

May 3, 2010

Internal Revenue Service
Department of the Treasury

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Department of Labor

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

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

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.)

To the Departments:

NAMI California is the state organization of the National Alliance on Mental Illness and our 22,000 members include those individuals with serious mental illness and their family members. NAMI California appreciates the opportunity to comment on the Interim Final Rules (IFRs) for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Act), as published in the February 2, 2010, Federal Register. For many years there has been discrimination in health insurance benefits against people needing and seeking coverage for mental health and substance use disorder services. With passage of the Act we believe that Congress has largely ended this discrimination, and we are particularly pleased that the IFRs implement the law to its full extent.

1) We agree with and support the parity standard devised by the Departments as one that ensures that mental health and substance use disorder 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 requirements in the Act. Specifically, the IFRs reflect the Act 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 Act. This two-step test is necessary in order to implement parity requirements for more complex financial requirements and quantitative treatment limitations. The first step is to determine whether the type of financial requirement or quantitative treatment limitation applies to substantially all, i.e., 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 to determine the predominant level, i.e., 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 IFRs addresses our concern and will provide parity in the application of these various requirements and limitations to mental health and substance use disorder services.**

2. We also agree with the Departments’ determination of six discrete classifications of benefits in which parity is applied: inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency care, and prescription drug coverage.

It is reasonable and acceptable to compare inpatient-to-inpatient and outpatient-to-outpatient medical/surgical benefits with mental health/substance use disorder benefits for applying the parity standard to financial requirements and treatment limitations. This reflects the statutory language of the Act, which distinguishes inpatient from outpatient coverage in general. In addition, the Act is intended to provide for benefits parity and not on a service-by-service basis. The six categories should allow health plans to apply parity appropriately without overburdening them with multiple classifications.

3. We suggest that the final rules clarify the scope of service parity requirement.

Although the preamble to the rules explicitly states that the rules do not address scope of services, other parts of the regulations define a scope of service parity requirement both across each of the required six classifications for applying the rule, and within each of the classifications. In addition, the underlying Act is clear that limits on the scope and duration of treatment must be applied no more restrictively in the mental health/substance use disorder (MH/SUD) benefit than in the medical/surgical benefit.

A plan that offers only one type of MH/SUD treatment service in any of the six required classifications, while at the same time offering many medical/surgical services within the relevant classification, does not comply with the parity rules if the comparatively low level of MH/SUD services is a result of the application of a treatment limitation to MH/SUD benefits that is more restrictive than the predominant treatment limitation of that type that applies to substantially all medical/surgical benefits in the classification.

A plan that refuses to cover a MH/SUD service because there is no medical/surgical analogue violates both the rules and the Act if the plan does not likewise refuse to cover medical/surgical benefits that have no MH/SUD analogue. In addition, practical and policy concerns weigh against allowing plans to refuse to cover MH/SUD benefits without medical/surgical analogues.

We consider it critical that the final rules clarify that the scope of service parity requirement applies both across each of the required six classifications and within each classification.

4. We endorse the specific provision in the IFRs that apply the Act to out-of-network benefits.

This provision reflects 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 mental health services out-of-network.

5. We agree with the Departments' determination that the Act 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 Act is not as clear with regard to separate deductibles, out-of-pocket maximums, and other cumulative financial requirements, Congress clearly intended to end benefits discrimination against mental health and substance use disorder services in enacting the law. Therefore, plans that apply separate, even if equal, deductibles, out-of-pocket maximums, or other requirements on plan enrollees for mental health/substance use disorder services, when such requirements are not placed on other services, are engaging in a form of discrimination banned by the Act.

Separate deductibles and out-of-pocket maximums have represented a real burden to people with private health coverage who have sought treatment for their mental health and substance use disorders. These individuals and their families have had to meet separate and additional out-of-pocket costs, not imposed on physical health services, before gaining insurance payment for their mental health and substance use disorder treatment. As a result, 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 mental health and substance use disorder services.

6. We agree with the application of the Act to nonquantitative treatment limitations and urge that it be retained in the final rules.

Congress clearly intended to end benefits discrimination. We support the way the Departments have applied this Congressional intent to the limitations that health plans place on mental health and substance use disorder benefits that are not quantitative and yet limit the scope or duration of these benefits when compared to medical/surgical benefits.

The standard applied to nonquantitative treatment limitations is reasonable. It requires parity for mental health and substance use disorder benefits with medical/surgical benefits as a general rule, while allowing differences only where clinically appropriate.

The illustrative list of nonquantitative treatment limitations to which the Act applies is also helpful since it includes some of the most common limitations that have been applied inequitably to mental health and substance use disorder services. Mental health professionals and the patients they serve will greatly benefit in the application of the law to the various nonquantitative treatment limitations provided in the IFRs.

First, applying the law to medical management standards that limit or exclude benefits based on medical necessity or appropriateness, or based on whether a treatment is experimental or investigative, will have the broadest favorable impact, and we support its inclusion in the list.

Second, how a plan determines usual, customary, and reasonable charges can be complex. Under the IFRs, this determination cannot be made on a more restrictive basis. Usual, customary, and reasonable charges are typically applied to out-of-network coverage. These charges drive the health plan and 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 disorder benefits when establishing these

charges, it can then create an unequal and greater financial requirement on the use of out-of-network mental health/substance use disorder benefits. It is this type of disincentive placed on individuals seeking out-of-network mental health services that Act is meant to end. For this reason, we particularly support inclusion of this nonquantitative treatment limitation in the IFRs.

Third, the IFRs make clear that health plan standards for provider admission to participate on a health plan's network are nonquantitative treatment limitations to which the Act applies. The Departments cite studies showing that approximately half of mental health care is delivered solely by primary care physicians. As the Departments note, this trend is likely due in large part to discrepancies in cost sharing for services delivered by mental health professionals and primary care physicians.

Patients are being treated by primary care providers also in part because patients do not have adequate access to mental health providers in their health plan's network. We believe that this situation is exacerbated by a stigma that is still associated with seeking services for mental health and substance use disorders. Plan enrollees are reluctant to complain to their employer's human resources department about access to mental health care, when they would not hesitate to complain about accessing a pediatrician, orthopedist, or other provider for a physical problem. This reluctance to complain may allow health plans to employ higher standards for mental health provider admission to network panels.

We agree with the Departments that a "shift in source of treatment from primary care physicians to mental health professionals could lead to more appropriate care, and thus, better health outcomes" (p. 5423). Therefore, we applaud the Departments for making clear that the parity law applies to this nonquantitative treatment limitation that plan enrollees seeking mental health and substance use disorder treatment have faced for many years.

7. We urge the Departments to clarify in the final rules that the "predominant and substantially all" standard and the "comparable/no more stringently" standards both apply to nonquantitative treatment limitations.

There are two standards to which plans must adhere related to nonquantitative treatment limitations. A plan may violate this section by utilizing processes, strategies, evidentiary standards, or other factors in the context of mental health and substance use disorder benefits that are either: (1) not comparable to or (2) applied more stringently, than those utilized in the context of medical/surgical benefits.

The Act unequivocally applies the "predominant and substantially all" standard to all treatment limitations. Although there is ambiguity in the rules regarding whether the "predominant/substantially all" and the "comparable/no more stringently" tests are separate or additive, to remain consistent with the language and intent of the Act, we believe the rules should be interpreted to apply both standards to nonquantitative treatment limitations. The Act sets forth three inquiries to determine plan compliance with the treatment limitation requirements: (1) Is the limitation applied to substantially all medical/surgical benefits; (2) Is it the predominant treatment limitation; and (3) Is it more restrictive in the mental health/substance use disorder benefit than in the medical/surgical benefit? The statute applies the three-part test to all treatment limitations. Because of the difference between quantitative and nonquantitative treatment limitations, and the practical difficulties of applying the "no more restrictive" test in the context of nonquantitative treatment limitations, the rules establish a second standard to implement the "no more restrictive" statutory test. This second standard is the "comparable and no more stringently" standard, and it is additive to the "predominant and substantially all" standard. We recommend that the final rules clarify that the "predominant and substantially all" standard also applies with respect to nonquantitative treatment limitations.

We agree that these three inquiries regarding treatment limitations are more sound and practical than a limited list of diagnoses for cost-containment purposes. In California, we have found that limitations by diagnosis produce unintended consequences such as delays in treatment and incentives for "upcoding from less severe to more severe diagnoses, when a less stigmatizing diagnoses is more accurate.

8. We agree with the Departments that mental health and substance use disorder providers should not be classified as “specialists” for the purposes of applying higher copayments. The Departments state this prohibition in the commentary to the rule, but it should also be included in the rule itself.

We appreciate that the Departments recognize in commentary a common practice by health plans to characterize “a large range of mental health and substance use disorder providers as specialists” for purposes of applying a higher copayment level for psychotherapy and other services and that continuation of this practice would violate the Act (p. 5413). This is indeed a common practice that has had a chilling effect on patient access to the services. In addition, as the Departments note, application of such higher copayment levels has inappropriately driven patients to seek care for their mental health and substance use disorder needs from primary care physicians (p. 5423).

For these reasons we want the Departments to apply the parity standard so that the copayment level for outpatient psychotherapy visits, for example, should be compared to the primary physician office copayment level, rather than a specialist level. As with the law’s prohibition of separate deductibles and other cumulative financial requirement above, applying the Act to prevent this practice will make an important improvement in the lives of many individuals needing and seeking treatment for their mental health and substance use disorders who have avoided treatment because they could not afford high copayments.

We note, however, that while the Departments discuss the prohibition of this practice in commentary to the rule, this prohibition is not included in the body of the rules. We urge that the Departments make this prohibition part of the final rules.

Thank you for considering our comments.

Sincerely,

NAMI California