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**Cc:** [Pedulla, Diane](#)  
**Subject:** Mental Health Parity Rule  
**Date:** Wednesday, January 08, 2014 6:05:06 PM  
**Attachments:** [DOL Letter 1-8-2014.pdf](#)

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Attached is our comments letter as requested.

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AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION  
PRACTICE ORGANIZATION

January 8, 2014

Employee Benefits Security Administration  
Department of Labor

Centers for Medicare and Medicaid Services  
Department of Health and Human Services

Internal Revenue Service  
Department of the Treasury

Re: Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and  
Addiction Equity Act of 2008

VIA FAX: 202-219-1942

To the Departments:

The American Psychological Association Practice Organization (APAPO) is providing comments on the final rules for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). APAPO is an affiliate of the American Psychological Association, the professional organization representing more than 137,000 members and affiliates engaged in the practice, research, and teaching of psychology. APAPO commends the Departments for issuing the final rules, which is a critical step in the battle to end discrimination against patients seeking mental health treatment.

As stated in our May 3, 2010 comment letter on the Interim Final Rules (IFR), APAPO agrees with the Departments that Congress intended MHPAEA to apply to non-quantitative treatment limitations (NQTLs) placed by health plans on mental health and substance use disorder benefits to the extent that they limit the scope or duration of these benefits compared to medical surgical benefits. In our 2010 comments we noted two specific NQTLs to which parity applies: (1) health plan methods for determining usual, customary, and reasonable charges, and (2) standards for provider admission to join health plan networks. APAPO thanks the Departments for continuing to include both of these examples in the final rules' illustrative list of NQTLs.

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## **Enforcement**

APAPO urges the Departments to enforce the requirements under mental health parity and to ensure that there is transparency in such enforcement. The need for enforcement became apparent when an epidemic of mental health provider rate cuts started in mid-2011, not long after the IFR had gone into effect. In collaboration with our state psychological associations, APAPO filed several rate cut parity complaints with the Departments and with state insurance commissioners. On October 5, 2011, we filed our first rate cut/parity complaint with the Departments regarding a large rate cut by BCBS of Florida (BCBS FL) that targeted only mental health reimbursement. In April 2012, we filed our first rate cut complaint against Humana with the Illinois Department of Insurance (IL DOI). In July 2012, we filed another complaint with the Departments, having learned that the Humana cuts had spread to ten states. We have since filed complaints about cuts by Humana with four other state insurance agencies.

With the exception of Illinois, no state has agreed to investigate our complaints. To our knowledge, no federal or state agency has concluded an investigation or taken enforcement action on our complaints. The lack of enforcement has emboldened Humana to continue to cut rates. At the time of our complaints, Humana had cut rates for the most commonly billed psychologists' code (45-50 minutes of psychotherapy) almost 20% below the lowest rates of other private insurers nationally. We have recently learned that Humana is cutting rates 10% further in a few states.

In Florida we are seeing how rampant rate cutting hinders patient access to treatment. Mental health providers there have been hit by cuts, largely from BCBS FL and Humana, but other issuers have also been cutting rates. Our state association reports that many psychologists are not just leaving networks, but also having to close their practices altogether. This will have long term impacts on the ability of Florida consumers to obtain needed mental health care. We urge the Departments to investigate and enforce reimbursement disparity to ameliorate the negative impacts on mental health patients.

On April 24, 2013, we sent the Departments a letter suggesting ways to make the upcoming final rules more enforceable, based on our experience trying to enforce the IFR. We again suggest the improvements noted in that letter:

- Have plans and insurers provide basic information in response to significant complaints from major parity stakeholders if parity enforcement agencies cannot act promptly (e.g., within 30 days).
- Streamline and clarify HHS' secondary jurisdiction as to fully insured plans by (1) placing a two-month limit on the time state insurance commissioners have to initiate action before HHS can exercise its secondary jurisdiction and (2) providing a list of state insurance commissioners that HHS knows lack the statutory authority or willingness to enforce federal parity law.

In addition, we suggest that the Department provide timeframes for completing their own investigations to avoid situations like the investigation of our BCBS FL complaint that has been pending for over 27 months with no resolution in sight.

**Reimbursement Disparities**

We are pleased that the Departments acknowledged reimbursement disparity as an NQTL but have concerns that these disparities will undercut all other parity protections if they are not adequately addressed. APAPO appreciates that the final rules reiterate the importance of provider reimbursement as a parity requirement. We note that the preamble to the final rules provides some additional guidance on the meaning of reimbursement parity by explaining that plans and issuers may consider a wide array of factors when determining reimbursement rates for both mental health and medical/surgical services. We commend the Departments for including among the factors the supply of providers and Medicare rates as we suggested in our April 24, 2013 letter.

But more is needed on this crucial parity issue. Enforcement will also make it clear to companies and other parity stakeholders how the Departments intend to apply the general list of reimbursement factors to real world facts. For example, we do not see how the listed reimbursement factors could justify the Humana and BCBS FL rate cuts. But until the Departments take action, we expect that Humana, BCBS FL, and other companies that are grossly underpaying mental health providers relative to medical/surgical providers will be able to construct arguments as to how some interpretation of the reimbursement factors justifies the reimbursement disparity.

As the agencies know from our prior letters, we consider massive reimbursement rate cuts that target only mental health providers the most insidious parity violations. When rate cuts force large numbers of psychologists and other mental health providers to leave the network, patients are affected in several ways. Patients seeking care may have critical care delayed or simply give up on obtaining treatment. Patients in care have their care disrupted, drop out of treatment completely and/or pay more out-of-pocket if they have out-of-network benefits. In essence, patient access to mental health treatment is severely curtailed, if not lost altogether. These impacts reduce the company’s mental health costs.

Many of these impacts are shown by data from our surveys of psychologists hit with large Humana rate cuts in Illinois, Ohio and Georgia:

Impact of Humana Rate Cut	Illinois	Ohio	Georgia
Surveyed psychologists who left the Humana network because of the rate cut	57%	40.7	45%
Percentage of psychologists still deciding whether to leave the network at the time of the survey	30%	29.6	n/a
Psychologists reporting disruptions in patient care	69%	49.1	43
Psychologists reporting patients dropping out of treatment completely	46.5	44.9	28%

While the rate cuts are the most dramatic example of provider reimbursement disparity, chronically low mental health provider rates are also a significant threat to parity. Many psychologists report that their reimbursement rates from private insurers have stayed flat or declined over the last two decades while many medical/surgical providers have received regular increases. The end result is the same: if low rates lead to an exodus of mental health providers then mental health patients suffer constrained access to needed care.

The Departments have indicated they may release additional guidance on reimbursement if necessary. While it would be helpful for the Departments to issue more detailed examples of how they intend to enforce the provider reimbursement NQTL, we believe that the most helpful step would be transparent enforcement of this NQTL so that parity stakeholders could see how the Departments apply the final rules to actual rate disparity complaints.

### **Transparency of Medical Necessity Criteria**

APAPO and its state psychological association affiliates in several states have experienced problems with certain BCBS companies limiting patient and provider access to their medical necessity criteria in ways that we believe violate the broad mandate of Section 512(a)(4) of the MHPAEA. These companies have been (a) limiting access only to circumstances where the company has denied care and/or only to those criteria on which the company based a denial and/or (b) refusing access on the grounds that the company has purchased proprietary medical necessity criteria from an outside vendor.

Section 512(a)(4) of the statute provides:

#### *(4) Availability of plan information*

The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits . . . shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current *or potential* participant, beneficiary, or contracting provider *upon request*.

(emphasis added). This language was incorporated essentially unchanged into the IFR and the final rules (see 29 CFR 2590.712(d)(1)).

Providing criteria only when the company has denied coverage and/or providing only the criteria used to evaluate a coverage decision flies in the face of the requirement that medical necessity criteria be given to *potential* plan participants, beneficiaries or providers who request them. Obviously, potential participants, beneficiaries and providers will not have been subject to (or had their patients subject to a coverage determination).

This broad requirement allows prospective mental health patients to determine, before enrolling with a plan, whether their condition and treatment will be covered. These companies apparently prefer that patients find this out after they have chosen a plan and been denied care. The requirement also allows providers to determine what the company will cover before joining a company network or before proposing a course of treatment to a patient.

Access to medical necessity criteria under MHPAEA should not be confused with the narrower access to criteria provided under the Employee Retirement Income Security Act (ERISA) as the latter right is triggered only upon review of a denial of care.

It is also notable that the “make the criteria available upon request” requirement is not limited to those criteria that the company chooses to rely upon in reviewing care. This is important because many patients present with a variety of mental health conditions and often have both a primary and a secondary diagnosis. For example, a company might focus its evaluation on a patient’s primary diagnosis and determine that the medical necessity criteria for that diagnosis do not justify further treatment. In fact, further care might be warranted if the secondary diagnosis (alone or in combination with the primary diagnosis) was taken into consideration but the patient and/or his or her mental health professional could not successfully argue this point without having access to other relevant criteria used by the company.

Finally, companies cannot evade the transparency requirement by using proprietary medical necessity criteria that they have purchased from an outside vendor. Section 512 contains no exception for proprietary criteria. If it did, companies could nullify this important transparency provision by all switching to proprietary medical necessity criteria. This MHPAEA provision has been on the books for six years so companies and plans have had time to adjust their business/contractual arrangements to ensure that they are in compliance and to find ways to address their proprietary concerns.

These restrictions are directly contrary to MHPAEA’s broad transparency requirement in Section 512(a)(4), the IFR, and the final rules. We ask that the Departments clarify that such restrictions on transparency are improper.

### **Medical Necessity and Long-Term Mental Health Patients**

A related medical necessity concern is that we hear numerous complaints that insurers constrain care of patients with long term mental health needs through practices that they do not apply to the care of chronic medical patients. Our psychologists report that even where patients have very severe mental health conditions (which may be caused by severe trauma or abuse, among other factors) that will require long-term treatment, the plan or company places what we call “up and out” pressure on the psychologist and the patient: the patient is expected to be on a trajectory to reduce and then terminate care within a matter of months, or within a year or two. Further, if patient’s condition is so severe that the psychologist is only able to stabilize the patient, the company often takes the position that treatment “isn’t working” so it is not considered medically necessary.

This places the psychologist and patient in a Catch-22 situation, either they are getting better to the point that they will soon be out of treatment or they are not improving so their care is not covered.

We do not believe that the same companies are placing “up and out” pressure on chronic medical patients. We doubt that diabetes patients are being told they should be improving and out of care in a year or that their condition has remained stable so therefore treatment must not be working. We believe that the disparate pressure companies place on mental health patients may reflect outdated beliefs, such as patients can choose to get over mental illness.

We raise this concern and ask the Departments to issue guidance on how they would evaluate disparities in medical necessity determinations for chronic mental health patients.

### **Medicaid/CHIP**

APAPO believes it is imperative that all health insurance programs include mental health parity and asks the Centers for Medicare and Medicaid Services (CMS) to issue regulations applying mental health parity to Medicaid and the Children’s Health Insurance Plan (CHIP) as soon as possible. With the implementation of the Patient Protection and Affordable Care Act the Medicaid population is growing significantly and this expansion will bring more beneficiaries in need of mental health treatment. Many of these beneficiaries come from under-served communities and have previously gone without treatment due to a lack of health care coverage. It is critical that they not face undue restrictions when seeking to access mental health services.

It is crucial that CMS apply the NQTLs to Medicaid and CHIP, notably provider admission to networks and payment rates, to ensure that mental health services for children and adolescents are both available and appropriately reimbursed.

APAPO appreciates this opportunity to comment on the final rules on mental health parity and looks forward to working with the Departments to clarify how the rules will be implemented. If you have any questions about these comments please contact our Director of Regulatory Affairs, Diane M. Pedulla, J.D., by telephone (202-336-5889) or email ([dpedulla@apa.org](mailto:dpedulla@apa.org))

Sincerely,



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