Dear Secretary Harris and Secretary Sebelius:

The American Psychological Association Practice Organization (APAPO) is pleased to hear that the Obama Administration will finalize the regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) by the end of the year. The APAPO is an affiliate of the American Psychological Association (APA), the largest scientific and professional organization representing psychology in the United States. APA’s membership includes more than 137,000 clinicians, researchers, educators, consultants and students.

We believe that the Interim Final Rule (IFR) was a bold step forward in parity protection, particularly with the inclusion of non-quantitative treatment limitation (NQTL) provisions which finally addressed some of the most pervasive discrimination against the mentally ill, such as aggressive management of their care and reimbursement disparity. But over two years of experience with trying to enforce the IFR provisions, and fielding hundreds if not thousands of parity complaints from members, has made it clear to us that enforcement of the final parity rule could be made more effective.

The IFR appears to have been designed with the notion that federal and state agencies tasked with enforcing it would have sufficient resources to investigate the often complex question of whether mental health provisions are at parity with medical provisions of a plan, and take necessary enforcement action. The implementation of the Affordable Care Act (ACA), however, appears to have overtaxed many of these agencies with the complex responsibilities related to implementation of the ACA, leaving them with scarce resources to enforce parity.

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1 For ease of reference, we use “mental health” to refer to both mental health and substance abuse services and “medical” to refer to both medical and surgical services.
Our efforts to combat what we consider the most insidious parity violations—massive reimbursement rate cuts that target only mental health providers—taught us much about what needs to be improved in the Rule. These cuts severely curtail patient access to mental health care and/or increase costs for patients forced into out-of-network care. With this simple tactic, plans can save mental health costs while undercutting all other parity protections.

This epidemic of rate cuts started in mid-2011, not long after the IFR had gone into effect. On October 5, 2011, we filed our first rate cut/parity complaint with your Departments regarding a large rate cut by BCBS of Florida that targeted only mental health reimbursement. In April 2012, we filed our first rate cut complaint against Humana with the Illinois Department of Insurance (IL DOI). In July 2012, we filed another complaint with your Departments, having learned that the Humana cuts had spread to ten states. In September 2012, IL DOI responded to our April complaint, primarily accepting Humana’s argument that MHPAEA “does not control rates agreed upon between providers and health plans.” Six weeks later, we provided a detailed argument why the NQTL provisions of the IFR require parity in “Standards for provider admission to participate in a network, including reimbursement rates” (29 CFR Section 2590.712(c)). To date, we have had no response from IL DOI to our arguments. Subsequently, we have filed complaints about the Humana cuts with four other state insurance agencies.

While we understand that some of these complaints are being investigated, to date no agency (federal or state) has taken enforcement action on this issue. Mental health patients continue to suffer. In Georgia, for example, where Humana cut psychologists’ reimbursement almost in half, 45% of surveyed psychologists were driven out of the network, 43% reported disruption in their patients’ care and 28% reported patients dropping out of care completely.

We suggest several improvements to the final parity rule to speed and enhance enforcement:

1. Provide basic information to major parity stakeholders if parity enforcement agencies cannot act promptly. Issue: Parity stakeholders, such as APAPO, are generally very familiar with a plan’s constraints on mental health care, but typically lack access to information on the parallel constraints on medical care. In situations where the parity enforcement agencies are not able to promptly investigate legitimate parity complaints, the complaining party is left in limbo, with little ability to verify a plan’s unsupported assertions that restrictions on mental health care are at parity with medical restrictions.

Proposed Solution. One option would be a system whereby the appropriate parity agency would make a determination in 30-days:

a) Whether a major parity stakeholder such as APAPO has raised what appears to be a legitimate parity complaint, i.e., the plan is subject to parity; the facts present a viable parity complaint; and there is a significant potential patient impact; and

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2 IL DOI was very helpful to us on a different parity issue. In December 2010, responding to complaints from APAPO and the Illinois Psychological Association, it determined that it would be a parity violation for BCBS of IL to require pre-authorization for all outpatient psychotherapy. We understand, however, that IL DOI is currently seriously understaffed due to budget constraints. We also note that in its September response to our complaint, the agency did offer to consider, apparently under state law, evidence that Humana’s rate cut had impacted patient access to care.
(b) Whether the federal parity enforcement agency believes that it can conclude the investigation within 4 months.

If the agency determines that it is a legitimate complaint but does not expect to be able to complete the investigation in 4 months (or if the agency later determines that it cannot conclude the investigation within 4 months), the agency would require the plan to make available to the complaining stakeholder certain basic information relevant to the particular problem. For example, if a stakeholder presented a colorable complaint that mental health care was subject to a high co-pay that appeared to apply to very few medical services, the plan might be required to provide to the stakeholder and relevant agency: a list of what medical services are subject to the same high co-pay; the portion of medical costs those services constitute; and a detailed explanation of why they believe these co-pays are consistent with parity.

2. Streamline and clarify HHS’ secondary jurisdiction as to fully insured plans. Issue: We understand that the Department of Health & Human Services (HHS) takes the position that with respect to fully-insured plans it only has secondary jurisdiction to the primary jurisdiction of state insurance commissioners/agencies. Thus, HHS will only begin an investigation after the state agency has indicated that it will not take the complaint or that it would like HHS’ involvement. Under this arrangement, parity complainants may wait many months for a response from a busy state agency, or waste time complaining to a state agency that cannot or will not address federal parity complaints.

Proposed solutions: 1) Place a two-month limit on the time that state insurance commissioners have to initiate action on a complaint before HHS can exercise its secondary jurisdiction. 2) Provide a list of those state insurance commissioners that HHS knows have indicated that they lack statutory authority to enforce federal parity law, or are not willing to do so.

3. Reinforce that reimbursement of network mental health providers must be at parity and clarify what “comparable” means in this context.

Issue A: The IFR took an important step forward in recognizing that plans can greatly reduce access to mental health care and their mental health costs by underpaying mental health professionals relative to medical providers. Paragraph C in the list of NQTL examples is “Standards for provider admission to participate in a network, including reimbursement rates.” (29 CFR Section 2590.712(c)). Despite this clear language, we have seen Humana assert that MHPAEA “does not control rates agreed upon between providers and health plans,” as noted above.

Proposed solution: (A) Reiterate in the final rule that the NQTL provisions do require parity in reimbursement rates for network mental health professionals.

Issue B: Because we have not seen any enforcement yet on this crucial issue, we do not know how your Departments interpret “comparable” reimbursement rates for mental health services. We have heard, for example, of some plans arguing that they could be in compliance with this provision if they are simply matching their competitors’ slashed rates for mental health reimbursement while matching their competitors’ high medical reimbursement rates.

With the advent of new CPT® codes for psychotherapy in January of this year, some companies have used the new codes as an excuse for more rate cuts. Other companies have decided to not reimburse
psychologists for certain of the new codes or not to recognize the value differential between related codes – restrictions that we do not believe are applied to comparable medical codes.

Proposed solution: The Agencies could clarify that “comparable” network reimbursement is measured by factors such as:

- How the plan’s mental health and medical reimbursement rates compare to Medicare rates, e.g., does the plan reimburse mental health at 80% of Medicare rates, while reimbursing medical at 110% of Medicare?

- Reimbursement trends over time, e.g., has the plan kept mental health rates flat for fifteen years before cutting them, while medical rates have been subject to periodic inflationary increases over time and no cuts?

- Does the plan fail to reimburse some of the new mental health CPT codes that went into effect this January (or fail to recognize gradations in value between related codes, e.g., paying the same amount for a 45-minute and a 60-minute therapy session), while properly reimbursing medical CPT codes?

4. Place a floor on the disparity between management of mental health and medical services allowed under the November 2011 Department of Labor FAQ.

Issue: We are concerned that Q6 in the November 2011 Department of Labor FAQ on parity indicates that as long as a health plan uses the same criteria for selecting which services (both mental health and medical) are subject to management, it is acceptable to have a result where twice the proportion of mental health services is subject to management. In the Q6 example of a plan in compliance, 60% of mental health conditions are subject to concurrent review but only 30% of medical conditions.

What is more troubling is that the FAQ could be read as saying that a plan could develop criteria that would result in an even more disparate outcome, e.g., 90% of mental health services being managed vs. only 10% of medical services. Mental health care often involves variability, such as in treatment approaches. This allows a plan to discriminate against mental health care while being technically in compliance. It can simply pick selection criteria that weigh heavily against mental health care, resulting in far greater management of mental health care.

Proposed Solution: This potential loophole could be closed by setting a floor on how disparate the results could be from a plan’s application of the same selection criteria. For example, the floor could be that even if the plan applied the same selection factors, this cannot result in a plan managing mental health services 50% more frequently than medical services.

We would be happy to meet with the Agencies to discuss refinements to our suggestions above and/or alternative means of achieving the goal we believe you share with us – making MHPAEA more enforceable and more of a tangible benefit for mental health patients. We would hate to see plans exploiting loopholes and lack of enforcement to discriminate against mental health patients with impunity.

We know that some parity stakeholders are resorting to litigation against large insurers in an attempt to get enforcement, and APAPO may soon have to do so as well. But litigation does not provide the quick
relief to mental health patients that agency enforcement should offer. Moreover, the success of litigation may turn on legal issues that have little relation to parity compliance or the potential harm to mental health patients.

We appreciate the work that your Departments have put into developing, interpreting and implementing the IFR and upcoming final rule and we thank you for this opportunity to share our thoughts on this issue. If you have questions please contact Alan Nessman, Esq. at anessman@apa.org or Shirley Ann Higuchi, Esq. at shiguchi@apa.org. They can both be reached at (202) 336-5886.

Sincerely,

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