

**Congress of the United States**  
**Washington, DC 20515**

May 18, 2011

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

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

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

Dear Secretaries Solis, Sebelius and Geithner:

We are writing to urge you to issue final or sub-regulatory guidance on the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (MHPAEA). Allowing the law to be implemented without specific guidance on scope of service, disclosure of medical criteria, and non-quantitative treatment limitations increases the likelihood that plans will continue to offer only very limited behavioral health benefits while offering an array of medical benefits and claim compliance with MHPAEA; this was clearly not Congressional intent.

In September 2009 and May 2010, 73 House Members and Chairmen and Subcommittee Chairmen of the three committees of jurisdiction encouraged you to issue regulations clarifying Congressional intent on scope of service and medical management parity, among other issues. We remain committed to ensuring the implementation of the MHPAEA reflects the Congressional intent behind the law. We have a particular interest in the following areas:

***Scope of Services:*** Although there are differing interpretations of whether the Interim Final Regulations confer a scope of services, the preamble states that no scope of services is conferred and solicits additional comments on this issue. We continue to believe that without clear guidance on this issue, we will continue to see plans deleting all intermediate levels of behavioral health care, as well as other essential treatment and diagnostic services, while offering a full continuum of treatment levels for medical and surgical conditions.

There are many examples in the marketplace that document the current practices in place by insurers. For instance, plans are excluding residential treatment for substance use and eating disorders and applying pre-authorization requirements to mental health/addiction benefits that are not applied to medical benefits covered by the plan. We believe these examples illustrate violations of the quantitative and non-quantitative treatment limitation rules as applied to general plan design, and violate scope of services and continuum of care parity as inherently addressed in the statute and defined in the regulations.

Let us be unequivocal – while the MHPAEA was never intended to be a mandate for coverage of specific mental health conditions or addictive disorders – once a plan has chosen to provide coverage for a specific mental health or substance use disorder, the basic framework of the law is to equalize behavioral and medical benefits and end the discrimination that has for so long limited access to behavioral benefits, as compared to the medical benefits covered by plans. Plan participant and beneficiary access to a similar scope of services and continuum of care on the behavioral health side as is provided on the medical side was clearly an integral part of the MHPAEA.

Some contend that clarifying a scope of services requirement in the regulations may somehow establish a mandate for coverage of mental health conditions or substance use disorders. While the MHPAEA does not mandate that a plan provide a mental health or substance use disorder benefit, once the plan does so, the primary purpose of the MHPAEA is to ensure that such behavioral health benefits are on par with the medical/surgical benefits provided under the plan. Despite claims that equalizing the continuum of medical and behavioral health benefits will drive up costs.

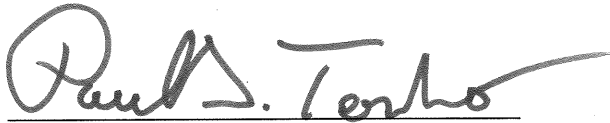
***Need for Disclosure of Medical Criteria:*** It is necessary to assess whether medical management or other forms of cost containment techniques are applied to behavioral health conditions in a manner that is comparable to and no more stringent than the medical management applied to other medical conditions. To that end, plans should be required to disclose the medical management criteria and policies used to manage medical and surgical conditions, as well as the medical criteria used to manage behavioral health conditions. Without having access to both sets of criteria, there is no ability to make the necessary comparison of the behavioral health and the medical management criteria used. We fail to see how the statute or regulations can be enforced without this information.

While we thank the Department of Labor for releasing a Frequently asked Questions (FAQ) on its website advising that plans must provide medical necessity criteria for both medical/surgical and mental health/addiction benefits, this guidance is non-binding and, to date, plans are still not complying.

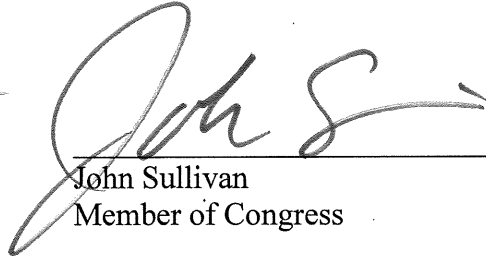
***Need for Specific Guidance on Enforcement of Non-Quantitative Treatment Limits:*** Final regulatory or sub-regulatory guidance is also needed to address how non-quantitative treatment limitations, such as discriminatory pre-authorization requirements, geographic limitations and other forms of discriminatory utilization review will be enforced. The statute and the Interim Final Regulations are very specific that treatment limitations include both quantitative and non-quantitative treatment limits. Final guidance on non-quantitative treatment limits should also clarify that inappropriate scope of services limitations are a form of limitation on treatment services. Without additional guidance on how agencies will enforce non-quantitative treatment limits, consumers and providers have no ability to know whether they will receive services or reimbursement for essential behavioral health care. To provide more certainty, the Departments of Labor and Health and Human Services should provide sub-regulatory guidance on non-quantitative treatment limitations with specific examples and an enforcement timetable so that providers and consumers will have some ability to plan for the delivery of their care in the immediate future.

We hope this helps to clarify the Congressional intent on these three important issues. We look forward to working with you to ensure that clarifying guidance is issued so all Americans can fully access the benefits promised to them under the law.

Sincerely,



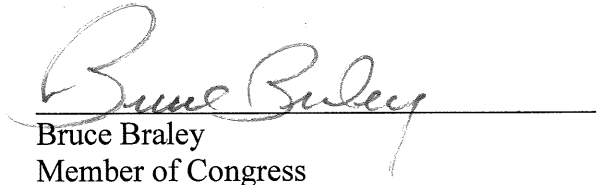
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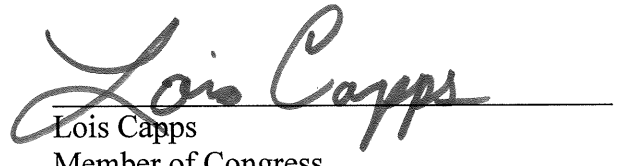
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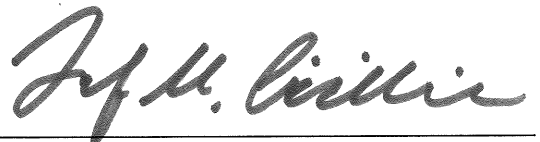
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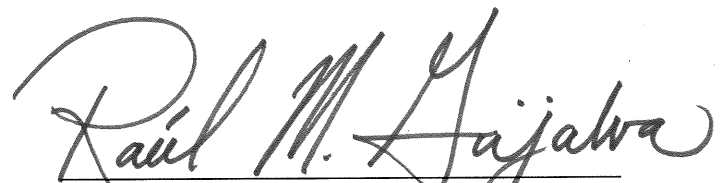
  
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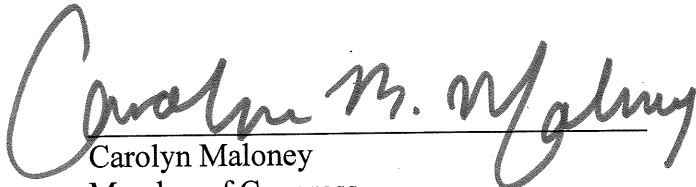
  
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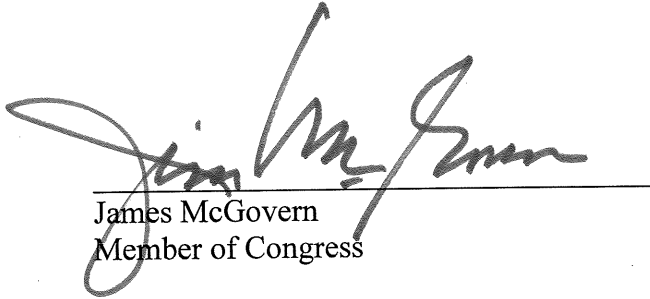
  
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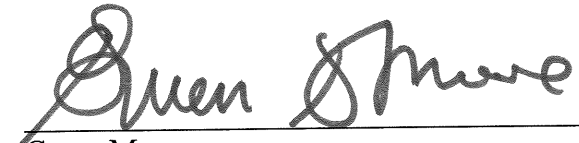
  
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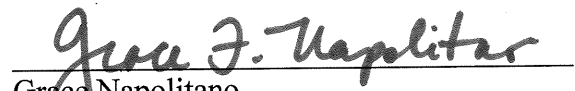
  
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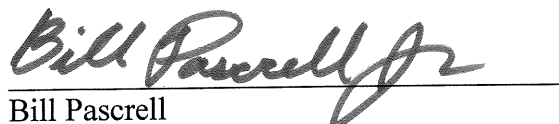
  
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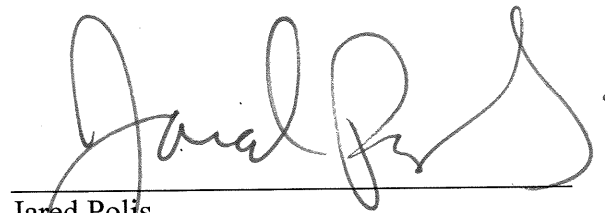
  
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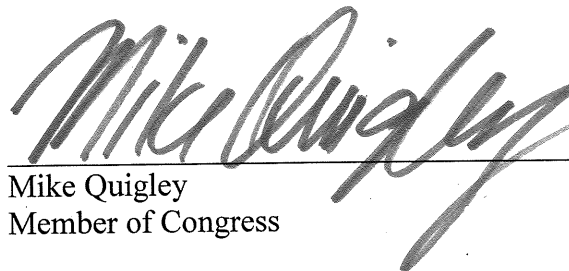
  
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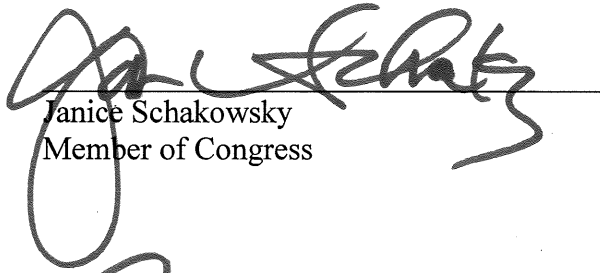
  
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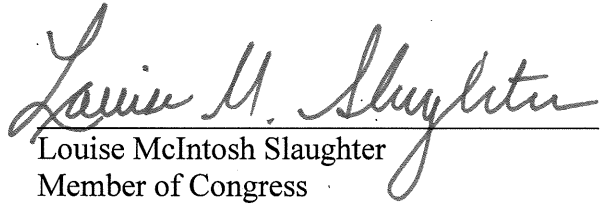
  
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Janice Schakowsky  
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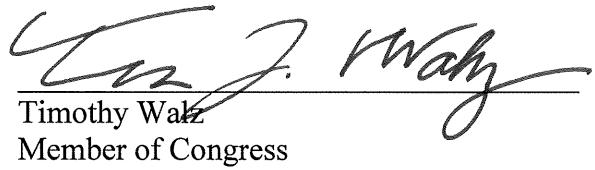
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Louise McIntosh Slaughter  
Member of Congress



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Chris Van Hollen  
Member of Congress



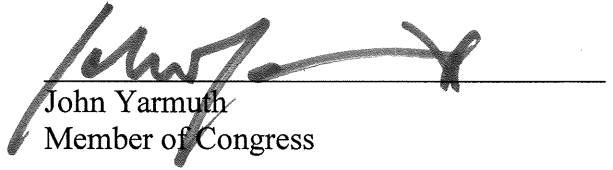
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Timothy Walz  
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