must use for mental health benefits the same determinative methodology applied to physical health benefits. Criteria used and reasons for denials relating to mental health and addiction treatment must be made to beneficiaries in clear terms, and it must be clear that these standards are equitable to those that are provided for medical and surgical benefits.

Further, the law required that guidance and information should be provided by the Federal agencies to inform participants and beneficiaries on how they may obtain assistance from the state consumer and insurance agencies. This language was included to ensure that individuals have the ability to challenge their employer or health plan if there are concerns that they are not following the requirements of this law. This guidance should be provided as soon as possible and be as clear as possible.

4. It was the intent of Congress that separate pools of deductibles for mental health and medical and surgical benefits be construed as financial discrimination. It would not be equitable for a plan to require an individual to pay an out of pocket deductable for medical and surgical benefits and then a separate deductable for mental health benefits. Further, it would impose a significant barrier to treatment for many individuals. Separate but equal deductibles and out of pocket maximums are discriminatory and should be prohibited.

5. Network design should not be a means of restricting coverage. Parity in "out of network" requirements were included specifically to combat discrimination through limited networks for mental health and substance use disorder benefits. If a plan has an out of network policy for its medical surgical benefits, the polices for out of network care for mental health and substance use disorder benefits should be no more restrictive financially or based on treatment limitations. This will allow individuals to get the services they need whether they can be found in or out of the network.

6. Field hearings revealed the existence of “phantom networks” that lacked sufficient mental health and addiction professionals to adequately manage the amount and scope of the clinical demands many of their subscribers faced, resulting in consumers choosing between providers without the required specialty or paying large out of pocket costs. We must ensure that there are enough and appropriate providers to provide services, so that network design does not become a means of restricting coverage. There are a wide range of mental health and substance abuse treatment providers (ie. psychiatrists, psychologists, marriage and family therapists, and/or counselors). Restricting the types or numbers of participating providers in a network should be construed as a treatment limitation. Further, participating providers must have the competencies and scope of practice expertise necessary to achieve equity with medical and surgical benefits.

7. Since many states already have parity laws, and vary widely in what they do and do not require, clarity is needed on which states laws would be preempted and under what circumstances. The regulations could specify that anything not requiring equivalence between physical and mental health benefits is more restrictive.

8. When evaluating cost exemption and small business exemptions, the regulations should make clear that actual experiential data be used when determining exemptions, rather than projections. If comparisons are made by category, as suggested above, the regulations should make clear that the cost exemption exclusion refers to increases in total costs. Further, it could be clarified that "the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year." Clarification would eliminate confusion around whether the plan gets exempt for the rest of that year and the following year, or just the following year.

9. A recognized, independent standard of existing medical practice should be used to define whether a diagnosis or condition is classified as mental health condition or a medical or surgical condition. This will avoid the potential for an insurer to define a generally recognized mental health condition as a medical benefit and therefore not subject to parity.

Thank you for your consideration.