National Alliance on Mental Illness

May 28, 2009

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
Washingotn, 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

On behalf of the more than 1,100 state and local affiliates of the National Alliance on Mental Illness (NAMI), I am pleased to offer comments on the Request for Information on the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA or "the Act"). NAMI is nation's largest organization representing children and adults living with serious mental illness and their families. NAMI's consumer and family membership worked hard for more than 17 years to help secure passage of the MHPAEA in Congress. We are anxious to work with DoL, HHS and Treasury to ensure full implementation and equitable coverage for both mental illness and substance use treatment in group health plans. NAMI has also joined separately with the Parity Implementation Coalition and the Coalition for Fairness in Mental Illness Coverage in submitting comments on the RFI.

PREVALENCE OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Almost half (46.4 percent) of all Americans will experience a mental illness or substance use disorder during their lifetime. One in four Americans experience mental illness each year. Mental health and substance use conditions cause more burden of disease than any other health condition – twice as much as cardiac disease. Nine percent of the population ages 12 and older, over 22 million Americans, were classified with substance use or dependence in 2007, but only 10 percent of them received treatment. The economic

impact of addiction alone is staggering, at an estimated $250 billion a year. Persons with severe mental illnesses accounted for $193 billion dollars in lost earnings in 2002 – more than the gross revenue of every Fortune 500 company except Wal-Mart. The faces and voices of MH/SUD span all facets of the population: rich, poor, young, aging, working and unable to find work.

INDIVIDUALS WITH MH/SUD ACCESS MORE CARE IN THE PUBLIC SECTOR

In principle, our Coalition believes that it is important that patients seeking MH or SUD services can identify quality caregivers, access quality care, and avail themselves of third-party payment for quality MH/SUD care just as they could care for any medical/surgical condition. All payers should provide equity in the way they pay for medical/surgical and MH/SUD care. Currently, MH/SUD treatment services are delivered by an uncoordinated patchwork of payers – Medicaid, Medicare, state programs and private insurance, as well as philanthropic and charitable organizations. Medicaid is the largest payer of mental health services and the second largest substance use disorder treatment payer. Private insurance is the second largest payer of MH/SUD services, but accounts for only 24 percent of mental health expenditures and only 10 percent of substance use disorder expenditures.

The proportion of private insurance spending on substance use disorders has significantly declined over the last decade as public expenditures have risen and spending for mental health has grown very little. One recent survey found that while 88 percent of insured workers had some coverage for substance use disorders, their benefits were characterized by higher cost sharing and annual and lifetime limits on inpatient and outpatient care.[1] The rate of out of pocket spending on MH/SUD is higher than for other medical conditions. For example, among employees with substance use disorder coverage, only 19 percent were enrolled in a plan that did not limit the number of hospital stays or office visits. In contrast, nearly all workers covered by medical insurance had unlimited hospital stays and office visits. Mental health treatment, while included in most health plans, is limited in the scope and duration of treatment and often involves higher co-pays and treatment frequency limits than general health services.

Another survey reported that in 2005, 90 percent of privately insured employed workers were in plans with special limits on outpatient mental health coverage.[2] By contrast, special limits on other types of medical treatment are rare; more often plans only impose an annual or lifetime cap on plan expenditures for an individual.[3]

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[1] Gabel, J., et al. (2007) Substance abuse benefits: still limited after all these years. Health Affairs 26(4) pp w474-w482

[2] US Bureau of Labor Statistics. (2007). National compensation survey: Employee benefits in private industry in the United States, 2005. Bulletin, 2589.

[3] Hodgkin D, Horgan CM, Garnick DW, Merrick EL (2009). Benefit limits for behavioral health care in private US health plans. Administration and Policy in Mental Health and Mental Health Services Research 36(1): 15-23.

Research shows that while health care costs in general have been increasing, the share going to mental health has remained steady with spending on health care growing twice as fast as spending on mental health care over a thirty year period through 2002. There have also been reports of low rates of spending on mental health services in health maintenance organizations relative to overall health spending. In addition, as referenced above, private insurance spending on substance use treatment has declined over the last decade. Moreover, a recent study reported that about two-thirds of primary care physicians could not get outpatient mental health services for their patients - a rate that was at least twice as high as that for other services - due in part to health plan barriers and inadequate coverage.[4]

Given the disparity in the benefit design between mental health and addictive disorders and medical/surgical conditions, NAMI believes it is imperative that MHPAEA is implemented to end the discrimination in access to services for individuals with these disorders and to provide equity with the coverage for other medical and surgical conditions.

LEGISLATIVE HISTORY

MHPAEA was signed into law on October 3, 2008. The law aims to ensure parity between coverage for MH/SUD and medical/surgical benefits in insurance plans that offer coverage for both benefits. Enactment of the legislation followed over a decade of congressional consideration of similar bills. During the 110th Congress, the legislation was introduced in the Senate as S. 558 and in the House as H.R. 1424. The bill was passed as part of the financial rescue legislation, the *Emergency Economic Stabilization Act of 2008*. Enactment followed fourteen field hearings around the country, consideration by five congressional committees, and floor deliberation in both congressional chambers.

Despite in-depth congressional consideration of the meaning and importance of the MHPAEA, portions of the law may raise questions of statutory interpretation. Because of potential ambiguities, NAMI joined the Parity Implementation Coalition (PIC) in asking attorneys at Patton Boggs to analyze the purpose, legislative history and various canons to help provide clarity on the statute. The analysis contains a review of the bill to determine the scope and meaning of the statute's key provisions, in addition to the intrinsic evidence surrounding the legislation to help clarify many of these issues. Much of the analysis and rationale developed by our colleagues at Patton Boggs is included in the comments below.

[4] Cunningham, P. (2009) Physicians' perspectives on access to mental health care. Health Affairs 28(3) pp w490-w501.

A. COMMENTS REGARDING ECONOMIC ANALYSIS, PAPERWORK REDUCTION ACT AND REGULATORY FLEXIBILITY ACT

MHPAEA covers 150 million individuals under ERISA, over 27 million individuals under Medicaid managed care plans, 2.6 million individuals under SCHIP managed care plans, and 26 million individuals under Taft-Hartley plans.

The Congressional Budget Office (CBO) provided cost estimates of the separate House and Senate parity bills in March and September of 2007. CBO did not provide a detailed cost estimate of the parity legislation as enacted in the financial rescue package.

In its scoring of the stand-alone House and Senate parity bills, CBO stated that the new law would result in higher premiums for employer-sponsored health benefits. CBO estimated premiums would rise by 0.4 percent. In CBO's view, higher premiums would result in more of an employee's compensation being received in the form of non-taxable employer-paid premiums and less in the form of taxable wages. Under CBO's estimate of S. 558, it concluded the law would reduce federal tax revenue by $1 billion over the 2009–2012 period and by $3 billion over the 2009–2017 period. CBO estimated that enactment would increase direct federal spending for the Medicaid program by $280 million over the 2009–2012 period and by $790 million over the 2009–2017 period. CBO estimated that the bill would cause an increase in private sector spending by prohibiting insurers and plans from imposing different treatment limitations and/or financial requirements for MH/SUD than for medical/surgical benefits. Further, CBO stated that the direct costs on the private sector would total about $2.5 billion in 2010 and would grow in later years.

CBO made important assumptions – including that behavioral health changes among plans – changes in the types of health plans that are offered and reductions in the scope or generosity of health insurance benefits – would offset 60 percent of the potential impact of the bill on total plan costs. CBO stated that the remaining 40 percent of the potential increase in costs – less than 0.2 percent of the group health insurance premiums – would occur in the form of higher spending for health insurance. These costs would be passed on to the workers both through their taxable compensation and other fringe benefits. CBO estimated that Medicaid payments to managed care plans would only increase by 0.2 percent. This is less than the projected premium increase for employer-sponsored insurance because, Medicaid programs currently offer a broader scope of mental health benefits than most private sector insurance programs.

While CBO does not score savings in "out years," NAMI joins PIC in asserting that the savings that will accrue to plan sponsors – reductions in collateral health care costs, emergency room visits and absenteeism alone – will at least offset the premium increases projected by CBO.

B. COMMENTS REGARDING REGULATORY GUIDANCE

1A. DO PLANS IMPOSE OTHER TYPES OF FINANCIAL REQUIREMENTS OR TREATMENT LIMITATIONS ON BENEFITS? HOW DO PLANS APPLY FINANCIAL AND TREATMENT LIMITATIONS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS?

Group health plans and insurers manage mental health and addictive disorder benefits in numerous ways. Given the 1996 Mental Health Parity Act (MHPA), some limits may uniquely apply to substance use conditions. Limitations on MH/SUD benefits include but may not be limited to:

- Annual and lifetime caps
- Deductibles
- Co-pays
- Coinsurance
- Excessive mandatory out-of-pocket spending
- Limits on the frequency of treatment, number of outpatient visits, and days of inpatient coverage
- Exclusion of certain levels of care such as residential treatment or partial hospitalization (in or out of network)
- Utilization review, especially prior-authorization practices
- Utilization review being conducted by professionals with no training in mental health or substance use disorders
- Unclear, unpublished or arbitrary medical necessity and appropriateness criteria, including ever-changing criteria lacking clear definitions for specific levels of care such as “inpatient,” “residential,” “detox,” or “rehab”
- Coverage requirements based on the patient completing an entire course of treatment—refusal to pay for any care unless an entire prescribed package of care is “completed”
- Coverage predicated upon completion of utilization review with exceedingly short time frames (as little as an hour after completion of the clinical assessment) or upon a requirement that face to face assessments take place only in the state of the plan’s corporate headquarters
- “Fail first” policies, such as requirements that the patient must participate in but “fail” 1 – 2 times at outpatient treatment within the last year in order to be eligible to use inpatient, rehabilitation or residential benefits or that they must fail on a less expensive medication prior to having access to a more expensive medication for addiction detox or rehab care
- Review of the evidence base for particular treatment service requests to determine whether or not services are evidence based - often MH/SUD treatments are reviewed and then denied on a more restrictive standard than medical/surgical treatments

- Review of treatment service requests to determine whether or not services are cost-effective
- Use of restrictive fee schedules
- Limits on specific providers, such as approving services only if offered by providers who meet geographic licensure requirements (e.g., they hold a license in the state of the plan's corporate headquarters)
- Onerous rules on participation in preferred provider networks that are more restrictive for MH/SUD providers (including elimination of providers from network if they allow a plan participant to self pay for care deemed "not medically necessary" by plan)
- Many MH/SUD treatments with scientific evidence are denied because there are not clear medical/surgical analogs
- Prohibiting plan coverage for specific diagnostic categories, e.g., eating disorders and/or other specific diagnoses
- Prohibiting plan coverage for MH/SUD services that are mandated by third parties such as court orders, even if such services are medically necessary
- Limitation of adequate expertise in provider networks

Medical management: Survey data

Clearly, under MHPAEA Congress intended for plans to medically manage benefits. At issue is how restrictive can these practices be before MHPAEA is violated?

For the purpose of these comments, medical management is defined as synonymous with utilization management.[5]

To help our understanding of current marketplace medical management practices, NAMI worked with the Parity Implementation Coalition to poll members and asked them to provide the most commonly used medical management practices on mental health and substance use disorder benefits. The list above includes the most commonly reported medical management practices – these include both treatment limitations and financial requirements on providers, networks and specific services.

In general, our non-scientific survey finds that restrictions are somewhat greater on substance use disorder benefits than on mental health benefits, and are particularly restrictive on residential, inpatient or "rehab" benefits. While this is not a surprising result given that stricter utilization of these types of more costly benefits tend to be common on both behavioral and other medical benefits, what is surprising from our survey is how common the restrictions are, 2/3 of large plans have these kinds of

[5] For example, the term "medical management" can refer to the management and treatment of a specific disease to reduce complications and improve outcomes (*i.e.*, the management of diabetes). These comments do not use the term "medical management" in this way.

restrictions on MH/SUD benefits) and how the definitions of the benefit vary from plan to plan. The criteria for utilizing these benefits would change, even in the same year, allowing plans to deny coverage even when the plan document specifies that coverage is provided for a specific level of care.

Providers reported to us, although less frequently, instances where outpatient mental health services have not been covered, or the in-network rate for outpatient care has been so low ($20 per session) as make it unfeasible for a provider to offer such services and maintain the financial viability of their practice or the agency where they practice.

Coalition members also frequently reported that intensive outpatient treatment for substance use disorders has either not been covered, or the day and visit limits have been extremely restrictive.

Both providers and consumers have reported to us that payment is often refused because the plan only covers certain types of providers. The non-covered providers fall under a wide range including physicians, physician assistants, any provider that is not located at a hospital, licensed mental health counselors, and licensed clinical social workers. Some plans exclude all practitioners except in-house practitioners; others exclude all services other than those provided through state-certified agencies or thorough agencies operating in the public sector.

We heard from consumers whose coverage – even when the particular category was covered in their plan benefits summary – was denied because they had a co-occurring mental health or substance use disorder, or had co-occurring chronic pain. Many consumers reported their plan simply had no MH/SUD out-of-network benefits at all, even if their plan provided out-of-network coverage for their medical/surgical benefits.

The survey confirmed what was widely reported by witnesses at parity field and Congressional hearings – MH/SUD benefits are managed more restrictively and children and adolescents face significant obstacles in accessing mental health and substance use disorder treatment. One study suggests that half of the children experiencing depression are not receiving care.[6] Most often reported was that there were either no providers or facilities specializing in child or adolescent services in the plan's network, or that plans would only pay for care delivered by specialists trained in child or adolescent issues and none were available in the network.

We know that concerns with access to behavioral health care are an issue for individuals and families seeking care for their mental health and addictive disorders. In a 2004 survey done in Massachusetts, the study found that behavioral health coverage denials

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[6] Glied, S., & Neufeld, A. (2001). Service system finance: Implications for children with depression and manic depression. *Biological Psychiatry, 49,* 1128–1135.

accounted for half of all appeals in 2002.[7] The denial rates for MH/SUD services are reported to be much higher than medical/surgical services. This represents a dramatically disproportionate statistic, with behavioral health claims comprising less than 5 percent of all healthcare claims paid, yet comprising 50 percent of appeals from denied care.

The regulations need to take into account that in some states and federal plans with parity, medical management techniques other than treatment limitations or financial requirements have allowed plans to circumvent the benefit design improvements that parity attempts to achieve.[8] In a study of states with parity, large increases in health care utilization have not occurred; a result some attribute to medical management techniques rather than benefit design. While the regulations should provide for the use of medical management criteria, its use as applied should not result in discriminatory access to mental health and substance use disorder services. Therefore, **NAMI shares the recommendation of the Parity Implementation Coalition that MHPAEA be interpreted to ensure that all medical management techniques (utilization review, pre-authorization, preferred provider network criteria, use of fee schedules, use of evidence based review criteria, reviews for experimental vs. non experimental) should be regulated, and may not be more restrictive for MH/SUD services as compared to medical/surgical services.**

Scope of Services and Treatment Limitations

A key issue under the implementation of MHPAEA is whether the definitions of "mental health benefit" and "substance use disorder benefit" include services as part of what a benefit is. If so, regulations will need to clarify whether plans have complete flexibility to include or not include "services" when they offer "benefits," and if they can only offer a few or no services specific to MH/SUD conditions and still meet the Congressional intent of the MHPAEA.

The first step in determining which particular services may or may not be covered under the Act is to determine whether "services" are covered under the statute generally. If the Act does not require plans to provide services at all, the question of which precise services are covered becomes moot.

The text of the Act speaks most often to the concept of "benefits," rather than services. The Act states that the financial requirements and treatment limitations applicable to "mental health or substance use disorder benefits" can be no more restrictive than the treatment limitations applied to medical/surgical benefits.[9] The issue, then, is whether services are included within the definition of benefits.

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[7] Balser, R. & Tolman, S. (2006) Joint Committee on Mental Health and Substance Abuse 2005 – 2006 biennial report. Retrieved May 11, 2009 from: *archives.lib.state.**ma**.us:8080/dspace/bitstream/2452/37738/1/ocn312129952-2005-2006.pdf*

[8] Frank, R. G., & McGuire, T. G. (1998). Parity for mental health and substance abuse care under managed care. *Journal of Mental Health Policy and Economics, 1*(4), 153–159.

[9] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C.A. § 1185a(a)(3)(A).

Mental health benefits are defined in the Act as "benefits *with respect to services* for mental health conditions."[10] (Emphasis added) In like manner, the Act defines substance use disorder benefits as "benefits *with respect to services* for substance use disorders."[11] (Emphasis added) The plain language of the Act, with its explicit reference to services in the definition of mental health benefits, is strong evidence that Congress intended to include services within the definition of MH/SUD benefit. Under the 1996 mental health parity law, a similar definition was used for both MH/SUD and medical/surgical benefits.

Interpreting the Act otherwise would lead to an illogical result that should not be ascribed to Congress. If health plans were allowed to qualify as providing "benefits" while not providing any services, it would severely undermine the statute passed by Congress. The logical extension of this analysis, then, is how few included services would suffice without violating the treatment limitations section of the Act, either as to intent or the explicit section of the bill?

Some have argued, for example, that an employer can choose to provide benefits for a mental health condition and then choose to not cover any treatment services specific to that condition (*e.g.*, depression is covered but antidepressant drugs are not covered nor is psychotherapy covered). Therefore, would a plan's decision not to provide treatment for a mental health condition (once a plan has chosen to offer benefits for a mental health condition) violate the treatment limitations section of the Act (*i.e.*, no treatment limitation can be more restrictive for a MH/SUD condition than for medical/surgical conditions)?

Again, NAMI believes that MH/SUD benefits under the statute encompass some level of treatment services. The question then becomes, can treatment services be limited under the definition of the mental health and substance disorder benefits? The answer to this question seems to be yes.

The statutory language does not appear to preclude limits on treatment services. The applicable language states only that MH/SUD treatment limitations must be "no more restrictive" than the treatment limitations for medical/surgical benefits.[12] This language implicitly recognizes that there may be limits in the coverage of medical/surgical benefits. Indeed, the practical reality of insurance coverage demonstrates that these limits exist. The statute does not say that no similar limits can be applied to mental health and substance use disorder coverage. Instead, it simply says that the limitations can be no more restrictive. By implication, some limits on mental health and substance use disorder services are authorized.

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[10] § 1185a(e)(4).

[11] *Id.*

[12] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, 29 U.S.C. § 1185a(a)(3)(A)(i).

Proponents of limiting services have pointed to the definition of the MH/SUD benefit to argue that they do not have to cover every service and, accordingly, do not have to cover specialized services. The definition of mental health benefits means "benefits with respect to services for mental health conditions" as defined under the terms of the plan and in accordance with applicable Federal and State law.[13] The argument would be that plans maintain the flexibility to determine which services to provide because the statute specifically allows them to be "defined under the terms of the plan." However, this argument omits the critical words "for mental health conditions."[14]

A natural reading of the sentence shows that it is the mental health conditions that are defined under the terms of the plan, not the mental health services. That is, under this language, the plan appears to have flexibility as to what mental health conditions it covers. **However, once it decides to cover the condition, it is subject to the requirement with respect to services discussed above.**

In addition, the law says treatment limitations and financial requirements can be no more restrictive than the *predominate* treatment limitations and financial requirements applied to *substantially all* medical/surgical benefits covered by plans. The Act defines "predominant" as most common or frequent, but fails to set a bright-line standard regarding when a financial requirement or treatment limitation will be considered the most common or frequent.[15]

Imagine, for example, that a plan desires to limit the frequency of treatment. **To be in compliance with the Act, the proposed frequency limit must be the most common type of frequency limit, not the most common treatment limitation generally.** To use another example, with respect to financial requirements, a co-pay would be predominant if it is the most common or frequent co-pay charged by the plan. It does not matter whether a co-pay is the most common or frequent financial requirement generally. If a plan imposes a co-pay for MH/SUD benefits that is rarely used for medical/surgical benefits, NAMI believes it would be in violation of the statute.

Thus, a financial requirement or treatment limitation is predominant if it is the most common or frequent limit of a specific type. Unfortunately, exactly how common or frequent a limitation must be to be predominant is not addressed in the law.

We understand that "substantially all" was defined in the 1996 MHPA as being 2/3 of benefits covered under the plan, but specific clarifications in the regulations of how common or frequent a limitation or requirement must be to be "predominate" or "substantially all" would be helpful. It should be noted that this same analysis

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[13] *Id.* at § 1185a (e)(4). The definition of substance use disorder benefits is substantially similar.

[14] *Id.*

[15] § 1185a(a)(3)(B)(ii).

specifically applies to low income persons – eligible for Medicaid through TANF or other income related eligibility categories – served in managed care plans.

Coverage of specialized services such as residential psychosocial rehabilitation services for addiction, which have no clear analog in medical/surgical benefits

The question remains whether a plan is required to cover specialized services that do not have direct analogs in medical/surgical treatments. Again, the Act says very little about whether individual services are required to be covered in all cases.

However, the statutory language contains broad language prohibiting separate treatment limitations on MH/SUD services. The treatment limitations section of the Act states that health plans must ensure that "there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorders."[16] Under a strict reading of the Act, a plan that refuses to cover a mental health service that has no analog in medical/surgical may violate this section of the Act. If a plan refuses to cover a particular MH/SUD service that does not exist outside of mental health, it is clear that the treatment limitation applies only to mental health or substance use disorders. Although some may argue that this is a wooden application of the statute, it is a reasonable argument to make. The language also may indicate the desire of Congress to have the protection apply broadly. If Congress had meant to limit this language and the protection against treatment limitations it supplies, it could have done so.

With regard to specific services, NAMI believes that a major component of the appropriate continuum of mental health and substance use disorders care, day treatment or partial hospitalization services, do have a medical-surgical analog. Inpatient rehabilitation benefits for stroke and spinal cord injury patients on the medical/surgical side are often continued in partial hospitalization or 'day rehab' programs. **NAMI joins the Parity Implementation Coalition in recognizing that the MHPAEA requires that any plan that covers 'day rehab' services for patients with such medical/surgical conditions would need to cover 'day treatment' services for mental health and substance use disorders in order to be compliant under MHPAEA.**

Medications

While the Act is silent on medications, plan utilization trends demonstrate that pharmacotherapies are an ever-growing part of MH/SUD benefits. **NAMI believes if a plan provides both medical/surgical and MH/SUD benefits, the Act requires the plan to cover medications that treat mental health and substance use disorders in a manner that is no more restrictive than the coverage for medications for medical/surgical conditions.**

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[16] *Id.*

As a starting point, it is important to note that the Act does not impose a requirement on plans to provide mental health and substance use disorder benefits.[17] Rather, the statute applies only to a plan that "provide[s] both medical and surgical benefits and mental health or substance use disorder benefits."[18] Thus, a plan is under no independent obligation to provide MH/SUD benefits. By extension, if a plan does not offer a MH/SUD benefit, it clearly is not required to cover medications for the treatment of MH/SUD, even if the plan offers coverage for medical/surgical medications. Assuming that the plan offers both medical/surgical and MH/SUD benefits, the question is whether the Act applies to medications at all. By the plain language of the Act, treatment limitations and financial requirements applicable to MH/SUD benefits can be "no more restrictive" than those that apply to medical/surgical benefits.[19]

In light of current clinical and treatment practices in both the MH/SUD and medical/surgical areas, it seems clear that medications can be equated with services. Both the medications themselves and the prescription of these medications by appropriately licensed practitioners are considered to be treatment services within the health care field. In practice, medications are one of the most common treatment services provided by both MH/SUD and medical/surgical conditions.

The statutory text also gives support for including medications as "services" under the law. The law defines benefits as "benefits with respect to services" for mental health and substance use disorders.[20] It would be reasonable to interpret the phrase "with respect to" to mean "relating to." So understood, the Act defines benefits as practices *relating to* services. Clearly, in the course of mental health treatment, the services provided by certain mental health professionals (e.g., psychiatrists) often involve treatment with medications. In such a case, the medication "relates to" the services being provided by the practitioner. Interpreted in this manner, medications fall within the definition of "benefits" and are thus included within the treatment limitations and financial requirements sections of the law.[21] A prominent illustration is requiring plan beneficiaries to "fail first" on older, cheaper medications before being given access to more modern medicines.

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[17] As stated by the House Education and Labor Committee in its Report on the legislation, "The bill does not mandate group health plans to provide any mental health coverage." H.R. REP. NO. 110-374, pt. 1 (2007).

[18] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A. 1185a(a)(3)(A).

[19] *Id.* at § 1185a(e)(4).

[20] H.R. REP. NO. 110-374, pt. 1 (2007) (Educ. & Labor Comm.); H.R. REP. NO. 110-374, pt. 2 (2007) (Ways & Means Comm.); H.R. REP. NO. 110-374, pt. 3 (2007) (Energy & Commerce Comm.); S. REP. NO. 110-53, at 3 (2007) (Sen. Comm. on Health, Educ. & Labor, 2007).

[21] In many ways, the analysis of this question is similar to the analysis of whether "medical necessity" requirements can be more stringent for MHSU benefits than for medical/surgical benefits.

Several specific examples of disparate treatment of MH/SUD medications were raised in NAMI survey. For example, coverage was refused for an injectable MH/SUD pharmacotherapy in several plans surveyed. The reason for the denial was that the plan only covers injectable drugs if they are used for chemotherapy or surgeries. This is a clear example of the type of arbitrary denial of coverage for MH/SUD treatments than is allowed for medical/surgical conditions. A second plan denied coverage for a SUD medicine because it alleged "there was a lack of evidence," or use of the drug was not evidence-based. The regulations should clearly state that MH/SUD services cannot be reviewed by scientific criteria that are more restrictive than those used for medical/surgical services.

Our analysis assumes that plans are allowed to utilize requirements for determining which medications are covered under the plan. This assumption seems warranted given the flexibility plans have to impose restrictions such as limits on services covered and medical necessity criteria. **This does not mean, however, that plans are able to use evidence-based criteria for medications that are more restrictive for MH/SUD benefits than for medical/surgical benefits.** First, the legislation does not contain specific authorization that requirements for medications may be more restrictive for one benefit category than the other. Thus, specific textual authorization is lacking.[22] More importantly, as evidence-based requirements can be used as treatment limitations, the Act provides quite the opposite. If requirements for medications fit within the Act, they can be no more restrictive under the MH/SUD benefits than under the medical/surgical benefit. More generally, the text of the legislation aims for equity in plan benefits and requirements rather than enhanced restrictions in one area as opposed to another. The legislation states that treatment limitations imposed upon MH/SUD benefits must be no more restrictive than those imposed on medical/surgical benefits.

NAMI believes the Act also requires no more restrictive management of drug formularies for MH/SUD than for medical/surgical benefits. Thus, the Act would only require coverage of one drug for each FDA clinical indication under the MH/SUD benefit if only one drug for each FDA clinical indication is provided under the medical/surgical benefit.

The treatment limitation section of the Act includes "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope and duration of treatment."[23] Since the Act does not specifically mention drug formulary management, the regulations must determine whether it falls within the treatment limitations section of the Act. Drug formulary management will only be subject to the law's parity requirements if it falls within the treatment limitations section. Based on the language, history, and intent of the Act, we believe that it does.

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[22] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A § 1185a (2009).

[23] § 1185a(a)(3)(B)(iii).

The non-exclusive nature of the treatment limitations list, combined with the similarity of formulary management to the other listed limitations, demonstrates that formulary management is included within the treatment limitations section. The treatment limitations section includes a specific list of treatment limitations. However, the text of the Act demonstrates that the list does not cover *all* the possible treatment limitations. The Act precedes the list with the word "including," demonstrating that the list is not intended to be exhaustive. In addition, the phrase "other similar limits" demonstrates that other limitations can come within the definition.[24] Drug formulary management is similar to all of the listed limitations. Frequency of treatment, number of visits, and days of coverage all have to do with managing or limiting a benefit in some way, presumably to keep costs down. Similarly, formulary management is concerned with restricting access to medications for the same purpose. Certainly the "scope" of treatment is limited by a formulary that does not cover certain medications. Thus, formulary management appears to fall within the treatment limitation definition.

If formulary management fits within the definition of treatment limitation, what restrictions does the statute impose? The statute states that plans must ensure that "treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage)."[25]

As described above, it seems clear that if a plan offers medications for medical/surgical conditions, its coverage of mental health and substance use disorder medications must be no more restrictive. However, this is not the same as a blanket requirement as to which drugs must be covered. The fact that a plan offers some medications within the medical/surgical benefit does not mean that it has to cover at least one drug for each FDA clinical indication within the substance use disorder benefit. Rather, this requirement would only materialize if a plan offered one drug for each FDA clinical indication within the medical/surgical benefit category. **If a plan offered one drug for each FDA clinical indication within the medical/surgical benefit and did not do so in the mental health or substance use disorder benefit, NAMI believes it would be in violation of the Act. Accordingly, the analysis must be performed based on the coverage contained in each plan.**

Varying plans

NAMI and the Parity Implementation Coalition believe insurer and employer sponsored plans that provide a number of health plans with multiple and very different cost benefits, cost-sharing, deductibles, and co-pays will not violate the Act, because the Act applies only to a specific plan, not to a range of separate products. **However, individual plans that provide benefits with multiple and different financial requirements for MH/SUD services will not be in compliance with the Act's provisions unless the**

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[24] *Id.*

[25] § 1185a(a)(3)(A)(ii).

requirements are no more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits.

The Act is clear that it addresses individual health plans and not the range of plans offered by a health insurer. The first paragraph that the Act adds to the Employee Retirement Income Security Act (ERISA) states that, "in the case of *a* group health plan…that provides both medical and surgical benefits or substance use disorder benefits, *such plan*…shall ensure" that certain requirements are met.[26] (Emphasis added) The rest of the Act speaks repeatedly about "a plan"[27] or "the plan."[28] Furthermore, the statute never prohibits insurance companies from offering different products, or requires them to employ the same financial requirements across insurance plans. Thus, the financial requirement limitations in the law are applicable with respect to each individual plan, not to the spectrum of an insurer's products.

By contrast, individual plans that provide benefits with multiple and different financial requirements for MH/SUD benefits are not likely to meet the law's command unless the requirements are no more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits.

The Act's use of "no more restrictive" invites a comparison between two things. Here, the comparison is between medical/surgical benefits and MH/SUD benefits. The Act states that financial requirements applied to MH/SUD benefits cannot be "more restrictive than" those applied to medical/surgical benefits. The Act is clearly addressing restrictions *between* MH/SUD and medical/surgical benefits. Thus, financial requirements must be compared across benefit categories (*i.e.*, between MH/SUD and medical/surgical benefits), not within one of the benefit categories.[29]

This being the case, we believe that plans can offer multiple and very different financial requirements within each benefit as long as these requirements are not more restrictive in one benefit as compared to the other. In other words, a plan can offer multiple and very different financial requirements for different parts of a MH/SUD benefit (*i.e.*, different co-pays for different services or categories of services). However a plan will violate the Act if the multiple and very different financial requirements in the MH/SUD benefit are more restrictive than those in the medical/surgical benefit. Thus, the Act envisions a fact-specific analysis in which the restrictiveness of the financial requirements in one benefit is compared with the restrictiveness of the financial requirements in the other benefit.

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[26] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A. § 1185a(a)(3)(A).

[27] *Id.*

[28] § 1185(a)(3)(A)(i).

[29] *Id.*

In addition to the "no more restrictive" analysis, the law imposes two additional requirements. First, the financial requirement must be predominant. A financial requirement is considered to be predominant if it is the most common or frequent of that particular type of requirement. Thus, a financial requirement must be no more restrictive than the most common or frequent of such type of limit. For example, if the limit in question is related to out-of-pocket expenses, any out-of-pocket requirements for MH/SUD treatment must be no more restrictive than the most common out-of-pocket requirement imposed under the medical/surgical benefit.[30]

The Act imposes a further condition on treatment limitations. In addition to being the most common financial requirement, the requirement in question must also be applied to substantially all medical and surgical benefits under the plan. Thus, if the requirement in question is a copayment amount, this requirement can be no more restrictive than the requirement applied to substantially all medical/surgical benefits under the plan.[31]

Putting these three subparts together, **the law states that no MH/SUD financial requirement can be more restrictive than the most common requirement of that type that is applied to substantially all medical/surgical benefits.**

Parity in continuum of services

Closely related to the variety in the types of plans issue, is whether a plan must provide parity in the continuum of care of medical/surgical and MH/SUD benefits. From our survey, we learned that plans offer a full continuum of care in the medical/surgical side but may only cover detoxification and outpatient services in the SUD benefit. We believe this type of coverage would violate the Act's "no more restrictive" standard.

Because the Act requires parity in coverage, but does not mandate that a plan provide MH/SUD benefits, group health plans are not required to provide a MH/SUD benefit. If a plan does not provide a MH/SUD benefit, the plan is likewise not required to provide coverage for specific services or a full continuum of services under such benefit. If, however, a plan provides MH/SUD benefits, as well as medical/surgical benefits, the plan may not impose limitations on the scope or duration of treatment under the MH/SUD benefit that are more restrictive than those imposed under the medical/surgical benefit. Additionally, the Act provides that there be "no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits."[32] Thus, the analysis of this question must focus on the scope and duration of treatment covered under the medical/surgical benefit. If a plan offers a full continuum of services under its medical/surgical benefit, *and* only two levels of services, such as detoxification and

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[30] *Id.*

[31] *Id.*

[32] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A § 1185a(A)(3)(i), (ii)(2009).

outpatient levels of care for alcohol or drug use disorders under its MH/SUD benefit, the plan will not be in compliance with the parity requirements under the Act.

Evidence Based Treatment

MH/SUD conditions are treatable by evidence based therapies and the knowledge of what constitutes appropriate care has grown markedly. However, in the survey conducted by the Parity Implementation Coalition, respondents noted an increasing use of "lack of evidence based treatment" as a reason for denials of care. The evidence base for treatments for medical/surgical conditions may not be more rigorous than those used for MH/SUD. In a recent JAMA article, researchers reported that recommendations issued recently by the American College of Cardiology are largely developed from lower levels of evidence in our opinion.[33]

To illustrate these points, an insured obtaining mental illness treatment may be admitted for acute inpatient care, followed by psychiatric stabilization, often followed by outpatient therapy. To analogize, an insured obtaining medical/surgical care typically may be admitted for surgery, followed by intensive care in a monitoring unit, followed by continued hospitalization in a regular patient room, or sometimes transferred to a less intensive rehabilitation facility, followed by outpatient therapy. If a plan covers every such level and type of medical/surgical care for substantially all medical and surgical benefits, but only provides for certain levels or types of care for a substance use or mental health disorder, such as acute inpatient treatment and medication management only, there likely exists a limitation on the duration and scope of treatment under the MH/SUD benefit that is more restrictive than that under the medical/surgical benefit; NAMI believes that such a limitation would be in violation of the Act's "no more restrictive" standard.

If treatment services are able to be limited under the definition of MH/SUD benefits, how limited can those treatment services be? The Act sets forth a two part test for determining if a treatment limitation is prohibited: a treatment limitation is prohibited if it is more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. Accordingly, the Act seems to envision a plan-specific inquiry regarding what treatment limitations are permitted. If a plan chose to severely limit these services, it would have to show the limitation is the most common or frequent limit under the plan. The plan would also have to show that it applies a similar limit to substantially all medical and surgical benefits under the plan. While the law appears to provide plans' flexibility as to what mental health conditions and substance use disorders it covers, once it decides to cover the condition or disorder, it is subject to the "no more restrictive" standard.

Opponents of this view may argue that the treatment limitations section does not apply to treatment services in the first place. The Act states that "[t]he term 'treatment limitation'

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[33] Tricoci, P. et al (2009). Scientific evidence underlying the ACC/AHA clinical practice guidelines. *JAMA,* 301*(8)*, p. 831-841.

includes limits on the frequency of treatment, the number of visits, days of coverage, or other similar limits on the scope and duration of treatment."[34] Proponents of greater plan flexibility will argue that this section addresses *how* services are covered, not *which* services are covered. In other words, the Act discusses limits on the frequency, number, and days of treatments, not limits on which treatments may be offered. The statutory interpretation canon of *ejusdem generis* expresses a presumption that when several items in a statutory list are followed by a general term, the general term is to be construed to be "of the same class" as the items in the list. Here, the list discusses frequency of treatment, number of visits, days of coverage, and the more general "other similar limits on the scope and duration of treatment."[35] Under *ejusdem generis*, the "other similar limits" will be construed to be of the same class of the limits expressed immediately prior. The other limits referred to how services are to be covered (*i.e.*, in what frequency, for how long, etc.), not which services are to be covered.

This argument appears to NAMI to be rebutted by the Act's plain language. The list in question states that the term "treatment limitation" "include[s]" limits on frequency, number of visits, and days of coverage or other similar limits on scope and duration of treatment. The word "includes" shows that the list is demonstrative rather than comprehensive. In other words, choice of the word "includes" means that the listed treatment limitations are simply examples, not an exhaustive list of the possible treatment limitation subject to parity.[36] If Congress had wanted the treatment limitations section to only apply to the listed limits, it could have used stronger, more limiting language. Accordingly, NAMI believes limitations on services should be included within the treatment limitations definition. If so, limitations on services are subject to the law's "no more restrictive standard."[37]

Access to Services

The treatment limitation section addresses limits that the plan can put on the services it covers. While fee schedule amounts are not listed as one of the cited policies in the treatment limitation section of the Act, disproportionately low fee schedules are commonplace for MH/SUD providers and account for much of the lack of access for children, adolescents and seniors. To help NAMI assess whether lower fee schedules are more commonplace for MH/SUD providers than for medical/surgical providers, we asked the actuarial and benefits consulting firm Milliman to analyze major medical and behavioral health conditions in 2007 MedStat MarketScan claims; this data represents 24.2 million commercially insured members. Milliman examined the differences in average allowed cost per visit relative to Medicare allowable levels and the percentage of

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[34] § 1185a(a)(3)(B)(iii).

[35] Paul Wellstone and Pete Domenici Mental Health parity and Addiction Equity Act of 2008, 29 U.S.C. § 1185a(a)(3)(B)(iii).

[36] *Id.*

[37] *Id.* at § 1185a(a)(3)(ii).

visits provided in network.[38] Below, Tables 1A and 1B document that behavioral health providers are reimbursed on average over 10 percent less than providers of medical/surgical services and behavioral health consumers are nearly 15 percent more likely to receive care out of network, thereby driving up their out pocket expenses. These high out of pocket expenses are comparable to the out of pocket expenditures found by Levitt et al in their 2008 forecast of private and public MH/SUD expenditures. In their study, they found that consumers' out of pocket expenditures totaled 14 percent of total MH/SUD spending and an additional 4 percent of total spending came from consumer self pay.[39]

Table 1A - Summary of Outpatient Visit Results

Diagnostic Category	Unique Users	Users Per 1,000	Average # Office Visits	Average Allowed as % of MCR	% Visits In-Network
Substance Abuse	51,122	2.114	11.44	135.4%	83.6%
Adjustment Reaction	360,628	14.913	6.37	93.3%	75.0%
Neurotic Disorders	136,305	5.637	6.16	100.1%	70.6%
Depression	735,253	30.405	5.99	105.2%	83.4%
Anxiety	446,342	18.458	4.22	103.6%	75.9%
Behavioral - Other	561,478	23.219	3.25	109.8%	81.2%
Behavioral Subtotal			**5.17**	**103.4%**	**79.3%**
Cancer	677,049	27.998	3.00	122.4%	90.4%
Diabetes	902,427	37.318	2.47	111.9%	91.7%
Ischemic Heart Disease	314,365	13.000	1.87	110.1%	90.3%
CHF	39,941	1.652	1.86	112.4%	90.3%
Arthritis	1,689,088	69.849	1.82	114.8%	91.1%
Hypertension	2,105,702	87.078	1.80	108.7%	91.6%
Asthma	620,680	25.667	1.63	111.0%	93.9%
Stroke	30,978	1.281	1.57	117.5%	89.0%
COPD	374,618	15.492	1.37	110.4%	91.6%
Gastritis	109,409	4.524	1.14	106.7%	92.8%
Medical Subtotal			**1.97**	**113.2%**	**91.4%**

Table 1B - Outpatient Results Split Between Behavioral and E&M Visits

Diagnostic Category	Ave. Allowed as % of MCR - INN		Ave. Allowed as % of MCR - OON		% Visits In-Network	
	BHV Visits	E&M Visits	BHV Visits	E&M Visits	BHV Visits	E&M Visits
Substance Abuse	136.7%	128.9%	134.5%	117.7%	83.8%	80.7%
Adjustment Reaction	86.7%	120.6%	111.7%	109.9%	74.7%	90.9%
Neurotic Disorders	90.1%	118.6%	118.6%	112.7%	68.8%	91.8%
Depression	100.3%	120.2%	120.0%	114.1%	82.6%	91.5%
Anxiety	94.3%	115.6%	121.0%	109.2%	72.6%	91.7%
Behavioral - Other	103.9%	113.9%	120.3%	110.2%	76.3%	90.6%
Behavioral Subtotal	**96.8%**	**116.6%**	**118.2%**	**111.4%**	**77.7%**	**90.9%**

[38] These were visits provided by a behavioral health specialist (physician, psychiatrist, psychologists et al) who are using specific CPT codes.

[39] Levitt, K. et al. (2007). Future funding for mental health and substance abuse: increasing burdens for the public sector. *Health Affairs, 27*(6), w513-522.

As noted previously, the list of treatment limitations that the plan can put on the services it covers is not exhaustive. Rather, the list includes "other similar limits on the scope and duration of treatment."[40] There are several arguments that could be made to argue that fee schedules should fall within the Act's authority and thus be subject to parity between MH/SUD and medical/surgical benefits. Out-of-network providers receive reimbursement based on fee schedules that are unilaterally imposed by the insurer, and are free to balance bill the beneficiary for the differences between the charges and the out-of-network fee allowed by the insurer. Thus, the setting of a low fee schedule by insurers often leads to additional financial requirements on the insured in the form of higher co-payments and out-of-pocket expenses. If the insured must pay higher out-of-pocket expenses because of the low fee schedule, and these expenses are not borne by an insured under the medical/surgical benefit, NAMI believes that this is a more restrictive financial requirement.

Arguing from a broad understanding of "treatment limitation," as opposed to a strict reading of the text, NAMI believes that a fee schedule that results in reduced access is clearly a "treatment limitation" in word and effect.[41] Indeed, a fee schedule that is so low that few providers can afford to offer associated services is arguably a greater treatment limitation than a limit on the frequency of treatment. To underscore this disparity in payment amounts between MH/SUD, we asked Milliman to compare the average allowed charges and in-network use between medical/surgical and MH/SUD. Milliman found that the average allowed cost/day for MH/SUD was $975.00 per inpatient day for MH/SUD and $6,122.00 per day for medical/surgical. The average billed cost per day using Milliman data was $1,787.00 for behavioral health and $13,701 for medical/surgical. The disparity in payment rates was nearly 6 times greater for medical/surgical than behavioral health on some of the most commonly treated ailments on both the medical and behavioral side.

In addition, the purpose of the Act would be clearly circumvented by reading "treatment limitations" to exclude fee schedule amounts. The purpose of the statute, generally, is to ensure parity and equity between MH/SUD and medical/surgical benefits and to end "the discrimination that exists under many group health plans with respect to mental health and substance-related disorder benefits."[42] If fee schedules are not included within the treatment limitations section, the parity requirements do not apply, and plans could presumably discriminate at will with respect to payment amounts. Congress was trying to end "discrimination" with respect to mental health and substance use disorder benefits. Permitting plans to implement low fee schedules for MH/SUD benefits would undermine this goal.

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[40] *Id.* at § 1185a(a)(3)(B)(iii).

[41] *Id.*

[42] H.R. REP. NO. 110-374, pt. 2, at 12 (2007) (Ways & Means Comm.).

Assuming that fee schedules are included in the treatment limitations section of the law, what are the restrictions on plans in setting fee schedule amounts? In other words, does the treatment limitations section of the law prohibit plans from setting fee schedule amounts that are so low that access is more restrictive for MH/SUD benefits than for medical/surgical benefits?

As in other areas of this analysis, the key question is whether the treatment limitation in the MH/SUD benefit (in this case, the fee schedule amount) is more restrictive than the predominant treatment limitation applied to substantially all medical/surgical benefits covered by the plan.[43] **If the low fee schedule results in decreased access to MH/SUD benefits, a strong argument can be made that it is "more restrictive" than the medical/surgical fee schedule and thus in violation of the Act.**

1B. How do plans apply limits to medical/surgical benefits? Are these requirements applied differently to both classes of benefits? Do plans vary coverage levels within each class?

As noted in previous sections, private insurance coverage has traditionally been less generous for MH/SUD than for medical care. Many private health plans limit the number of day visits or dollars available for MH/SUD benefits even when they do not similarly limit medical coverage. Moreover, Zuvekas and Meyerhoefer found in 2006 that patients' share of MH/SUD spending increased with the number of visits whereas their share of medical spending decreased with the number of visits – a finding that validates the imposition of discriminatory limits on MH/SUD.[44] In a 2009 survey of private health plans, Hodgkin et al found that 90 percent of covered services had special annual limits for outpatient MH/SUD, whereas other surveys have showed that general medical conditions are rarely subject to special limits.[45,46] The only limits widely used for general medical care are limits on lifetime spending, which one survey reported as applying to only half of covered worked in 2004 and being mostly in the $1 to 2 million range.[47]

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[43] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A § 1185a(a)(3)(A)(ii) (2009).

[44] Zuvekas, S., and Meyerhoefer, C. (2006). Coverage for mental health treatment: do the gaps still persist*? Journal of Mental Health Policy and Economics* 9(3): 155-163.

[45] Hodgkin D, Horgan CM, Garnick DW, Merrick EL (2009). Benefit limits for behavioral health care in private US health plans. *Administration and Policy in Mental Health and Mental Health Services Research* 36(1): 15-23.

[46] US Bureau of Labor Statistics. (2007). National compensation survey: Employee benefits in private industry in the United States, 2005. Bulletin, 2589.

[47] Kaiser Family Foundation. (2004). Employer health benefits: 2004 annual survey. California: Menlo Park.

To get a fuller picture of how requirements are applied differently on both classes of benefits, NAMI joined the Parity Implementation Coalition in asking Milliman to analyze differences in utilization management between MH/SUD and medical/surgical benefits. Milliman measured inpatient hospital use for 9 major medical/surgical DRGs and 9 behavioral health conditions (outlined in Table 2 below for comparison). Milliman compared average length of stay (ALOS) and benchmarked these ALOS within the Milliman published guidelines for "loosely managed" (LM) and "well-managed" (WM) delivery, separately for in-network admits and also all admits combined. The higher the percentage "towards well managed", the tighter the utilization management of the inpatient stays the more restrictive is the management of the benefit and the higher the barriers to accessing care. Table 2 demonstrates that an average of 57 percent of behavioral health claims were managed more restrictively while an average of 43.5 percent of medical claims were managed restrictively. This is a significant difference and highlights the fact that more restrictive management of behavioral benefits is common today even with more limited MH/SUD benefits. Implementing regulations must address this issue.

Table 2 - Comparison of Average Lengths-of-Stay

DRG	Admits-All	Admits-INN	Days-All	Days-INN	Actual ALOS - All	Actual ALOS - INN	Milliman Benchmarks	
							LM ALOS	WM ALOS
885	47,368	40,346	317,304	265,321	6.70	6.58	8.55	5.50
897	16,735	14,178	80,318	67,444	4.80	4.76	7.05	2.87
881	5,341	4,435	25,741	20,909	4.82	4.71	4.10	3.90
895	2,799	2,426	22,025	18,808	7.87	7.75	12.78	3.62
882	1,764	1,447	10,197	7,792	5.78	5.38	4.74	4.00
880	1,538	1,323	5,545	4,310	3.61	3.26	3.28	3.12
886	1,256	1,024	12,957	9,773	10.32	9.54	13.80	11.47
894	654	581	2,044	1,753	3.13	3.02	4.09	3.27
896	637	547	3,935	3,237	6.18	5.92	9.16	5.49
Behavioral Subtotal	**78,092**	**66,307**	**480,066**	**399,349**	**6.15**	**6.02**	**7.94**	**4.76**
	Percent towards Well Managed:				**56.3%**	**60.3%**		
470	36,806	32,074	117,240	102,626	3.19	3.20	3.64	2.47
249	14,188	12,714	29,486	26,405	2.08	2.08	2.36	1.56
203	8,080	7,198	18,918	16,861	2.34	2.34	2.77	1.83
639	6,674	5,843	15,721	13,641	2.36	2.33	2.77	1.92
65	3,975	3,458	18,669	16,027	4.70	4.63	5.79	4.13
305	3,479	3,056	7,818	6,773	2.25	2.22	2.57	1.90
192	3,344	2,901	11,072	9,527	3.31	3.28	4.07	2.36
292	3,049	2,632	12,133	10,581	3.98	4.02	4.96	3.35
392	2,886	2,535	7,818	6,792	2.71	2.68	3.02	1.88
	82,481	**72,411**	**238,875**	**209,235**	**2.90**	**2.89**	**3.37**	**2.27**
Medical Subtotal	**Percent towards Well Managed:**				**42.9%**	**43.5%**		

2. What terms or provisions require additional clarification to facilitate compliance? What specific clarifications would be helpful?

Medical management techniques for MH/SUD may not be more restrictive than medical management techniques applied to medical/surgical benefits

NAMI shares the Parity Implementation Coalition's view that while Congress intended plans to use medical management techniques, it did not intend them to apply these techniques in a more restrictive way on MH/SUD than on medical/surgical benefits.

Thus, the text and history of MHPAEA demonstrate that Congress likely did not intend to allow the use of more stringent medical management criteria for MH/SUD benefits than for medical/surgical benefits.

Because there are numerous types of techniques to control access to benefits in addition to the treatment limitations or financial requirements most commonly seen in benefit design, we described many medical management techniques in our response to question 1a under Section B. A critical issue, given the Act's silence on medical management, is determining Congressional intent as to the extent of medical management.

When considered in the context of the Act's legislative history, the absence of specific medical management language suggests that Congress did not mean to allow medical management that is more stringent for MH/SUD services than for medical/surgical services. Where a statute is ambiguous or silent on an issue, the legislative history can be an important and instructive tool to determine the meaning of the statute. Here, changes between the bill as introduced and the bill as passed indicate that Congress did not intend to allow more stringent medical management criteria for MH/SUD benefits than medical/surgical benefits, but that it did intend for some form of medical management.

Specific medical management language that was included in S 558 was dropped in the final statute.[48] This deletion is meaningful. Where, as here, a non-technical provision is dropped from the bill prior to final passage, there is a strong inference that its deletion was purposeful. Since the provision's purpose was to make very clear that medical management is authorized under the statute, the deletion of the provision indicates a desire on the part of the drafters to weaken the bill's medical management provisions. At its most basic, the deletion of the medical management provision indicates that Congress was not intending for medical management to be applied more stringently.

If Congress had wanted to strengthen a plan's ability to use stringent medical management techniques, it could have written such an authorization into the Act. At the very least, Congress could have kept in the final version of the MHPAEA the existing authorization regarding medical management found in S 558. Instead, Congress went in the opposite direction, and deleted the medical management provision entirely in the final version of the MHPAEA.

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[48] Paul Wellstone and Pete Domenici Mental Health parity and Addiction Equity Act of 2008, 29 U.S.C. § 1185a.

Proponents of more stringent medical management requirements may argue that the reason the provision was deleted from the legislation was simply because it was understood that medical management would be allowed under the bill. The argument that medical management of some sort is authorized by the statute is clear. However, stating that medical management is authorized is not the same as stating that more stringent medical management is authorized. Given the lack of explicit language and the deletion of the strongest medical management language before passage of the final bill, there is no evidence that the statute authorizes more stringent medical management. Clarification on these issues may be one of the more important issues regulators will have to contend with because it can mean the difference between individuals with MH/SUD conditions having access to care or not. **NAMI joins the Parity Implementation Coalition in recommending that the regulations clarify that plans with medical management interventions that are more restrictive for MH/SUD as compared to medical/surgical are not in compliance with the Act.**

The regulations should clarify that even if plans use the same medical necessity criteria for MH/SUD and medical/surgical coverage, a violation of the treatment limitations section of the law can occur if the end result is a reduction in access to services. To be subject to the parity requirements, medical management and medical necessity criteria must be found to come within the financial requirements or treatment limitations sections of the law. NAMI and the Parity Implementation Coalition believe they do.

More restrictive medical management determinations for MH/SUD may also violate the financial requirements section of the Act since the denial of access to plan-reimbursed mental health and substance use disorder services would mean that consumers would have to pay higher out-of-pocket expenses as compared to out-of-pocket expenses for medical/surgical services.

Although there has been a widely held view that plans would have less of a need for benefit limits given access to other cost containment strategies such as utilization management and providing profiling, a 2008 survey of managed care plans found that these plans had not chosen to abandon benefit limits, perhaps because they perceive risks in doing so and no gains.[49] Moreover, Barry and colleagues suggested plans may retain limits as a way to discourage enrollment of individuals likely to use MH/SUD benefits.[50]

Supply side rationing through plan medical management techniques is inherently less transparent than cost control through benefit limits. Regulations must ensure that these are applied no more stringently on MH/SUD than on other medical/surgical conditions. Based on a survey of Coalition members, network incentives appear to exert powerful

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[49] Hodgkin D, Horgan CM, Garnick DW, Merrick EL (2009). Benefit limits for behavioral health care in private US health plans. *Administration and Policy in Mental Health and Mental Health Services Research* 36(1): 15-23.

[50] Barry, C. et al. (2003). Design of mental health benefits: still unequal after all these years. *Health Affairs, 22*(5), 127–137.

control over the quality of services rendered. Network incentives arise from the cooperation that a plan can demand from providers who value being in-network; rigorous utilization review practices, network design and physician incentives all were reported by Coalition members as common methods to discourage enrollment by people with MH/SUD; thereby effectively curtailing access to services for individuals with MH/SUD.

Medical necessity criteria

Related to the overall medical management issue are questions surrounding medical necessity criteria. While the law clearly contemplated and concedes the use of medical necessity criteria, the legislation does not contain authorization for medical necessity criteria that are more stringent for one category of benefits than the other. Indeed, the legislation states that any treatment limitations for MH/SUD benefits must be no more restrictive than those imposed on substantially all medical/surgical benefits. Imposing more restrictive medical necessity criteria on one category of benefits would run counter to the purpose of parity: "the state of being equal or equivalent." Interpreting the Act to allow more stringent medical necessity criteria for MH/SUD services than for medical/surgical services would undermine the solution that Congress put in place to remedy "the discrimination that exists under many group health plans with respect to mental health and substance use disorder benefits." **Medical necessity is a mechanism for limiting access to coverage. Therefore, it fits within the treatment limitation definition and is thereby subject to the treatment limitation parity requirement. In light of the purpose of the Act, similar criteria that result in a reduction in access to services violates the Act.**

The lack of application of uniform medical necessity criteria for MH/SUD across the many health plans in the current marketplace has exacerbated the access issue for those with MH/SUD conditions. While there are not uniform medical necessity criteria for medical/surgical conditions, the Milliman analysis demonstrates that there is a greater impact on MH/SUD access as a result of the arbitrary and changing nature of criteria used in medical management of MH/SUD services. In fact, there are detailed utilization management criteria for SUD care, the Patient Placement Criteria for Psychoactive Substance Use Disorders published by the American Society of Addiction Medicine. If these consensus-developed criteria (the use of which are mandated in many jurisdictions) were more widely disseminated and implemented by plans and insurers and uniformly used, there would be much more consistency in medical management processes, at least for SUD managed care entities on the MH/SUD side.

2a. Medical Necessity & Treatment Limitations

The broad language of the treatment limitations section allows medical necessity to fit within its definition. The definition provides a non-exhaustive list of limits on treatment and indicates that "other similar limits on the scope and duration of treatment" come within the definition.[51] Medical necessity, like the other procedures and policies

[51] *Id.* at § 1185a(a)(3)(B)(iii).

mentioned in the statutory list, is a mechanism for limiting coverage. Thus, it fits within the treatment limitations definition and is subject to the treatment limitations parity requirements. To comply with the Act, a plan must ensure that "the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan."[52]

A very strong argument can be made that, in light of the purpose of the Act, it should be construed broadly to prohibit criteria that are the same in form but restrictive in practice. The House Education and Labor and Energy and Commerce Committees' Reports state that the purpose of the legislation is to ensure "fairness" and "equity" for mental health and substance use disorder services.[53] Equity and fairness are not achieved when the end result of medical necessity criteria is reduced access to treatment. The Ways and Means Committee stated that the legislation was necessary to "end the discrimination that exists under many group health plans with respect to mental health and substance-related disorder benefits."[54] To end discrimination in form, but not in effect, would be a hollow protection against discrimination.

In addition, the context of the Act demonstrates a desire by Congress to ensure meaningful parity coverage. The Act builds upon existing mental health parity law. In 1996, Congress passed and the President signed the Mental Health Parity Act (MHPA). The MHPA equates aggregate lifetime and annual limits for MH benefits with aggregate lifetime and annual limits for medical/surgical benefits. Thus, the statute gave a measure of protection from the costs of MH services. Legislation to expand mental health parity was introduced in the House in every subsequent Congress until passage of the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* in the 110th. From January to March 2007, the authors of the Act held field hearings around the country to learn about the impact of insurance and equity policies on access to MH/SUD care. In a report issues in May 2007, they found numerous barriers to accessing treatment, including "aggressive" benefit management.[55] It was in this context that the Act was passed. Congress was expanding a previous law. The context shows that Congress was attempting to address the problems, including barriers to treatment services, which existed despite the 1996 law. In this context, allowing an insurer to limit coverage through medical management criteria that reduces access would be counterintuitive.

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[52] *Id.* at § 1185a(a)(3)(A)(ii).

[53] H.R. REP. NO. 110-374, pt. 1 (2007) (Educ. & Labor Comm.); H.R. REP. NO. 110-374, pt. 3 (2007) (Energy & Commerce Comm.).

[54] H.R. REP. NO. 110-374, pt. 2, at 12 (2007) (Ways & Means Comm.).

[55] REPRESENTATIVE PATRICK KENNEDY & REPRESENTATIVE JIM RAMSTAD, ENDING INSURANCE DISCRIMINATION 15 (2007). In the same report, Dr. Steven Sharfstein of Sheppard Pratt Health System in Baltimore stated, "I am certain that we suffer more from varying interpretations of medical necessity and capricious and arbitrary denials than other specialties in medicine."

Finally, interpreting the Act to allow medical necessity requirements in the MH/SUD benefits that restrict access to services would lead to an illogical result that should not be ascribed to Congress. Congress wanted MH/SUD benefits to be no more restrictive than medical/surgical benefits. Permitting MH/SUD medical necessity requirements that make MH/SUD benefits unavailable, when medical/surgical benefits are available, seems overly restrictive. Plans should not be able to accomplish through medical necessity requirements what they cannot accomplish through other treatment limitations or financial requirements.

3. WHAT INFORMATION, IF ANY, REGARDING THE CRITERIA FOR MEDICAL NECESSITY DETERMINATIONS OF A PLAN OR COVERAGE WITH RESPECT TO MH/SUD IS CURRENTLY MADE AVAILABLE UNDER THE PLAN? TO WHOM IS IT MADE AVAILABLE AND HOW IS IT MADE AVAILABLE?

ERISA does not define medical necessity or provide a right to external administrative review of medical necessity determinations. However, when an ERISA plan denies a claim based on medical necessity, ERISA rules require the plan to either explain the clinical judgment used in applying the plan's terms or to include a statement of medical necessity criteria free of charge to the insured if requested. This explanation is required to be "written in a manner calculated to be understood by the participant."[56] Based on Coalition survey data, fully insured plans appear to have varying policies on their dissemination of medical necessity criteria – from disclosure on a company's website to policies not to make "proprietary" medical necessity criteria available to individuals with MH/SUD conditions at all. Even some ERISA plan participants expressed difficulty at getting their plan's medical necessity criteria. Other individuals reported that the plan would send the medical necessity criteria and reason for benefit denials to their provider only.

In general, because of the limited reach of current federal law governing medical necessity definitions and availability, medical necessity is still largely included in the terms of a contract negotiated between buyers and sellers. As a result, NAMI believes that the regulations need to clarify timeframes upon which medical necessity criteria must be made available once requested and should specify enforcement mechanisms for failure to comply. We also believe that regulations that specify criteria for evaluating the equivalence of medical necessity criteria across MH/SUD and general medical conditions could greatly facilitate the process of ending discrimination. Finally, NAMI believes that the regulations should require plans to not only make public the rationale for the MH/SUD denial but do so within a specific time frame.

4. WHAT INFORMATION, IF ANY, REGARDING THE REASONS FOR ANY DENIAL UNDER THE PLAN (OR COVERAGE) MUST BE DISCLOSED BASED ON REQUIREMENTS OF THIS ACT? TO WHOM IS SUCH INFORMATION CURRENTLY MADE AVAILABLE, AND HOW IS IT

[56] 29 U.S.C. § 1133 (2001).

MADE AVAILABLE? ARE THERE INDUSTRY STANDARDS OR BEST PRACTICES WITH RESPECT TO THIS INFORMATION AND COMMUNICATION OF THIS INFORMATION?

Four types of plans are covered by this law. These include self-insured plans regulated under ERISA; fully insured plans; Medicaid managed care plans (which are subject to both state and federal laws); and Taft-Hartley plans (where benefits were secured by workers via collective bargaining; such plans are regulated under ERISA). Each type may have separate rules governing the release of the reason for benefit denials to its plan participants.

Self-insured plans – Under ERISA, self-insured plans are required to explain a reason for denying benefits under the plan. Under existing ERISA regulations, these denials must provide an explanation of the denial and, in cases of medical necessity determinations, consumers may request copies of the documentation that plans used in making the determination. All of the information must be made available to consumers free of charge. The regulations also outline the process for appealing benefit determinations, the timelines for the appeals process, the steps included in the disclosure requirements and the fairness of the process. NAMI is confident that the intent of Congress was that nothing in the MHPAEA would weaken any of these requirements under ERISA.

Fully-insured plans – Fully insured plans are subject to state and federal laws so, for individuals insured under these plans, the ERISA benefit determination rules establish a floor for consumer protections with regard to plan benefit demonstrations since states may promulgate more stringent requirements for these plans. States can and do impose their own appeals standards on these plans.

Medicaid Managed Care Plans- The Balanced Budget Act of 1997 included a provision (section 4704(a)) explicitly applying the 1996 parity law to Medicaid managed care plans. Since the MHPAEA amends the 1996 parity law, the new parity law and implementing regulations should apply to Medicaid managed care plans as well. Millions of individuals with behavioral health conditions rely on Medicaid for their health care coverage. Medicaid is the largest single source of financing for mental health care in this country, comprising over half of state and local spending on mental health services. The regulations implementing MHPAEA should make clear that Medicaid managed care plans must fully comply with the new parity law.

State Medicaid managed care plans have the latitude to impose different requirements on how reasons for denials are communicated to insureds. In general, most Medicaid managed care plans are required to disseminate the reason for a denial in writing. A specific reason must be included in the letter and in some states it is required that the reason may not change at an appeals hearing. Timelines are also specified in many Medicaid managed care plans so that plan participants are informed of their rights in terms of grievance or appeals of the denial.

Although managed care plans in the public and private sector report that their plans often make reasons for denials available to insureds, during the parity field hearings and from our survey of individuals with mental health and addictive disorders, consumers often reported having difficulty obtaining the reason for benefit denials. Sometimes the appeal of the benefit determination was made on their behalf by their provider, and insureds never received a copy. Other times insureds requested a copy and never received a response, or the response was too complicated and insufficiently clear in its explanation. For example, at two of the parity hearings, witnesses testified that their plan said a particular treatment was experimental even though the consumer provided the plan with numerous studies on the efficacy of the service.

NAMI believes the timelines under ERISA for providing individual responses to claims-related information are worthy of consideration and could logically be extended to all consumers covered under MHPAEA as well as to the transparent provision of medical necessity criteria and an open explanation of reasons for benefit denials. NAMI also believes the ERISA regulations appropriately include expedited timelines for urgent and pending care.

5. Out of Network Coverage

The parity law does not require the identical scope and duration of network benefits in the MH/SUD benefit and the medical/surgical benefit. Instead, the law requires that if a plan covers both medical/surgical benefits and MH/SUD benefits, the out-of-network requirements can be no more restrictive for one benefit than the other. The only statutory text addressing plan networks states:

> In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner *that is consistent with the requirements of this section*.[57] [Emphasis added]

What, then, are the "requirements of [the] section?" The section requires that "treatment limitations applicable to…mental health or substance use disorder benefits" be "no more restrictive" than the treatment limitations applied to medical/surgical benefits, and that there be "no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits."[58] Accordingly, the question is whether network requirements can be considered "treatment limitations."[59] If so, the network

[57] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C.A § 1185a(a)(3)(A)(ii) (2009).

[58] *Id.*.

[59] A judge or agency might find that network requirements resulting in a higher out-of-pocket burden on the beneficiary come under the financial requirements section of the Act as well.

requirements for one benefit category must be "no more restrictive" than the requirements for the other benefit category or the plan violates the Act.

As defined by the Act, treatment limitations "include[s] limits on the frequency of treatment, the number of visits, days of coverage, or other similar limits on the scope or duration of treatment."[60] This language does not specifically list network requirements in its list of treatment limitations. However, the Act uses the word "including" prior to starting its list. This word choice indicates that the list is not exhaustive, but rather illustrative. If network requirements are "similar" to the items on the list, they are properly considered treatment limitations. The statute lists a number of items that are designed to limit treatment. Network requirements are a well-known tool for placing limitations on access to treatment in a health insurance plan. It is similar to the other treatment limitations in the list, and thus should qualify as a treatment limitation.

Because network requirements should qualify as a treatment limitation under the Act, to be "consistent" with the requirements of the section, the network requirements in a plan for the MH/SUD category must be "no more restrictive" than the network requirements for the medical/surgical category. To the degree to which the regulations can provide a methodology for comparing the characteristics of the MH/SUD network and those used for other medical specialties, the implementation of the law would be enhanced.

6. Which aspects of the increased cost exemption, if any, require additional guidance? Would model notices be helpful to facilitate disclosure to Federal agencies, State agencies, and participants and beneficiaries regarding a plan's or issuer's election to implement the cost exemption?

MHPAEA's legislative history is clear that Congress intended to protect strong state-based requirements and consumer protections. The law establishes a federal floor of protections, generally allowing more consumer protective state-based requirements to continue to apply to state regulated health insurance products and areas not preempted by ERISA. Today, many states now require insurance companies to cover mental health and/or addiction even though the federal law only applies when plans include mental health and substance use disorder benefits in their benefits package. Moreover, many states do not allow a cost exemption even though MHPAEA outlines specific cost exemptions. NAMI believes because there are varying state laws on both cost exemption and other critical issues, issuing model notices or guidance to states would be extremely important. **The regulations should provide a methodology that could be applied to determine if cost increases are specifically related to the implementation of insurance parity and not some other secular or contextual variable.**

Other issues relevant to regulations development

Preemption of State Law

[60] *Id.* at § 1185a(a)(3)(B)(iii).

During the legislative process, NAMI 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 (most especially those requirements to cover specific severe mental illness diagnoses) or to cover a minimum number of inpatient days or outpatient visits 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.

Medicaid Managed Care Issues

Background

Since the 1990s, the Medicaid program has increasingly relied on managed care to deliver services to its Medicaid population. Today, more than 65 percent of the total Medicaid population is served through managed care.[61] All states except Alaska,

[61] CENTERS FOR MEDICARE AND MEDICAID SERVICES, 2005 MEDICAID MANAGED CARE ENROLLMENT REPORT: SUMMARY OF STATISTICS AS OF JUNE 30, 2006 (2006), http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp.

Wyoming, and New Hampshire have at least a portion of their Medicaid population enrolled in managed care.[62]

Under Medicaid managed care, the Medicaid agency contracts with a managed care entity to provide care for beneficiaries in return for a fixed periodic payment per enrollee (*i.e.*, capitated payment). Under the most common scenario, the managed care entity manages a patient's care through a primary care physician or case manager.[63]

Federal requirements guarantee Medicaid beneficiaries free choice of providers. However, many states have obtained waivers under § 1915(b) of the Social Security Act (42 U.S.C. § 1396n(b)), which permits the Centers for Medicare and Medicaid Services (CMS) to waive the freedom of choice requirement or under § 1115 (42 U.S.C. § 1315), which gives CMS broad authority to waive statutory requirements for approved research and demonstration projects. These waivers allow states to provide Medicaid benefits through managed care plans. Additionally, the 1997 Balanced Budget Act (BBA) permits states to require Medicaid recipients to enroll in Medicaid managed care (MMC) plans without waivers.[64] States that have implemented mandatory managed care in Medicaid have generally taken two approaches to the delivery of mental health services. In the first approach, the managed care organization (MCO) that provides medical care also provides mental health services, either through its own provider network or by subcontracting with a behavioral health organization.[65] In the second approach, mental health is "carved out" from physical health, and individuals receive mental health services either on a fee-for-service basis or through a separate MCO that specializes in behavioral health.

MHPAEA applies to Medicaid managed care plans

Since passage of MHPAEA, questions have arisen as to the applicability of the Act to Medicaid Managed Care (MMC) plans. First, must MMC plans comply with the Act? Relatedly, would a specialty MH/SUD managed care plan be considered a MMC plan? If a MMC plan has a member enrolled for total health coverage and then provides partial or no MH or SUD benefits because these benefits are provided elsewhere (*e.g.*, through Medicaid fee-for-service funds, a specialty MMC plan, or a combination) what are the obligations for compliance with the Act? Does a MMC Plan have the option of deleting MH/SUD diagnostic categories or is this prohibited by federal Medicaid statutes and guidelines? Finally, if a MMC plan provides for the coverage of a full range of inpatient

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[62] *Id.*

[63] 42 C.F.R. § 438.2 (2007).

[64] 42 U.S.C. § 1396u-2 (2000). BBA contains several exceptions to this policy: states are not permitted to require dual-eligible Medicare beneficiaries, special needs children, or Native Americans to enroll in managed care plans without federal permission.

[65] Cynthia Shirk, *Medicaid and Mental Health Services*, NATIONAL HEALTH POLICY FORUM BACKGROUND PAPER NO. 65, October 2008, at 13. *See also* Kristian W. Hanson & Haiden A. Huskamp, *Behavioral Health Services Under Medicaid Managed Care: The Uncertain Implications of State Variation*, 52 PSYCHIATRIC SERV. 447, 447 (2001).

care for medical/surgical conditions (including specialty medical/surgical hospitals), would that Medicaid plan be in compliance with the Act if it excludes care in institutions for mental diseases (IMDs)?

These are difficult questions to answer and there appears to be a great deal of confusion among state Medicaid and CMS officials regarding the correct interpretation of this set of issues. In an effort to provide clarification for further discussion of these important public policy questions that will soon affect enrollees in MMC plans, below is a legal analysis of the Act, Medicaid statute, federal regulations, and agency guidance to analyze the questions.

1. Must Medicaid managed care plans comply with the Act?

The Medicaid statute requires that MMC plans comply with the parity provisions of the Act. This conclusion is supported by both the legislative history of the Act, and the regulatory history of previous mental health laws.

The Act modified the Public Health Service Act (PHSA) to require that if a group health plan offers both medical/surgical benefits and MH/SUD benefits, the financial requirements and treatment limitations for MH/SUD benefits must be no more restrictive than those imposed in the medical/surgical benefit.[66] The Medicaid managed care statute refers to this section and mandates that managed care plans "comply" with its provisions. Specifically, the Social Security Act Section 1932(b)(8) specifies that "Each Medicaid managed care organization shall comply with the requirements of subpart 2 of Part A of title XXVII of the Public Health Service Act [42 U.S.C.A. 300gg-5 *et seq.*] insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage."[67] The statutory reference in the quote refers to the mental health parity provisions as passed in the 1996 Mental Health Parity Act (MHPA) and as modified by the 2008 Act. Thus, the Medicaid managed care statute requires that MMC plans comply with both the 1996 and the 2008 parity requirements.

This interpretation is consistent with Congressional views on the meaning and application of the Act. The Senate Committee on Health, Education, Labor, and Pensions (HELP) reported its version of the Act out of Committee on April 11, 2007. In the Committee Report accompanying the bill, the Committee stated that "[t]he bill's requirements for issuers of group health insurance would apply to managed care plans in the Medicaid program."[68] Similar language is included in the Congressional Budget Office (CBO) cost estimate included in the Committee Reports from the House Education & Labor, Energy & Commerce, and Ways & Means Committees.[69] Although the final legislation was not

[66] 42. U.S.C. 300gg-5(a)(3) (2000).

[67] 42 U.S.C. 1396u-2(b)(8) (2000).

[68] S. REP. NO. 110-53, at 5 (2007) (Sen. Comm. on Health, Educ. & Labor, 2007).

[69] H.R. REP. NO. 110-374, pt. 1 (2007) (Educ. & Labor Comm.); H.R. REP. NO. 110-374, pt. 2 (2007) (Ways & Means Comm.); H.R. REP. NO. 110-374, pt. 3 (2007) (Energy & Commerce Comm.).

identical to the bill enacted into law, no changes were made to the bill that would alter this analysis.

The view that MMC plans must comply with the parity provisions of the Act is also consistent with past agency interpretation of MHPA. The 1997 Balanced Budget Act (BBA) made a number of changes involving managed care to the Medicaid statute, including adding Section 1932(b)(8), the requirement discussed above that MMC plans comply with mental health parity requirements.[70] The Health Care Financing Administration (HCFA), the predecessor agency to CMS, subsequently released a number of letters to State Medicaid Directors explaining the effect of the BBA on Medicaid managed care. In a letter dated January 20, 1998, Sally Richardson, the director of the Center for Medicaid and State Operations, stated that the parity requirements of the 1996 Mental Health Parity Act (MHPA) "apply to Medicaid managed care organizations without exemptions."[71] This is so because Section 1932(b)(8) "specifically requires Medicaid managed care organizations to comply with MHPA by treating them, for that purpose, like health insurance issuers offering group health insurance coverage."[72] Although this letter was written during implementation of the 1996 Act, its reasoning continues to apply with respect to the 2008 Act. The 2008 Act simply added a section to the original 1996 parity law. This new section falls within the scope of Section 1932(b)(8)'s requirement that managed care organizations must comply with the parity requirements. Accordingly, Section 1932(b)(8) applies equally to the parity requirements in the 2008 Act. This means that MMC plans are subject to the 2008 Act's requirements.

2. Would a specialty MH/SUD managed care plan be considered a Medicaid managed care plan?

Whether a specialty MH/SUD managed care plan is to be considered a MMC plan is a fact-specific inquiry that depends upon whether the plan is offered by an organization that meets the definition of a Medicaid managed care entity set out in statute. However, since the Act applies only to plans offering both medical/surgical and MH/SUD benefits, a specialty plan by definition cannot ensure parity. Rather, the larger question of how parity is to be attained when a state carves out its mental health benefits must be addressed.

Under Medicaid managed care, the Medicaid agency contracts with a managed care entity to provide care for beneficiaries in return for a fixed periodic payment per enrollee

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[70] 42 U.S.C. 1396u-2(b)(8) (2000).

[71] Letter from Sally Richardson, Director of the Health Care Financing Administration, to State Medicaid Directors (January 20, 1998), available at: http://www.cms.hhs.gov/smdl/downloads/SMD012098d.pdf.

[72] This is not to say that MMC plans necessarily meet the requirements of a "group health plan" under the 1996 or 2008 parity acts. However, the statutory language of 42 U.S.C. 1396u-2(b)(8), and the analysis by HCFA demonstrate that MMC plans are treated like group health plans with respect to the parity requirements.

(*i.e.* a capitated payment).[73] Several states have also implemented specialty managed care programs. Such programs serve a particular condition such as mental health. Commonly, these programs are run as "carve-outs" in which medical/surgical care is coordinated by primary care physicians, while MH/SUD care is managed by another managed care organization.[74] Whether a plan under these circumstances qualifies as a Medicaid managed care plan depends upon whether it is offered by an entity that meets the statutory definition of a Medicaid managed care organization.

States are permitted to enroll Medicaid beneficiaries with "managed care entities."[75] A managed care entity is defined in statute as either a managed care organization (MCO) or a primary care case manager (PCCM).[76]

An MCO may be a health maintenance organization (HMO), a Medicare Advantage organization, a provider sponsored organization, or any other public or private organization which meets the requirements of the law and regulations.[77]

A PCCM is a physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide case management services. States also may permit certified nurse midwives, nurse practitioners and physician assistants to serve as PCCMs.[78]

These definitions set forth the permitted entities that can provide managed care to Medicaid beneficiaries. States then contract with an entity that meets the definitions above and that is willing to abide by a number of other requirements set forth in statute.[79] A specialty plan that meets one of the definitions above, is willing to abide by the law's requirements, and contract with the state to provide care for beneficiaries in return for a capitated payment is, by definition, a managed care plan.

However, specialty MH/SUD plans are by their nature focused only upon MH/SUD services. As noted, the Act applies only to plans that offer both MH/SUD *and*

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[73] 42 C.F.R. § 438.2 (2007).

[74] Kristian W. Hanson & Haiden A. Huskamp, *Behavioral Health Services Under Medicaid Managed Care: The Uncertain Implications of State Variation*, 52 PSYCHIATRIC SERV. 447, 447 (2001).

[75] 42 U.S.C. § 1396u-2(a)(1)(A)(i) (2000).

[76] 42 U.S.C. § 1396u-2(a)(1)(B) (2000).

[77] 42 U.S.C. 1396b(m)(1)(A) (2000); 42 C.F.R. § 438.2 (2007).

[78] 42 U.S.C. 1396d(t)(2) (2000).

[79] For example, MCOs must offer their members all of the services available under the state plan. 42 C.F.R. § 438.206(a) (2007). They must also provide the state with adequate assurances that they have the capacity to serve the expected enrollment in the service area and must make detailed disclosures to enrollees on the provider network and terms of the plan. Soc. Sec. Act § 1932. MCOs are also required to make adequate provisions against the risk of insolvency. Soc. Sec. Act § 1903(m)(1)(A)(ii).

medical/surgical benefits. Accordingly, specialty managed care plans do not fit comfortably under the requirements of the Act. Indeed, the structure of these plans makes it impossible for them to fulfill the requirements of the plan without transforming into comprehensive medical/surgical plans.

If a state decides to offer mental health benefits to its beneficiaries through a specialty MH/SUD plan rather than through a comprehensive MMC plan, what entity is responsible for compliance with the Act? In other words, if Medicaid managed care organizations are subject to the requirements of the Act, but the state has carved out mental health benefits and provided them through a different entity than the medical/surgical benefits, which entity would be required to comply with the Act? This question will be addressed below.

3. If a Medicaid managed care plan has a member enrolled for total health coverage and then provides partial or no MH or SUD benefits because these benefits are provided elsewhere (*e.g.*, through Medicaid fee-for-service funds, a specialty Medicaid managed care plan, or a combination) what are the obligations for compliance with the Act? In other words, which entity is subject to the Act—the Medicaid MCO, the state Medicaid Agency, the specialty MH/SUD plan or no one?

The policy and legislative intent behind the statute demonstrate that states should ensure parity between medical/surgical and MH/SUD benefits even in states that carve out MH/SUD benefits.

States that have implemented managed care in Medicaid have generally taken three approaches to providing mental health services to Medicaid beneficiaries.[80] In the first and most common approach, the MCO that provides medical care also provides mental health services, either through its own provider network or by subcontracting with a behavioral health organization. In the second approach, mental health is "carved out" from physical health. Under this approach, the state or county contracts directly with a specialty health care entity for the delivery of MH/SU services. Under a carve-out approach, an individual receives mental health services either on a fee-for-service basis or through a separate MCO that specializes in behavioral health. Finally, some states provide limited mental health services under the same MCO that provides medical/surgical care and then pay for other mental health care using state general funds.[81]

If MMC plans are subject to the requirements of the Act, what entity in the varied situations above must comply with the Act? In the case of a state that offers medical/surgical and MH/SUD benefits through the same MCO, the answer is clear. **<u>As</u>**

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[80] Cynthia Shirk, *Medicaid and Mental Health Services*, NATIONAL HEALTH POLICY FORUM BACKGROUND PAPER NO. 65, October 2008, at 13.

[81] *Id.*

outlined above, in such a case the MCO would be subject to the provisions of the Act.

However, the question becomes complex in states that use a carve-out approach. An example is useful to clarify the difficult issues raised by carve-out approaches. A state may provide Medicaid medical/surgical benefits through a MCO, but contract with a separate specialty MCO to provide MH/SU benefits. In such a case, what MCO would be responsible for complying with the Act: the MCO that has contracted with the state only to provide medical/surgical benefits, or the MCO that has contracted with the state only to provide MH/SU benefits? Or, would the state have a requirement to ensure that there is parity between the coverage offered by the separate MCOs? Similar concerns are raised if the state carves out mental health benefits and pays for them under traditional fee-for-service arrangements. Would the medical/surgical MCO have to comply with the Act? Would the state?

The issues depend partially on whether the implementing agencies engage in a narrow or broad reading of the Act, relevant statutes, and policy objectives. This analysis will consider narrow and broad readings of the Act in turn.

Under the narrow analysis, the state is not required to ensure parity between the benefits offered by the plans, and is not required to ensure that the benefits it provides under a fee-for-service carve out approach provide parity with those offered under the medical/surgical MCO. As noted, the Act only applies to group health plans.[82] The state is clearly not a group health plan and, accordingly, has no duty under the Act. Furthermore, the statute mandating that managed care plans follow the parity requirements applies specifically to MCOs, not states.[83] Accordingly, the state has no obligation to ensure parity.

A broader reading of the Act would impose an obligation to comply. A very strict reading of the Medicaid managed care statute would impose a duty on each MCO to comply with the Act since the managed care statute says that "*each* Medicaid managed care organization" must comply with the parity law [emphasis added]. However, requiring a medical/surgical MCO to cover MH/SUD benefits, when the state has expressly contracted with a specialty MCO to perform that function, would run counter to the flexibility built into the Medicaid statue and would undermine the state plan. Accordingly, the issue of parity is more properly addressed at the state level.

Denying the Act's protections to Medicaid beneficiaries simply because a state has decided to carve out its MH/SUD services is inconsistent with the intent of Congress, and produces an illogical result that Congress did not intend. It is clear that Congress wanted the parity requirements to apply to Medicaid MCOs, and that it understood that, through these entities, Medicaid beneficiaries would receive parity between medical/surgical and

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[82] *Id.*

[83] 42 U.S.C. § 1396u-2(b)(8) (2000).

MH/SUD benefits. When Congress enacts a statute, it is assumed that it knows the statutory context in which it legislates. Here, the Act was enacted in the context of an existing statute mandating that MCOs comply with the parity requirements. Congress did not repeal or modify this statute, deciding instead to apply the new parity requirements to managed care plans. It is clear that Congress knew of, and was supportive of, Medicaid recipients enrolled in MCOs receiving mental health coverage on par with that provided in the medical/surgical area. Permitting a state and its MCOs to avoid the requirements simply by moving Medicaid beneficiaries to a carve-out approach would be inconsistent with the broad reach of the Act envisioned by Congress. It could also incentivize MCOs that provide comprehensive care to attempt to avoid providing parity coverage by encouraging their states to carve out mental health populations.

Failing to apply the Act's requirements in states with a carve-out approach would also produce an illogical result not envisioned by Congress. If the parity statute is not applicable in states that carve out their MH/SUD benefits, the statute would guarantee parity for a beneficiary in one state while denying it for a beneficiary in another state. Although the Medicaid is a program designed to create various benefits amongst different states, in the managed care statute, Congress implemented a sweeping requirement: *each* managed care plan must comply. A construction of the statute in which carve out states are not subject to parity would also leave a large and growing number of Medicaid beneficiaries across the country without the protections of the Act. Medicaid is the largest payer of mental health services in the United States.[84] As of 2006, eighteen states had carved out their Medicaid mental health benefits. Refusing to extend the Act's protections to states that have carved out their mental health benefits would mean that millions of Medicaid beneficiaries in over one-third of the states would not benefit from the Act's provisions. Such a result should not be ascribed to a Congress that broadened existing parity provisions.

The above analysis demonstrates that which entity should be subject to the Act when a state carves out mental health benefits in its Medicaid managed care plan is a complex issue. However, **construing the statute to provide no parity in carve out states may be inconsistent with the intent of Congress and would present an absurd result that should not be ascribed to Congress.**

4. If a Medicaid Managed Care plan provides for the coverage of a full range of inpatient care for medical/surgical conditions (including specialty medical/surgical hospitals) would that Medicaid plan be in compliance with the Act if it excludes care in institutions for mental diseases (IMDs)?

A Medicaid managed care plan that excludes care in institutions for mental diseases (IMDs) will only violate the parity statute if such exclusion is "more restrictive" than the treatment limitations applied in the medical/surgical benefit. Whether this exclusion is

[84] Cynthia Shirk, *Medicaid and Mental Health Services*, NATIONAL HEALTH POLICY FORUM BACKGROUND PAPER NO. 65, October 2008, at 13.

more restrictive is a plan-specific and fact-intensive inquiry that will vary from plan to plan.

An IMD is a hospital, nursing facility, or other inpatient institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to people with mental diseases.[85] The status of an institution is determined by its general character as demonstrated by its patient population. If more than 50 percent of the patients have severe mental illness, this is strong evidence that the institution is an IMD. Thus, the criteria of most importance in classifying an institution as an IMD are the services it provides and the prevalence of patients with mental disease. Determination of when a facility qualifies as an IMD is fact-intensive, and a facility can change to an IMD as its patient population changes. Classification of an IMD is important because no federal funding is available for inpatient services in an IMD for anyone between the ages of 21 and 65 years.[86]

The Act states that for plans that offer both medical/surgical and MH/SU benefits, treatment limitations and financial requirements in the MH/SU benefit must be no more restrictive than those imposed under the medical/surgical benefit. For purposes of this question, this analysis assumes that the MMC plan in question covers both medical/surgical benefits and MH/SUD benefits. Thus, the first question to consider is whether a limitation on access to IMDs qualifies as a treatment limitation or a financial requirement.

Although an argument could be made that refusing access to necessary treatment in an IMD falls under the financial requirements section of the law,[87] the stronger argument is that such a limitation falls under the treatment limitation section of the Act. The Act states that a treatment limitation "includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope and duration of treatment."[88] These limitations center on how much, or how often, treatment is given or allowed. A limitation stating that treatment is never to be given in an IMD seems to be a "similar limit on the scope and duration of treatment" under the Act. Even if exclusions of coverage are not specifically listed in the treatment limitation list, the phrasing of the statute suggests that the list is demonstrative rather than comprehensive. That is, the list does not include every treatment limitation that will qualify under the statute. Use of the word "includes" and "other similar limits" demonstrate that the listed treatment limitations are simply examples, not an exhaustive list of the possible treatment limitation

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[85] 42 U.S.C. 1396d(i) (2000); 42 C.F.R. § 431.620 (1979); 42 C.F.R. § 440.140 (2006); *State Medicaid Manual,* Pub. 45, § 4390.

[86] 42 U.S.C. 1396d(a)(16) (2000).

[87] If a plan refuses to cover IMD services, the beneficiary will have to pay out-of-pocket for the services. If a similar limit is not imposed in the medical/surgical benefit, it could be argued that the plan has violated the financial requirements section of the law because this is an out-of-pocket expense that someone in the medical/surgical benefit would not be required to pay.

[88] 42 U.S.C. § 300gg-5(a)(3)(b)(iii) (2000).

subject to parity.[89] Accordingly, exclusions of services provided in IMDs should be included within the treatment limitations definition.

It is important to note, however, that the central question in deciding whether the parity statute is violated is whether the treatment limitations in the MH/SUD benefit are more restrictive than in the medical/surgical benefit, *not* how a particular facility is treated. If the medical/surgical benefit provides coverage for a full range of inpatient care, then to be compliant with the Act any treatment limitations in the MH/SUD benefit must be no more restrictive. This does not necessarily mean, however, that the full range of inpatient MH/SUD care must be provided in an IMD. If a Medicaid beneficiary can obtain a full range of inpatient care in settings other than an IMD (such as in an inpatient behavioral health entity with 16 beds or less), then the plan may be in compliance with the Act even if it excludes IMDs. If an IMD is the only place that can provide a full range of inpatient care, and the plan excludes IMD coverage while providing the full range of inpatient care in the medical/surgical benefit, then the plan will be in violation of the Act.

Notice to Beneficiaries

Individuals with mental health and addictive disorders often have difficulty finding in-network providers. As such, NAMI believes plans should provide beneficiaries with a 60-day notice in advance of a change in their benefits so that individuals with MH/SUD conditions can make necessary arrangements to find new providers.

Establishment of a Consumer Advocate Office

Given that 150 million individuals are covered under ERISA and 27 million individuals are covered by Medicaid managed care plans, a single individual at the Department of Labor and the Department of Health and Human Services to assist consumers with questions regarding new benefits and rights under MHPAEA is unworkable. A new Consumer Advocate Office at each Agency should be directed to assist with information about MHPAEA's new consumer rights and benefits; and to assist with appeals of adverse benefit determinations, including pre-authorization decisions and partial denials.

CONCLUSIONS

NAMI believes mental health and substance use disorder benefits under the Act encompass some level of treatment services. Although plans can limit treatment services, the statute imposes restrictions on such limitations. Specifically, these limits must be no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits covered by the plan. In addition, a plan must ensure that "there are no separate treatment limitations that are applicable only with respect to mental health

[89] *Id.*

or substance use disorders." A plan that refuses to cover a mental health or substance use disorder service that has no analog in medical/surgical may violate this section of the Act.

The text and history of this statute demonstrate that Congress did not intend to allow the use of more stringent medical management criteria for MH/SUD benefits than for medical/surgical benefits. Similarly, the text, purpose, and history of the statute demonstrate that Congress did not intend to allow medical necessity criteria for mental health and substance use disorder benefits to be more stringent than those used for medical/surgical services. The purpose and context of the Act demonstrate that similar criteria that result in a reduction in access to services violates the Act. Interpreting the statute otherwise would misconstrue the intent of Congress.

Regarding medications, if an insurance plan provides both medical/surgical and MH/SUD benefits, the Act requires the plan to cover medications that treat MH/SUD conditions in a manner that is no more restrictive than the coverage for medication for medical/surgical conditions. Allowing requirements for medications to be more restrictive for MH/SUD benefits than for medical/surgical benefits goes against the language and purpose of the statute, and is, therefore, not permitted. The Act requires no more restrictive management of drug formularies as between MH/SUD benefits and medical/surgical benefits, but it would require coverage of only one drug for each FDA clinical indication in the MH/SUD benefit if only one drug for each clinical indication is provided in the medical/surgical benefit.

As noted, the law requires that treatment limitations and financial requirements for MH/SUD benefits be no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits. The Act defines "predominant" as most common or frequent, but fails to set a bright-line rule regarding when a financial requirement or treatment limitation will be considered the most common or frequent.

Insurance companies that provide a number of health plans with multiple and very different cost benefits, cost-sharing, deductibles, and co-pays will not violate the Act because the statute applies only to a specific plan, not to a range of separate products. However, individual plans that provide benefits with multiple and different financial requirements for MH/SUD services will not meet the Act's provisions unless the requirements are no more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits.

If a plan covers every level and type of medical/surgical care for substantially all medical/surgical benefits, but only provides for certain levels or types of care for mental health or substance use disorders, NAMI believes that the plan has violated the Act's "no more restrictive" standard.

Coverage of treatment by only certain types of providers falls within the treatment limitations section of the law and is, therefore, subject to the Act's no more restrictive standard. Whether exclusion of a certain provider type violates this standard is a fact-

specific inquiry that is dependent upon the exclusion of provider types in the medical/surgical benefit.

MHPAEA requires that if a plan covers both medical/surgical benefits and MH/SUD benefits, the out-of-network requirements for MH/SUD can be no more restrictive than the out-of-network requirements for medical/surgical. Moreover, permitting fee schedules to be so low that access is reduced is inconsistent with a broad reading of the statutory text and the purpose of Congress.

MHPAEA does not preempt state laws requiring coverage or offering of mental illness treatment – whether those state laws mandate coverage of specific diagnoses or minimum coverage standards for specific services.

The Medicaid statute requires that Medicaid managed care plans must comply with the parity provisions of the Act. This conclusion is supported by both the legislative history of the Act, and the regulatory history of previous mental health laws. The policy and legislative intent behind the statute demonstrate that states should ensure parity between medical/surgical and MH/SUD benefits even in states that carve out MH/SUD benefits.

Finally, consumers should be given a 60 day notice before changes can be made to their benefit and there ought to be a Consumer Advocate Office at the Department of Health and Human Services and Department of Labor to help consumers understand and access their new benefits.

The NAMI looks forward to the timely implementation of the parity regulations and appreciates the efforts of the DoL, HHS and Treasury to promulgate regulations.

Sincerely,

Michael J. Fitzpatrick, MSW
Executive Director