



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION  
PRACTICE ORGANIZATION

August 31, 2016

**Via Electronic Mail**

To: Mental Health and Substance Use Disorder Parity Task Force

The American Psychological Association Practice Organization (APA Practice Organization) is a companion advocacy organization to the American Psychological Association.<sup>1</sup> APA and the APA Practice Organization have worked on federal parity issues for a quarter of a century, culminating in the enactment and implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

In addition to joining in the comments submitted by the Committee for Whole Health, the APA Practice Organization is pleased to provide the following separate comments offering our unique views on ongoing parity challenges and possible solutions.

These comments follow our April 2013 and January 2014 comments on parity implementation and enforcement (attached). We submitted our earlier comments to the three federal parity agencies (HHS, Labor and Treasury, collectively the Agencies) before and after they issued the Final Parity Rule implementing MHPAEA. Many of the concerns raised in those letters continue as issues that we address here, *e.g.*, the connection between reimbursement parity and access to care, the need for prompt enforcement, and the lack of information on medical/surgical limitations.

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<sup>1</sup> APA, in Washington, D.C., is the largest scientific and professional organization representing psychology in the United States. APA's membership includes more than 117,500 researchers, educators, clinicians, consultants and students. APA works to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives. The APA Practice Organization advocates on behalf of psychologists engaged in the practice of psychology in all settings.

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We appreciate all of the hard work that the Agencies have invested in the implementation and enforcement of MHPAEA, including the refinements that went into the Final Parity Rule; guidance to consumers, plans and states; the variety of MHPAEA enforcement actions reflected in the Department of Labor’s January 2016 report to Congress;<sup>2</sup> and meeting with us periodically to discuss our parity complaints and concerns. We will discuss these issues in greater detail at our September meeting with the Agencies.

### **A. Reimbursement Disparity and Network Adequacy**

Psychologists continue to experience rate disparity, and its direct impact on network adequacy is one of the most insidious parity problems. A plan can comply with all other aspects of parity but if its reimbursement for mental health services<sup>3</sup> is too low, it reduces the number of providers in the network and constrains affordable access to care.

In 2011, several companies drastically reduced reimbursement rates, targeting only mental health professionals. While that epidemic of mental health rate cuts seems to have leveled off, many rates are still too low to ensure network adequacy. Many of our member psychologists report not receiving a cost of living increase from insurance companies in 10 or 15 years. Because of inflation, this is functionally a gradual but steep decline in reimbursement. We suspect that most comparable medical professionals, by contrast, receive regular cost of living increases.

We also continue to hear frequent reports from psychologists about desperate consumers who can’t get an appointment even after calling many mental health professionals in the network listing. In our view, this is the clearest indication of network inadequacy. These conditions force consumers to pay higher out-of-network costs; deprive them of coverage altogether if they do not have out-of-network coverage; or cause them to simply give up when the search for an available provider is too frustrating. Unfortunately, the stigma still associated with mental illness, and the debilitating effects of it, make many of these consumers reluctant to complain about difficulties in accessing care.

The coexistence of these problems is not a coincidence. We have consistently seen a direct correlation between reimbursement adequacy and network adequacy. We find that companies that pay well have good network adequacy. Conversely, companies with low reimbursement rates have inadequate networks.

It is important to note that network adequacy is a fluid concept that is often misjudged and improperly measured by insurers and enforcement agencies. For

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<sup>2</sup> <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/parityeducationreport.pdf>

<sup>3</sup> For brevity, we use the term “mental health” to refer to both mental health and substance use treatment.

example, many companies can make their networks look good on paper, yet consumers trying to access the network can't get an appointment within a reasonable time or distance. This is partly the result of not updating network information to reflect providers lost to resignation, moving, retirement or death. We believe that the real measure of access is whether a consumer needing mental health care can get an appointment within a reasonable time, at a reasonable distance, with a mental health professional suited to the patient's particular needs.

The last point is important because some companies have the unenlightened view that "a mental health professional is a mental health professional is a mental health professional." Companies with this view reimburse poorly and get what they pay for -- inadequate networks substantially composed of the least trained, least experienced mental health providers and with few of the providers in high demand who deal with specific populations and conditions, such as eating disorders, trauma, child and adolescent or elder care. A truly adequate network is able to handle the full array of complexity that the patient population presents. It offers a range of mental health professionals with varying degrees of training, specialists in a variety of areas, and professionals with appropriate language skills and cultural competencies.<sup>4</sup>

Potential solutions regarding network adequacy are listed in the Potential Solutions section at the end of this comment.

## **B. Enforcement Delays/Difficulties**

We appreciate that the January 2016 DOL report cites a large number of investigations and enforcement actions. We remain frustrated, however, that only one of the seven "rate cut/network adequacy" complaints we have brought to the Agencies over the last several years has been resolved.<sup>5</sup>

We don't fully understand what has caused the delay, but we think that solutions may lie with more funding and other resources for the Agencies' enforcement efforts, combined with greater clarity and/or a better process for federal intervention in cases where HHS has secondary jurisdiction to state agencies (for cases involving fully insured plans). The one resolved complaint was in Florida,

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<sup>4</sup> See Nov. 16, 2014 letter to the National Association of Insurance Commissioners (NAIC) from numerous stakeholders including APA. The letter proposes changes to NAIC's model act regarding health plan network adequacy.

<sup>5</sup> We note that the Agencies did help us to promptly address an access to medical necessity criteria under MHPAEA in Minnesota. This comment generally does not mention specific states because we plan to publicize these comments to our members, and have not had a chance to discuss with Agencies what information they have shared with us is appropriate to publicize. We are happy to provide those details to the Task Force if that helps its analysis.

where the state insurance agency clearly lacks authority to enforce MHPAEA, allowing HHS to handle the investigation on its own.<sup>6</sup>

By way of background, in October 2011, we filed our first such complaint with the Agencies complaining that a large rate cut by BCBS of Florida, which targeted only mental health, severely impacted access to mental health care. Humana then followed with even deeper rate cuts in various states -- as much as 50% -- that had even more dire effects on access.<sup>7</sup> Starting in April 2012, we filed six complaints with state insurance agencies and one omnibus complaint with the Agencies.

Unfortunately, four years after we filed most of those Humana complaints, we are still waiting for movement. In some states, the state agency never responded. In others, the state agency found no parity violation but did not provide a cogent explanation supporting that determination (*e.g.*, state agency simply stated that “action was not warranted” on the complaint). In still others, the state agency did not properly examine the issue (*e.g.*, looking only at network adequacy, but not reimbursement parity) and has issued no determination. At our last meeting with the Agencies early this year, they advised that there might be further investigation with respect to one of the states. But so far, none of our six Humana complaints has led to a resolution supported by a proper analysis.

As noted above, we hope that these problems might be resolved through greater resources for the Agencies’ parity enforcement activities, combined with a better/clearer process for HHS to step in where the state insurance agency has failed to act or properly evaluate the complaint.

### **C. Lack of Information re Limitations Imposed on the Medical/Surgical Care**

One of the greatest challenges we face in analyzing or bringing a parity complaint is determining what comparable limitations a company is applying to medical/surgical (med/surg) care. This is based on our experience fielding hundreds of member inquiries about potential parity issues, and from advocating on our own parity complaints.

Mental health patients, providers and stakeholder organizations often have a clear understanding of limitations a company may be imposing on mental health care that

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<sup>6</sup> When that complaint was resolved, we had a clear understanding of the factual finding and determination, although we were disappointed with the result and have a concern about a part of the analysis, which we will discuss with the Agencies.

<sup>7</sup> Humana’s cuts brought its rates to 67% and then 60% of Medicare rates for the most commonly billed mental health code, for 45-50 minutes of psychotherapy. In most complaints, we cited evidence of the rate cut’s impact on the network and patients. For example, in Illinois 57% of psychologists responding to our survey had left the Humana network and 30% more were considering leaving, 69% reported disruptions in patient care and 46% reported patients dropping out of treatment completely. Further state data is found in our attached January 2014 comments at p. 3. We collaborated on these complaints with the state psychological association in each state.

seem like parity violations. At the provider and stakeholder level, we often have a sense of whether similar constraints *seem* likely on the med/surg side, but we have little ability to determine what limitations the company is actually imposing on the vast array of med/surg services.

We believe that this information gap, combined with the unavoidable complexity of parity law,<sup>8</sup> is a key reason why more consumers, patients and providers do not assert their parity rights.

For example, a persistent parity concern is patients with serious, chronic mental illness, such as those with severe PTSD combined with severe depression. These patients and their mental health providers are often under what we call “up and out” pressure to have the patient on a short-term trajectory to get them improved and out of treatment. Those goals are not realistic for this patient population, who need long term care to just maintain their status or level of functioning, as do many patients with chronic medical conditions. But how are patients with severe PTSD and depression to know how the company’s “up and out” pressure on them compares to the pressure put on patients with comparable chronic medical conditions like diabetes, kidney disease or cancer.<sup>9</sup>

Similarly, with our Humana rate disparity/network adequacy complaints, we have determined that for the most commonly billed mental health procedure code (45-50 minutes of therapy), the company is paying as little as 60% of the Medicare rate for that code. We think it is highly unlikely that Humana is reimbursing the most commonly billed med/surg codes (“evaluation & management” office visits) that far below Medicare rates.<sup>10</sup>

Unfortunately, finding hard data to support this reasonable suspicion has proved to be virtually impossible. It is made even more challenging because we understand that a substantial portion of med/surg services are provided by large medical practices that have the bargaining power to negotiate rates well above the scheduled rates, while very few psychologists or other mental health professionals have such bargaining power. Thus, the critical comparison information – what a company is actually paying for the most common med/surg services -- can only be

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<sup>8</sup> For example, not all plans are subject to MHPAEA, there are different complex standards for NQTLs and quantitative limitations, and parity comparison are between services in the same “category.”

<sup>9</sup> It is our understanding that while MHPAEA gives consumers, subscribers and providers broad access to a company’s medical necessity criteria for mental health care, access to medical necessity for med/surg care is much narrower under ERISA. It is typically limited to criteria used to deny the particular patient’s care. But even if that broad access to med/surg medical necessity criteria were available, that might not give a clear picture of how those criteria are applied to a real cases, *e.g.*, what portion of med/surg patients are under “up and out” pressure to reduce, then terminate, care?

<sup>10</sup> Recognizing that rate disparity is an unwieldy “apples to oranges” comparison of a small group of mental health procedure codes to a vast universe of med/surg codes, we have suggested to the Agencies this simple baseline analysis: compare what percentage of Medicare rates a company reimburses for the most commonly billed mental health and med/surg codes.

found in the company's claims database, or in the confidential rate schedules that medical practices have been able to privately negotiate.

We propose potential solutions to this problem in Nos. 5 and 6 below.

### **Conclusion**

While the Agencies have made great strides in implementing and enforcing MHPAEA, we urge the Administration to take action to address the persistent problems that keep the law from reaching its full potential.

We look forward to working further with the Task Force and the Agencies. If you have questions regarding these comments or the potential solutions suggested below, please contact Alan Nessman at [ANessman@APA.org](mailto:ANessman@APA.org) or (202) 336-5886.

Sincerely,



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Executive Director for Professional Practice

### **Potential Solutions**

#### **Reimbursement disparity and network adequacy**

- 1) Assess the impacts of reimbursement disparity on patient access to care through network adequacy measures recently revised by the National Association of Insurance Commissioners and being developed in certain states.
- 2) Promote more timely resolution of parity complaints on these issues, as aided by the next two potential solutions.

#### **Timely Resolution of Parity Complaints**

- 3) Devote greater funding and resources to the Agencies' parity enforcement activities.
- 4) Develop and implement a better/clearer process for HHS to step in where the state insurance agency has failed to act or properly evaluate the complaint.

### Lack of Access to What Limits are Imposed on the Med/Surg Side

5) In our attached April 2013 comments submitted in anticipation of the Final Parity Rule at pp. 2-3, we proposed that the Agencies work with us to develop baseline information on med/surg limitations that companies would make public in response to a parity complaint that on its face appears to have potential. We reiterate here that greater transparency, which we could help the Agencies define, would allow consumers, patients, providers and stakeholders to get at least a basic sense of the fundamental parity comparisons. This transparency is particularly important where, as in the case of our Humana complaints, it takes several years for these determinations to be made by the responsible state and federal agencies.

6) Make it clear in guidance to consumers that they shouldn't be stymied by the inability to determine whether there are comparable med/surg limitations. Rather, the consumer should make the complaint and let the regulators figure this out.