



June 17, 2020

Jolie H. Matthews  
Senior Health and Life Policy Counsel  
National Association of Insurance Commissioners (NAIC)  
Executive Office  
444 North Capitol St, NW  
Hall of the States, Suite 700  
Washington, DC 20001

Dear Ms. Matthews:

The Parity Implementation Coalition (PIC) is pleased to submit these comments to support the *Mental Health Parity and Addiction Equity Act* (MHPAEA) (B) Working Group Quantitative Treatment Limit/Financial Requirement [Template](#) and [Instructions](#). The template and its accompanying instructions will assist with determining a health plan's compliance with benefit classification requirements and Quantitative Treatment Limit (QTL) testing outcomes that MHPAEA requires.

The PIC is also writing to support the MHPAEA (B) Working Group's [MHPAEA Assumptions](#) document. We strongly agree that MHPAEA is "about addressing discriminatory differences in how plans/issuers apply limitations to MH/SUD benefits," that parity requires comparability analyses and that such analyses must be completed at inception and on an ongoing basis, per Department of Labor (DOL) sub-regulatory guidance.

The PIC is an alliance of mental health and substance use disorder consumer and provider organizations. Members include the Depression and Bipolar Support Alliance, Mental Health America, National Association for Behavioral Healthcare, National Alliance on Mental Illness, National Association of Addiction Treatment Providers, and Young People in Recovery. In an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders, many of these organizations have advocated for more than two decades to support the passage of parity legislation, issuance of regulations and enforcement of both.

### **History**

MHPAEA was enacted to ensure "parity," or fairness between mental health and/or substance use disorder (MH/SUD) benefits and medical/surgical benefits that a health plan covers. As enacted in 2008, MHPAEA did not require a plan to offer MH/SUD benefits, but if the plan does so, it must offer the benefits on par with the other medical/surgical benefits it covers. The statute ([P.L 110-343](#)) states that plans must 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.”*”

In 2010, The Departments of Treasury, Labor, and Health and Human Services issued Interim Final Regulations (IFR) implementing the law. In 2013, the departments issued a Final Rule (FR).

Under the IFR, “substantially all” is defined as meaning two-thirds and “predominant” is defined as meaning more than one-half of medical/surgical benefits in the same classification. In response to the IFR, the PIC [commented](#) in support of this definition of “substantially all and predominant,” stating that the definitions were “clear, logical and will help to ensure the strong parity protections envisioned by Congress.” This standard was reiterated in the Final Rule and plans are prohibited from imposing a financial requirement or quantitative treatment limitation on MH/SUD benefits that is more restrictive than the “predominant” financial requirement or quantitative treatment limit that applies to “substantially all” medical/surgical benefits in the same classification.

The IFR also prohibited plans and issuers from having cumulative requirements (such as deductibles or out-of-pocket maximums) or cumulative quantitative treatment limits (such as annual or lifetime day or visit limits) on MH/SUD that accumulate separately from the cumulative financial or quantitative treatment limits for medical/surgical in the same classification. The PIC commented in strong support of the combined deductibles included in the IFR as an “effective way to achieve parity within cumulative financial requirements.”

In 2011, DOL released sub-regulatory guidance ([FAQs about Affordable Care Act Implementation \(Part VII\) and Mental Health Parity Implementation](#)) on the co-pays that can be charged for MH/SUD versus medical/surgical services. The guidance stated, “the standard for determining the maximum copayment that can be applied to mental health/substance use disorder benefits is determined by the predominant copayment that applies to substantially all medical/surgical benefits within a classification.”

In 2012, DOL released additional sub-regulatory guidance ([FAQs for Employees about the Mental Health Parity and Addiction Equity Act](#)). In the guidance, DOL states, “A plan may not create sub-classifications for generalists and specialists to determine separate predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. However, if the predominant level of a type of financial requirement that applies to substantially all medical/surgical benefits in a classification is the one charged for a medical/surgical specialist, then that “specialist” financial requirement can be applied for all mental health or substance use disorder benefits within that classification. On the other hand, if the predominant level of a type of financial requirement that applies to substantially all medical/surgical benefits in a classification is the one charged for a medical/surgical generalist, then the financial requirement charged for all mental health or substance use disorder benefits within that classification cannot be higher than the “generalist” financial requirement for medical/surgical benefits.”

### **Ongoing Plan Non-Compliance with MHPAEA**

Unfortunately, since the issuance of the IFR and FR and subsequent sub-regulatory guidance, we have continued to receive reports from consumers and providers regarding non-compliance with the law’s requirements. One of the most common barriers reported by the patients and providers PIC members serve is lack of disclosure by health plans so that analyses on both the quantitative and non-quantitative treatment limitations can be performed to ensure MHPAEA compliance.

For example, health plans are charging MH/SUD patients a specialist co-pay, but do not disclose the analysis used to determine the “predominate” and “substantially all” co-payments within a classification. Absent the disclosure of this information, participants, beneficiaries, and authorized representatives are hard pressed to challenge that plans are not in compliance with MHPAEA. As such, we believe this template with its clear instructions is an essential tool for ensuring parity compliance.

More recently, we learned of this health plan non-compliance with MHPAEA and a complete disregard for health plans’ legal obligation to disclose certain information to its members from a provider who renders outpatient mental health services to individuals in Mississippi. Health plan members seeking medically necessary outpatient mental health care services are faced with, in some cases, an out-of-pocket expense as much as five-times greater than other medical/surgical conditions. We are aware of plans in Mississippi classifying in-network outpatient mental health professional services rendered in an “office” setting as a “specialist” provider type without disclosing the required documentation that would clearly indicate that the quantitative treatment limitation was appropriately applied to two-thirds of the medical/surgical covered benefits in the same outpatient medical/surgical provider type classification and that the health plan is in compliance with MHPAEA.

State Insurance Commissioners must exercise their authority and require health plans to disclose the information as presented in the proposed templates. Consumer health plan members, such as the individuals we have talked with in Mississippi, will continue to seek medically necessary mental health outpatient services only to be surprised with a requirement to meet their full deductible before the health plan will begin to share the cost of care with the member(s). The expense associated with stabilizing and subsequently managing individual’s mental health conditions becomes a financial burden he or she cannot bear. Higher out-of-pocket costs incurred to treat and manage mental health conditions than out-of-pocket expenses associated with the treatment and management of other medical conditions defeats one of the key underlying tenets of the law.

We also support requiring that the results from any compliance review of audits be made public. We believe making this information public allows for market corrections by making sure all plans and beneficiaries know the “rules of the road,” rather than forcing patients and providers to address each violation on a plan-by-plan basis.

In closing, the PIC endorses the template and its accompanying instructions because we believe they will improve MHPAEA compliance and enforcement. The PIC would be pleased to discuss these comments in greater detail at your convenience. Our Coalition Coordinator, Carol McDaid, may be reached at [cmcdaid@capitoldecisions.com](mailto:cmcdaid@capitoldecisions.com).

Sincerely,



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Marvin Ventrell  
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