Coalition for Fairness in Mental Illness Coverage

May 28, 2009

Submitted via the Federal eRulemaking Portal: http://www.regulations.gov

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-4137-NC
P.O. Box 8017
Baltimore, MD 21244-8010

U.S. Department of the Treasury
Internal Revenue Service
Attention: CC:PA:LPD:PR (REG – 120692-09)
Room 5205
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Dear Sir or Madame:

The Coalition for Fairness in Mental Illness Coverage was formed over thirteen years ago to win equitable mental health coverage. The Coalition members include: American Hospital Association, American Medical Association, American Psychiatric Association, and American Psychological Association, Association for Behavioral Health and Wellness, Federation of American Hospitals, Mental Health America, National Alliance on Mental Illness and National Association of Psychiatric Health Systems. The organizations represent consumers, family members, health professionals, and health care systems and administrators. The Coalition was extensively involved in the negotiating and drafting of both the Senate bill and the final law and vigorously supported its final passage.

We are responding to your request for information with specific comments that all nine organizations would like to call your attention to in the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Many of our organizations are also submitting separate and more detailed comment letters to your agencies.

Issue 1: The Coalition seeks clarification on which group health plans and health insurance issuers are subject to comply with the MHPAEA. We feel that a review of the entities that the law applies to would be very helpful. There are two particular instances in which we seek specific clarification—one is clarification that the law does not apply to Employee Assistance Programs and the other is clarification as to whether or not it applies when several companies, with fewer than 50 employees each but more than 50 total, join together to collectively purchase health coverage for all of these employees.

Issue 2: 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).

We believe the parity standard of "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.

In the previous Mental Health Parity Act of 1996 (MHPA), "substantially all," 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 Agencies' 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 impose either the same or a lesser limit on mental health benefits. 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.

The term "substantially all" applies to plans 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 a 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 requirements or treatment limitations that are applied to "substantially all" the medical/surgical benefits should be those requirements or limitations that are applied to the mental health/substance use benefit. Of course, a plan or coverage may apply a lesser financial requirement or treatment limit to mental health/substance abuse benefits, 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.

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 should not impose a limit on outpatient psychotherapy visits.

In another 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.

We believe that it is appropriate 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.

Issue 3: The language in the cost exemption section of MHPAEA requires that "determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries." 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.

The Coalition also wants to reinforce that MHPAEA requires a group health plan seeking an exemption to have complied with the law for the first six months of the year involved and that 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. We also 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.

Issue 4: The Coalition worked hard to ensure that state mandate laws (where applicable) were not preempted by the MHPAEA and the upcoming regulations offer an important opportunity to provide guidance and clarity to the states regarding the preemption of and preservation of state laws that either mandate coverage of mental health and substance use disorders, set minimum standards for coverage of these disorders, or require equitable coverage.

It is important to note that the MHPAEA does NOT articulate a new or different standard for preemption of state law. Instead, the MHPAEA incorporates the standards in ERISA and the Public Health Service Act set forth by Congress in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This preemption standard serves to protect state law, and allows for federal displacement of state law only in cases where a state law "prevents the application" of federal law, in this case the equitable coverage standards in the MHPAEA.

It is our understanding that this means states can continue to enforce, and in the future develop, state laws requiring equitable coverage for mental health and substance use disorders relative to medical/surgical coverage.

Clarification is necessary to assist with the identification of those instances when state laws are to be preserved. It is particularly important to provide examples that illustrate how broader mandates that remain in effect in states interact with the new federal law. For example, any mandate to cover mental health services (whether only for people with certain serious mental disorders or only for a certain number of days) should remain in force. The federal law would then preempt any inappropriate limits on those services, and thus a mandate for 30 days of inpatient care would become a mandate for coverage of inpatient mental health care at parity with other inpatient health services. Additionally, statements that explain how a mandated minimum benefit becomes a parity benefit and how mandated coverage of serious mental illness remains in effect and becomes mandate for parity for serious mental illness are necessary.

Thank you for the opportunity to respond to the RFI. If you have any questions about the Coalition's comment letter please contact the Coalition Chair, Pamela Greenberg, President and CEO, Association for Behavioral Health and Wellness, at greenberg@abhw.org or (202) 756-7726.

Sincerely,

American Hospital Association

American Medical Association

American Psychiatric Association

American Psychological Association

Association for Behavioral Health and Wellness

Federation of American Hospitals

Mental Health America

National Alliance on Mental Illness

National Association of Psychiatric Health Systems