

May 3, 2010

**VIA ELECTRONIC SUBMISSION**

Department of Health and Human Services  
Centers for Medicaid and Medicare Service  
U.S. Department of Health and Human Services  
P.O. Box 8016  
Baltimore, MD 21244-1850  
Attention: CMS-4140-IFC

Department of Labor  
Employee Benefits Security Administration  
Office of Health Plan Standards and Compliance Assistance  
Room N-5653, U.S. Department of Labor  
200 Constitution Ave. NW  
Washington, DC 20210  
Attention: RIN 1210-AB30

Department of the Treasury  
Internal Revenue Service  
Room 5205, IRS  
P.O. Box 7604  
Ben Franklin Station  
Washington, DC 20044  
REG-120692-09

**Re: Comments to the Interim Final Rules Implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008**

Dear Departments:

Thank you for the opportunity to submit comments regarding the interim final regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”). Please consider this a joint submission by the following Massachusetts-based organizations, each of which is dedicated to the promotion of mental health parity: Mental Health Legal Advisors Committee, Health Care For All, National Alliance on Mental Illness of Massachusetts, Health Law Advocates, Massachusetts Society for the Prevention of Cruelty to Children, and Children’s Hospital Boston.

We view the regulations as an important step forward in promoting the goals of MHPAEA to increase equity in insurance coverage and treatment for mental health and substance use disorder services. As advocates for individuals who utilize behavioral health services, our comments are informed by our extensive experience working on insurance coverage matters. In practice we have seen first-hand the disparities that can

exist in access to treatment of behavioral health conditions versus medical conditions because of unfair coverage determinations and inconsistent application of standards. Our organizations have worked in Massachusetts to advocate for, develop, pass and oversee implementation of comprehensive behavioral health parity laws and, as a result of that work, have additional insights as to how obstacles to parity in coverage may persist, despite legislative intent, unless regulations effectively implement such laws.

We share the hope of the Departments that these regulations will mitigate misapplications of MHPAEA and we seek to assist in developing regulations that enforce the enhancement of coverage created by MHPAEA as opposed to unduly restricting the statute's provisions.

### **I. Quantitative and Nonquantitative Treatment Limitations**

We greatly appreciate the inclusion of both quantitative and nonquantitative treatment limitations as a prohibited action under the regulations. Our experience in Massachusetts, where such a limitation was not included in our Parity Laws, has suggested that plans or insurers use differing and, most often, more restrictive nonquantitative treatment limitations for mental health and substance use disorder services than for similar medical and surgical services. These include, for example, more frequent reviews of medical necessity for a particular mental health service than for a comparable medical service or differing standards in evaluating requests of out-of-network treatment. In addition, mental health managed care utilization review processes are different, more restrictive, and require more one-on-one conversations to "convince" payors that patients need the particular service. In Massachusetts, we have witnessed a proliferation of the use of "carve-out" insurance providers by both public and private insurers to manage delivery of mental health and substance use disorder benefits. These "carve-outs" typically create far more rigorous standards for nonquantitative treatment limitations such as pre-admission screenings, concurrent review standards, and medical necessity standards. We believe that the use of more rigorous standards by "carve-out" insurers is prohibited under the MHPAEA regulations and encourage clarification on this issue.

We view the establishment of parity on these grounds as an important step forward in promoting improved access to mental health and substance use disorder treatment. We support the inclusion of additional examples in the regulations to further illustrate the application of MHPAEA to nonquantitative treatment limitations and additional clarification that any use of nonquantitative treatment limitations in evaluating mental health and substance use disorder benefits must be comparable and applied no more stringently than for medical/surgical benefits.

### **II. Additional Clarity as to Covered Diagnoses, Conditions and Services**

We advocate for greater clarity as to which diagnoses, conditions and services will be covered. While increasing specificity, the guidelines should require the broadest possible scope of coverage. The MHPAEA defines mental health and substance use disorder

benefits in terms of services for mental health/substance use disorder benefits “as defined under the terms of the plan and in accordance with applicable Federal and State law” and the regulations clarify that plan terms defining whether the benefits are mental health or substance use disorder benefits must be consistent with “generally recognized independent standards of current medical practice.” The ambiguity in the phrase “generally recognized independent standards of current medical practice” may permit plans to exclude coverage of conditions, services or providers that may not meet “medical” standards, but are commonly accepted conditions and treatment options within the behavioral health community. In addition, we are deeply concerned that the lack of specificity on this issue will lead to overwhelming confusion as plans develop different definitions and consumers struggle to determine whether their particular diagnosis, condition or requested service is covered under their plan. The burden on consumers to decipher coverage and compliance with parity laws will be tremendous if the regulations do not offer a more tailored/definitive approach to defining the diagnoses and conditions subject to parity. In addition, plans and insurers may narrowly define such services, thus making the goal of parity an illusion.

### **III. Scope of Services**

With respect to the “scope of services” or “continuum of care” issue identified in the preamble to the regulations, we support the idea that MHPAEA be interpreted (and clarified through the regulations) to require group health plans that offer mental health and substance use disorder benefits to provide benefits for any evidence-based treatment or treatment “which is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the [insured] that endanger life, cause suffering or pain, cause physical deformity or malformation, threaten to cause or aggravate a handicap, or result in illness or infirmity”.<sup>1</sup> We appreciate that the Departments recognize, in the preamble, that not all treatments or treatment settings for mental health conditions or substance use disorders correspond to those for medical or surgical conditions and that MHPAEA prohibits plans and insurers from imposing more restrictive treatment limitations as to mental health and substance use disorder benefits than medical and surgical benefits. MHPAEA is best interpreted to require benefits for any evidence-based treatment or treatment in accordance with the above proposed definition of covered conditions. The stated purpose of MHPAEA, described in the House Report for the Committee on Ways and Means, issued on October 15, 2007, (regarding what was then known as H.R. 1424) was to establish “true parity” and to “end the discrimination that exists under many group health plans with respect to mental health and substance-related disorder benefits”. See section (D)(A) of the Report under the PURPOSE heading. Equity in treatment requirements cannot be met without acknowledgement that “treatment” in the mental health/substance use disorder arena encompasses a variety of practices and services.<sup>2</sup>

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<sup>1</sup> This definition of treatment is taken from the definition of medical necessity used by Massachusetts’ Medicaid program. 130 CMR §450.204.

<sup>2</sup> We also submit that one frequent exclusion of health insurers relates to the provision of services for children with autism and encourage the Departments to make clear that such services are, in fact, covered

Because not all treatments or treatment settings for mental health conditions or substance use disorders correspond to those for medical or surgical conditions, parity will not exist if the comparison is that of medical or surgical treatments and settings. For example, in Massachusetts, our Parity Laws recognize a category of behavioral health services distinct from inpatient and outpatient – that of “intermediate care” settings. An example of an “intermediate care” setting is a partial hospitalization program, which is commonly used in both mental health and substance use disorder treatment. If the regulations do not make clear that services, such as partial hospitalization programs, which do not generally correspond to medical/surgical treatments or treatment settings, are required under MHPAEA, these important treatment methods and settings will potentially be excluded by plans because there is no equivalent setting in medical/surgical treatment. The MHPAEA goals of improved access to behavioral health treatment and the overturning of years of inequity in benefit coverage between behavioral health treatment and medical/surgical treatment will not be met unless it is clear that the standard for mental health and substance use disorder conditions is evidence-based treatment or treatment in accordance with the above proposed definition. MHPAEA represents a significant step forward in the achievement of parity in coverage for treatment for mental health and substance use disorder conditions, however, to not define the scope of services as proposed will result in continuing discrimination of group health plans in coverage for treatment of mental health and substance use disorder conditions.

Thank you again for the opportunity to submit comments regarding these important issues. If you have any questions or concerns, please contact Megan Mahle at Health Law Advocates by phone at (617) 275-2984 or by email at [mmahle@hla-inc.org](mailto:mmahle@hla-inc.org).

Sincerely,

Frank Laski, Executive Director  
Mental Health Legal Advisors Committee

Amy Whitcomb Slemmer, Executive Director  
Health Care For All

Laurie A. Martinelli, Executive Director  
National Alliance on Mental Illness of Massachusetts

Matt Selig, Executive Director  
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Marylou Sudders, President and CEO  
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Children's Hospital Boston