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The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Comment On: CMS-2009-0040-0048
Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Document: CMS-2009-0040-DRAFT-0089
RI

Submitter Information

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General Comment

I am very supportive of most of the provisions of the interim final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. These rules address many of the inequities in health insurance coverage of mental health care when compared to medical/surgical care that I have observed in the course of my 20 years in teaching, research, and mental health practice.

However, in my opinion, two areas have not been sufficiently clarified. I am quite concerned that unless these points are more clearly specified in the final regulations, loopholes will remain that will permit widespread violation of the legislative intent of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008:

1. In my opinion, the interim final rules do not define clearly enough the rules regulating the comprehensive scope of services parity between mental health/substance abuse services and medical/surgical services. Given the language of the Act and the positions already taken by the Departments in the interim final regulations, I request that the Final Rules clarify that benefits for MH/SUD must be comparable in scope to the benefits provided in medical/surgical care both across and within each classification. Unless parity in scope of services is required in the final regulations, the intent of the Act will not be achieved.

2. I strongly support the application of parity requirements to both QTLs and NQTLs as being consistent with the Act and allowing for broad application of the parity requirement with regard to treatment limitations. However, in order to implement the intent of the Act, the regulations must specify more clearly that any NQTLs that are applied by plans must be comparable for MH/SUD and medical surgical benefits, and that any NQTLs for MH/SUD must be no more restrictive than NQTLs that are predominant across the broad range of medical/surgical benefits.

Attachments

CMS-2009-0040-DRAFT-0089.1: RI

Comments RE: Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

I am a clinical psychologist and serve on the clinical faculty in the Department of Psychiatry and Human Behavior of the Brown University School of Medicine. I have been in full time practice for more than 20 years, working with children and adults with neurodevelopmental and neuropsychiatric problems. I have published and presented on numerous topics in psychology in journals and at national and international conferences.

I am very supportive of most of the provisions of the interim final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. These rules address many of the inequities in health insurance coverage of mental health care when compared to medical/surgical care that I have observed in over **[your number of years]** 20 years of mental health practice.

However, in my opinion, two areas have not been sufficiently clarified. I am quite concerned that unless these points are more clearly specified in the final regulations, loopholes will remain that will permit widespread violation of the legislative intent of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008:

1. In my opinion, the interim final rules do not define clearly enough the rules regulating the comprehensive scope of services parity between mental health/substance abuse services and medical/surgical services. Given the language of the Act and the positions already taken by the Departments in the interim final regulations, I request that the Final Rules clarify that benefits for MH/SUD must be comparable in scope to the benefits provided in medical/surgical care both across and within each classification. Unless parity in scope of services is required in the final regulations, the intent of the Act will not be achieved.
2. I strongly support the application of parity requirements to both QTLs and NQTLs as being consistent with the Act and allowing for broad application of the parity requirement with regard to treatment limitations. However, in order to implement the intent of the Act, the regulations must specify more clearly that any NQTLs that are applied by plans must be comparable for MH/SUD and medical surgical benefits, and that any NQTLs for MH/SUD must be no more restrictive than NQTLs that are predominant across the broad range of medical/surgical benefits.

The importance of the question of parity of scientific review criteria is well illustrated by experience with EEG biofeedback for the treatment of ADHD. There is a substantial body of research demonstrating the efficacy of this form of treatment. Fifteen studies have been published and were recently included in a meta-analysis. This includes 10 prospective controlled studies with credible active controls involving 476 subjects. These studies showed a large effect size for inattention and impulsivity and a moderate effect size for hyperactivity. These effect sizes are equivalent to those shown for stimulant medication. Four prospective pre/post studies have been published involving 120 subjects, showing larger effect sizes. Predicted neurophysiological change has been demonstrated using fMRI, qEEG, and event related potentials. Several studies have shown that the degree of improvement in brain function and symptoms is positively correlated with the degree to which EEG change is shown during training sessions. Several long term follow-up studies (3 and 6 months, and 1, 2, and 3 years after the training ended) have been completed indicating that the improvement observed in these studies endures. However, despite this substantial body of research, EEG biofeedback is not covered by most health insurers due to claims that there is insufficient scientific evidence.

These same insurers however cover many medical surgical services with far inferior scientific support. Much more stringent and restrictive criteria are employed in scientific review of mental health and substance abuse treatments than are met for the preponderance of medical surgical treatment. The result is an egregious violation of the principles of parity and equality.

To give just one of many possible examples: The Journal of the American Medical Association (JAMA) recently published a review of the evidence base supporting the joint cardiovascular practice guidelines of the American College of Cardiology (ACC) and the American Heart Association (AHA). (Tricoci P, Allen J, Kramer J, Califf R, Smith S (2008) Scientific Evidence Underlying the ACC/AHA Clinical Practice Guidelines, JAMA, February 25, 2009—Vol 301, No.8)

In this review, the 16 current practice guidelines that reported levels of scientific evidence were reviewed and the degree of scientific support for 2711 specific practice recommendations was assessed and paced into one of three categories:

- Level of evidence A: recommendation based on evidence from multiple randomized trials or metaanalyses
- Level of evidence B: recommendation based on evidence from a single randomized trial or nonrandomized studies
- Level of evidence C: recommendation based on expert opinion, case studies, or standards of care.

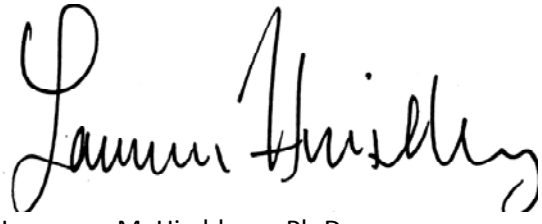
The results show that only 11% of the 2711 recommendations are based on level of evidence A – multiple randomized trials. Of the remaining recommendations, 41% are based on level of evidence B – a single randomized trial or non-randomized studies, and 48% are based on level C – expert opinion or case studies.

This makes it clear that at least in cardiology, the actual scientific review criteria currently in use in the predominant body of medical surgical practice, at least in cardiology, are less restrictive than those routinely employed for scientific review of mental health and substance abuse treatment and include anecdotal evidence (expert opinion), case studies, non-randomized studies, or a single randomized trial. Specifically, health insurers routinely limit reimbursement of EEG biofeedback as lacking scientific evidence, despite the fact that there is stronger evidence than for many covered services in cardiology.

For this reason, it is critically important, in order to implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, that the regulations specify more clearly that any NQTLs that are applied by plans must be comparable for MH/SUD and medical surgical benefits, and that any NQTLs for MH/SUD must be no more restrictive than NQTLs that are predominant for all medical/surgical benefits.

Thank you for your careful consideration of these requests.

Sincerely,



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