

National Coalition for Mental Health Recovery

1101 15th Street, NW #1212

Washington, DC 20005

www.ncmhr.org

**The National
Coalition for
Mental Health
Recovery
is united by these
values:**

Recovery:

We believe it is possible
for everyone.

Self Determination:

We need to be in control
of our own lives.

Holistic Choices:

We need meaningful
choices, including a range
of recovery-oriented
services.

Voice:

We must be centrally
involved in any dialogues
and decisions affecting us.

Personhood:

We will campaign to
eliminate stigma and
discrimination.

Steering Committee:

Daniel Fisher
Joseph Rogers
Kathy Muscari
Effie Smith
Carole Glover
Linda Corey
Mike Finkle
Sally Zinman
Molly Cisco
Alan Green

877-246-9058
www.NCMHR.org

May 3, 2010

Internal Revenue Service
Department of the Treasury

Employee Benefits Security Administration
Department of Labor

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

Re: Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
(published in 75 Fed. Reg. 5410 et seq.)

VIA EMAIL: E-OHPSCA.EBSA@dol.gov

To the Departments:

The National Coalition for Mental Health Recovery (NCMHR), representing tens of thousands of people with psychiatric histories across the United States, appreciates the opportunity to comment on the interim final rules (IFR) for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as published in the February 2, 2010, Federal Register. With the passage of the MHPAEA, we believe that Congress has taken an important step forward to end health insurance benefits discrimination against people needing and seeking coverage for mental health and substance use services, and we are pleased that the IFR implements the law to its full extent.

Below, we have addressed some of our major areas of concern.

1. The rules do not apply to employers with fewer than 50 employees which is a significant portion of the U.S. working population. If small employers are not required to provide parity in insurance coverage, persons in recovery from mental illnesses will be severely limited in their employment options. We urge the Departments to consider including small employers in the rules. To those who might believe that this would unduly raise insurance costs, we would point out that a large majority of persons who have medical insurance do not need to use behavioral health benefits, even if offered within their coverage.

2. The language chosen to describe the scope of services is inappropriate.

Even the Social Security Advisory Board Report, September 2006, states that we need to redefine disability. The report concluded, “A new system must support an integrated approach providing an alternate path directed to economic self-sufficiency, independence, and community inclusion.” Parity opens up access so that individuals with mental health problems may seek affordable services, treatment, and supports that are essential to recovery and to community integration. The more integrated people are into the life of the community – such as advancing their education, living in safe, affordable housing, and entering the workplace – the fewer public entitlements they will need.

The federal definition of medical necessity is no longer appropriate since we now know that people recover from even the most severe states of emotional distress, often referred to as mental illness. The definition should be amended to include recovery and community integration for persons with long-term mental health problems.

The rules use the term “generally accepted medical standards” and other ambiguous terminology. There are many conditions and many effective services and supports that do not fit into the category of “generally accepted medical standards.” Mental health recovery cannot be measured simply by a reduction in symptoms. The United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), defines mental health recovery as “a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.” Further, SAMHSA identified ten fundamental components of recovery: Self-Direction, Individualized and Person-Centered, Empowerment, Holistic, Non-Linear, Strengths-Based, Peer Support, Respect, Responsibility, and Hope. These components lead to resiliency in persons dealing with the challenges all people face. Federal medical standards have lagged far behind the innovations and extraordinary successes in the mental health/substance use disorder arena, including significant cost-saving applications, that have been achieved across the U.S. We urge the Departments to consider expanding this language to include other standards of care that are not solely based on medical definitions, interventions or outcomes. We urge the Departments to consider allowances that promote flexibility in assessing, planning and measuring services and outcomes. Recovery practitioners and researchers have defined several evidenced-based practices and emerging practices, and we urge the Departments to include these and other promising practices within the scope of services and to require plans and States to learn how these practices are designed, administered, delivered, funded and measured. For example, these include, but are not limited to, consumer-run alternatives to psychiatric hospitalization, which have proven effectiveness and save many millions of dollars per year in the U.S.

3. We have concerns about the limitations of appropriate and cost-effective services within the required six broad categories of benefits – inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care and prescription drugs. States or health plans offering mental health/substance use disorder (MH/SUD) benefits must offer benefits in each classification for which any medical benefits are provided. Unfortunately, the scope of services for substance use disorders (SUD) or mental health (MH) benefits are not

specified; this, therefore, permits States and group health plans to define the services covered in the benefit packages. Ancillary services considered essential to recovery are not specifically referenced in the rules. For example, respite care, warm lines, overnight hold beds, crisis diversion facilities, and residential support services are not addressed in the current rules. If the scope of services is left to States and health plans, we have serious concerns that such services will not be included, unnecessary costs will be incurred, and individuals will experience gaps in support, ultimately compromising their overall health.

4. Psychiatric hospitalization is not an evidence-based practice. We recommend that all possible non-coercive steps be taken to demonstrate that other avenues have been tried prior to hospitalization. We urge increasing the creation of alternatives to hospitalization to minimize force and cut costs.

We have concerns about the application of the MHPAEA to nonquantitative treatment limitations particularly as to what is considered “clinically appropriate standards of care,” and we urge an expansion of this definition to include evidence-based practices and other promising practices that have been researched and found to be effective.

The IFR requires that a group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan, “...any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.”

The essence of parity, although not explicitly included in the IFR, is interpreted to mean that medical care is voluntary. It is not forced onto individuals but, rather, it is a choice by the individual or family, and protected by law. However, because of the pervasive abrogation of individuals’ civil rights – even a person accused of serious criminal behavior is given greater legal protection and due process than a person diagnosed with mental illness – these issues are not being properly considered by the courts (Gottstein, 25 *Alaska L. Rev.* 51 [2008]; see, also Perlin, 42 *San Diego L. Rev.* 735, [2005]; and Morris, 42 *San Diego L. Rev.* 757, 772–74 [2005]). Research clearly shows that forcing patients to take medication is not supported by clinical evidence (Jarrett et al., *Coerced medication in psychiatric inpatient care: literature review*, *Journal of Advanced Nursing*, 538-548, Dec. 2008), and that coercive interventions are routinely traumatizing to the individuals they purport to help and make people fearful of seeking treatment (Campbell and Schraiber, *In Pursuit of Wellness: The Well-Being Project*, 1989). In addition, involuntary interventions are a poor substitute for building recovery-focused, culturally attuned, community-based mental health and social support services.

The IFR does not address the coverage, or lack of coverage, for involuntary “treatment” interventions. The National Coalition for Mental Health Recovery (NCMHR) supports

minimizing the use of intrusive, coercive or mandated involuntary “interventions.” While we recognize the need for the system to have the capacity to detain persons who pose an imminent threat to self or others, we urge the respect for human and civil rights so that the intent of parity respects the dignity of individual choice to the maximum extent feasible. The Departments are encouraged to include, within the scope of services and clinically appropriate standards of care, alternatives to forced interventions and coercion, including coverage for peer-run alternatives, and promising as well as evidence-based practices.

5. We agree with and support the parity standard devised by the Departments as one that ensures that mental health and substance use benefits are not discriminated against in health plan benefit design.

We believe that the parity standard devised by the Departments fully and appropriately implements the statutory requirement in the MHPAEA. Specifically, the IFR reflects the MHPAEA requirement that a group health plan that provides both medical/surgical and mental health/substance use disorder benefits must ensure that the financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than those requirements or limitations placed on medical/surgical benefits.

The Departments essentially keep in place the current parity standard, effective since 1998, as it applies to annual and lifetime dollar limits. We agree and support retention of this standard for annual and lifetime dollar limits.

For all other financial requirements and quantitative treatment limitations, the Departments employ a two-step test, based on the statutory language of the MHPAEA. The first step is to determine whether the type of financial requirement or quantitative treatment limitation applies to substantially all – meaning two-thirds – of all medical/surgical benefits in a classification. If not, the requirement or limitation cannot be applied to mental health/substance use disorder benefits. If it is applied to substantially all medical/surgical benefits, then the second step is applied to determine the predominant level – meaning the level that applies to more than one-half of the medical/surgical benefits. The predominant level may be applied to mental health/substance use disorder benefits. This level may be reached by a combination of levels, the least restrictive of which is then applied.

This second step – applying the predominant level – is necessary for some financial requirements and treatment limitations. The Mental Health Parity Act of 1996 provided parity only for annual and lifetime dollar limits. These are relatively simple financial requirements imposed by health plans or coverage, since plans generally do not apply a limit or have a single limit for the entire benefit.

The concept of the “predominant” level was necessary to address the greater complexity associated with a broader range of financial requirements or treatment limitations where there may be a number of varying levels associated with a particular financial requirement or treatment limitation. For example, while most health plans have a single lifetime limit that applies to its medical/surgical benefits, it may impose several levels of copayment requirements that are applied to various services, such as primary physician, specialty,

chiropractic, physical therapy and various other services.

In implementation of the parity standard with regard to these more complex financial requirements and treatment limitations, it is important to ensure that the predominant level is employed so that mental health and substance use disorder services are compared to the prevailing or common financial requirements or treatment limitations imposed on medical/surgical services. Mental health and substance use disorder services should not be compared to outlier requirements or limitations that would, in essence, allow health plans to avoid the intent of the law. Application of the predominant standard as provided in the IFR addresses our concern and will provide parity in the application of these various requirements and limitations to mental health and substance use disorder services.

We also appreciate the specific provision in the IFR that applies the MHPAEA to out-of-network benefits, reflecting clear Congressional intent to apply parity to out-of-network services. This provision is particularly important for mental health professionals and their patients, since plan enrollees often seek out-of-network mental health services.

6. We agree with the Departments' determination that the MHPAEA prohibits health plans from applying separate deductibles, out-of-pocket maximums or other cumulative financial requirements on mental health/substance use disorder benefits.

We are pleased that the Departments have determined that, while the statutory language of the MHPAEA is not as clear with regard to separate deductibles, out-of-pocket maximums and other cumulative financial requirements, Congress clearly intended to completely end benefits discrimination against mental health and substance use disorder services in enacting the law. Therefore, plans that apply separate deductibles and out-of-pocket maximums have been a barrier to care where individuals have had to forego care when they could not meet the separate requirements. Prohibiting separate cumulative financial requirements will dramatically improve access to mental health and substance use disorder services for individuals and their families who need and use such services.

Sincerely,



Lauren Spiro
Director

