California Association of Social Rehabilitation Agencies

P.O. Box 388, 815 Marina Vista
Martinez, CA 94553
925-229-2300
www.casra.org

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Department of Labor
Employee Benefits Security Administration
Room N-5653
200 Constitution Avenue, NW
Washington, DC 20210

RE: Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equality Act of 2008 (Public Law 110-343)

To Whom It May Concern:

On behalf of the California Association of Social Rehabilitation Agencies (CASRA), I want to thank you for the opportunity to express our views about the Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equality Act of 2008 (the "Act"). CASRA is a state-wide association of not-for-profit, community-based organizations dedicated to promoting and strengthening community-oriented rehabilitation services that support recovery from the disabling effects of serious mental illness.

For over thirty years, CASRA member organizations have provided an array of community-based, rehabilitation and recovery-oriented services to persons experiencing significant behavioral health symptoms. Based upon the collective experience of our members, we offer the following comments.

Our first over-arching observation and concern is that the private insurance sector has severely limited experience with services based upon psychosocial rehabilitation goals, values and principles. Most private insurers only cover hospital-based acute care and traditional outpatient services. If day services are allowed, they are not rehabilitation oriented but, rather, day treatment programs focused exclusively on symptom alleviation. In order for services to be truly equitable, insurers must expand coverage for an array of rehabilitation programs, including both facility-based and in-home services.

Our second observation is that the private sector does not promote the use of alternatives to hospitalization and other institutional 24-hour care settings. Specifically, crisis residential treatment programs provide comparable, if not better, outcomes than hospital-based acute care,

at ⅓ to ½ the cost ($300 per day v. $1000 per day). This is important in the context of calculating cost exemptions. Benefit packages that utilize such alternatives will be significantly less expensive than the traditional hospital-based benefit.

In addition the above general observations, CASRA has identified specific responses to the request for information surrounding Public Law 110-343:

1. Treatment Limitation:

A. Coverage of Mental Health Illness Diagnoses: Regulation must be created specifying which diagnoses from the Diagnostic and Statistical Manual of Mental Disorders ("DSM") will be mandatorily covered under the Act. It is our interpretation of the Act that all diagnoses under the DSM will be covered. If this coverage is left open to interpretation, there will be extreme disparity from plan to plan, as well as state to state. Consumers, enrollees, and employers must be able to understand what mental health diagnoses will be part of their coverage.

Many state health care plans and insurers currently have "treatment limitations" based upon their respective parity law, which officially mandates treatment of only ten diagnoses in the DSM. Plans and insurers *may* reimburse for treatment above and beyond the statutorily mandated ten diagnoses. The problem with this open ended ability of plans and insurers to cherry pick the diagnoses which they cover is that the variance is immense and there is no consistency. Consumers, enrollees, and employers are left to self-educate on the treatment limitations of their coverage. Putting forward clear language in regulation as to which diagnoses fall under the Act's treatment limitations is absolutely necessary.

B. Utilization Review: Health care plans and insurers have "utilization review" policies to assess treatment limitations on individual enrollees. Generally speaking, mental health and substance use treatments are placed under heavier scrutiny than medical/surgical treatments. Unfortunately, in practice, some insurers/plans will place a limit on the number of mental health visits when none exist in the contract. Clear language must be included in regulation as to the plan's/insurer's responsibility to adhere to the Act and not place treatment limitations on their enrollees' access to medically necessary mental health or substance abuse treatment.

2. Term Clarification:

A. Mental Health Illness and Substance Abuse Disorder: Regulation must clarify that the purpose of the Act is to serve both those suffering from mental health illnesses and substance abuse disorders. All three amendment sections: (a)-ERISA, (b)-Public Health Service Act, and (c)-IRS Code at sub-section (3) state:

> (3) Financial Requirements and Treatment Limitations.
> (A) IN GENERAL—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and,
(ii) 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 (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

Although the legislative intent behind the bill is to serve both those suffering from mental illness and substance abuse disorders, the way the language is currently written is open to interpretation by health care plans and insurers, as well as each individual state. Our recommendation is to clarify, through regulation, that Public Law 110-343 is to cover both mental health illness and substance abuse disorders, not either.

B. Preliminary Diagnosis: Through regulation, it must be clear that the initial mental health provider's diagnosis, the preliminary diagnosis, stands until another mental health provider declares otherwise. Plans and/or insurers routinely, and inappropriately, void the initial provider's preliminary diagnosis without provider input (knocking the patient out of parity coverage.) Clarity needs to be given that the preliminary provider's diagnosis stands until another provider amends that diagnosis (not the plan or insurer.)

C. DSM-Scope of Mental Illness: Clarification within regulation that the entire DSM is covered by the Act is essential. See prior discussion under "Treatment Limitation" heading.

3. Medical Necessity:

Currently, each plan and insurer creates its own medical necessity criteria. For obvious reasons this creates a lack of consistency, as well as a lack of clarity. It is imperative that there be a federal model put forward defining "medical necessity" so that the provider, the enrollee, and the consumer can all comprehend whether "medical necessity" applies to their mental health or substance abuse situation. In putting forward a model, it is crucial that the definition be created and vetted by all stakeholders, including mental health providers and consumers in addition to health care plans and insurers.

Moreover, medical necessity criteria is not generally made readily available to the enrollee, but only to the providers. Putting forth regulation encouraging transparency as to medical necessity criteria would be beneficial to the enrollee and consumer.

Lastly, creating an independent medical review system ("IMRS") to evaluate contested denials of treatment based on "medical necessity" would protect the patient from inappropriate or unlawful plan or insurer denials of coverage based on medical necessity. Sample IMRS

guidelines and principals can be further reviewed at California Health and Safety Code section 1374.30.

4. Denial of Reimbursement or Payment:

Providing to the patient, and the health care practitioner, the reasoning behind a denial of reimbursement or payment is essential in protecting a patient's right to treatment. In California for example, throughout the California Health & Safety Code and Insurance Code, language is utilized to mandate clear reasoning behind plan or insurer decision making. We would suggest mimicking this language in federal regulation such as: *If reimbursement or payment is denied by the health care plan/insurer, the decision shall be in writing, and shall include a clear and concise explanation of the reasons for the decision.*

5. Out-of-Network Coverage:

Allowing the patient to receive services out-of-network is often necessary based on exigent circumstances. Putting into regulation the following concepts protects the patient, while not creating undue hardship on the health care plan or insurer:

- For continuity of care purposes, if the patient's plan/insurance changes, allow patient to continue with their existing behavioral health care practitioner, provided that practitioner is willing to accept the new health care plan/insurer's rate of reimbursement;
- To assure timely access to care, if an in-network provider is not available to a patient within a timely manner, the plan/insurer shall reimburse the out-of-network practitioner;
- To assure timely access to care, if an in-network provider is not available to a patient within their geographic area within a timely manner, the plan/insurer shall reimburse the out-of-network practitioner;
- A definition of "timely access to care" needs to be developed and vetted by stakeholders including mental health providers and consumers, as well as health care plans and insurers; and,
- Plan/insurer to reimburse for any reasonable costs associated with urgent care or emergency services, or other extraordinary and compelling health care services, when the patient's decision to secure those services outside of the plan network was reasonable under the urgent or emergency circumstances;

6. Cost Exemptions:

Model notices would be helpful in facilitating disclosure to agencies, enrollees and beneficiaries regarding the plan or insurer's election to implement the cost exemption. In addition, regulation should be adopted mandating that the plan or insurer notify the enrollees and beneficiaries before they elect to take the cost exemption so that those directly affected by the exemption have the ability to select other coverage that includes their given diagnoses. Additionally, regulation should mandate strict enforcement of plan/insurer reapplication for cost-exemption so that plans/insurers cannot continue with exemption without cause. Lastly, whatever evidence a plan/insurer utilizes to support an application for exemption should be transparent to the consumer so that advocacy groups may appeal or rebut a flawed application.

In our earlier remarks, we noted the implications of plans that utilized alternatives to hospital and other institutional-based 24-hour care. The cost implications are obvious but it should also be noted that among all the research studies on alternatives to hospital-based acute care, there is no case where the outcomes of hospitalization were more positive than alternative treatment.

Thank you for your attention to this matter and please let us know if we can provide you any additional information.

Sincerely yours,

Betty Dahlquist

Betty Dahlquist, MSW, CPRP
Executive Director