Congress of the United States
House of Representatives
Washington, D.C. 20515

May 4, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

The Honorable Hilda Solis
Secretary
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

The Honorable Timothy Geithner
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Ave, NW
Washington, DC 20220

Dear Secretaries Sebelius, Solis, and Geithner:

We are writing to ask you to clarify several important issues as you promulgate a final regulation implementing the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA). Enacted on October 3, 2008, this landmark civil rights legislation is estimated to benefit approximately 140 million Americans and ensure that those who experience mental health and substance use disorders in plans affected by the law will receive health care on par with other medical conditions.

As you know, the final Mental Health Parity Law, MHPAEA, was the result of over 10 years of Congressional deliberation. Members of Congress worked diligently to craft statutory language that satisfied key stakeholders. The final law was a ground-breaking effort intended to lead to changes in the design and operation of health plans in order to end a century of stigma and second class treatment toward mental health and substance use disorders.

The Departments are to be commended for issuing timely and clear rules requiring covered health plans to comply with the MHPAEA. In particular, we are pleased that the Departments' rules correctly prohibited health plans from maintaining separate deductibles for medical and mental health services.

We believe there are a few areas in which the interim final rules must be clarified to comply with Congressional intent and to provide meaningful benefits to eligible participants and beneficiaries.

Key issues the final regulation must address:

Parity in services: It is the intent of Congress that if a plan offers mental health and substance use disorder benefits, the plan's range and scope of services must be no more restrictive than the plan's range and scope of services for medical/surgical services. While we applaud the Departments' adoption of the six classification system for comparing medical and mental health benefits, further guidance on the classifications are needed. We have heard from many health plans that they often do not believe apples to apples comparisons can be made with regard to medical and mental health benefits within these classifications. This is exactly the type of mythology that MHPAEA was intended to end. The Departments must provide additional guidance elaborating on how the range and scope of services should be comparable in the six categories to ensure that services in MH/SU are offered in parity with medical/surgical in each classification.

Parity in out-of-network services: Similarly, MHPAEA provides that if a plan or coverage provides coverage for medical or surgical benefits by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits by comparable out-of-network providers consistent with the parity rules. The final rules should make clear that access to out-of-network services is fully subject to MHPAEA.

Mental Health Parity Act (MHPA) of 1996 Rules: The Departments' interim rule inappropriately replaces the Departments' rule on MHPA 1996. As you know MHPAEA amended MHPA 1996 and did not replace it. We did so specifically because we supported the 1996 rules and wanted the rules to serve as a starting point to be built upon or changed as required by MHPAEA or subsequent laws.

Application of "predominant and substantially all": As defined in the statute, the "predominant and substantially all" standards apply to all treatment limitations, quantitative and non-quantitative. Some health plans are interpreting the interim rules not to subject non-quantitative treatment limitations to the "predominant and substantially all" standard. This is not correct under the law, and the final rules need to make clear that the statute applies "predominant and substantially all" to all treatment limits, quantitative and non-quantitative.

Medical Management – The final MHPAEA deleted all prior references to medical management. Congress specifically decided not to address medical management practices because there was no consensus on the types of medical management processes that are appropriate based on established medical evidence. Therefore, while the final rules are correct in establishing the principle that health plans must apply medical management practices in parity

for medical and mental health benefits, the Department should refrain from approving or disapproving specific techniques. The final rules also should not create administrative rules that permit plans to individually create exceptions for self-determined "recognized clinically appropriate standards of care," this is beyond the scope of the law.

Availability of Plan Information: The Departments' rule did not specify the manner in which health plans must provide the criteria for medical necessity determinations and reasons for any denial to plan participants. As the Departments well know, this has long been an area of abuse by health plans. The final rule should make clear that health plans must provide all relevant health plan documents to participants and beneficiaries no later than 30 days after a request (earlier for emergencies) at least equal to the Department of Labor's rules for claims procedures. Further, health plans must provide information sufficient for a participant or beneficiary to determine if the plan is applying the medical necessity criteria and other factors similarly for medical and mental health benefits.

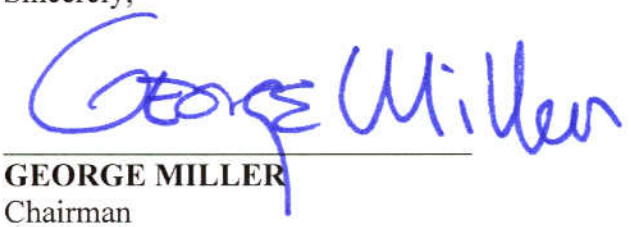
Medicaid Managed Care Plans: The regulations should clarify that Medicaid managed care plans are currently subject to MHPAEA and the Interim Final Regulations. This is consistent with the law and Congressional intent.

Protection of stronger state laws: The final regulations should clearly reflect that the HIPAA preemption rule applies to MHPAEA. Thus, there is no preemption of state laws that do not prevent the applicability of MHPAEA. States and health plans need clear guidance apprising them of the applicability of stronger state laws that provide mental health parity protections.

Finally, the above comments illustrate the complexity of the issues surrounding MHPAEA and the current wide lack of awareness of the new law by health plans and participants. The law requires the Department of Labor to provide assistance to stakeholders to help them understand and comply with the law. We look forward to continuing to be kept abreast of plans to educate the public, health plans and states on their rights and obligations under the new law.

We look forward to continuing to work with you on increasing access to equitable mental health services for the millions of Americans who need them.

Sincerely,



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