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May 3, 2010

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RE: Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (published in 75 Fed. Reg. 5410 et seq.)

Joan Erney, J.D.
At-Large Member
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RIN 1210-AB30

Via Email: E-OHPSCA.EBSA@dol.gov

North-Eastern Regional
Representative

To the Departments:

Laura Nelson, M.D.
Western Regional
Representative
Arizona

The National Association of State Mental Health Program Directors (NASMHPD) appreciates the opportunity to comment of the interim final rule (“IFR”) for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), as published in the February 2, 2010 Federal Register. NASMHPD, representing the mental health authorities in the 50 states, 4 territories and the District of Columbia, strongly supported the passage of the parity law and believes these regulations adhere to both the letter and spirit of the law. We also believe the process of issuing a request for information and an IFR provided sufficient opportunity for public comment and was in the public interest.

Terri White, M.S.W.
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Katharine Lyon, Ph.D.
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Robert W. Glover, Ph.D.
Executive Director
NASMHPD

The \$34 billion public mental health system serves over 6 million people annually. Most of these individuals are adults with serious mental illness or children with serious emotional disturbances. A tragic reality for many individuals in the public mental health system is a dramatically shortened lifespan due in large part to preventable, chronic conditions. The implementation of the parity law has the potential to foster early intervention and mitigate the worse effects of serious mental illness, increasing the opportunity for healthy and productive lives for many. As stated in the regulation, providing coverage for mental health and substance use disorders will mean more people obtain the care they need and fewer will exhaust benefits and resort to the public sector for services.

Prohibition against separate deductibles or other cumulative financial requirements

We applaud the departments for their choice to require combined deductibles, out-of-pocket maximums or other cumulative financial requirements on mental health and substance use disorder benefits. A prohibition against separate deductibles will greatly improve access to mental health and substance use services and will remove barriers to receiving quality care in the most appropriate setting. A combined deductible requirement is consistent with the goal of the parity law to end discriminatory practices that negatively impact people who need both general healthcare and mental health and/or substance use disorder services. This policy advances comprehensive healthcare that includes mental health and substance use disorder (MH and SUD) services.

Parity standard that ensures non-discrimination in mental health and substance use benefits

NASMHPD believes that the classifications of benefits (inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency care and prescription drug coverage) in which parity is applied are clear and inclusive and the requirement that parity applies in all classifications is correct and workable. We also support the prohibition on creating additional and separate classifications where parity would not apply.

We concur with the definition of nonquantitative treatment limitations and the requirement that a range of services cannot be applied more restrictively or more stringently to MH/SUD than medical/surgical. While the preamble states that scope of services is not addressed in the rule, the application of nonquantitative treatment limitations requires comparability between MH/SUD benefits and medical/surgical. Nevertheless, we request clarification on the application of the MHPAEA to scope of services beyond the requirement of parity for nonquantitative treatment limitations.

We encourage the departments to provide additional examples to illustrate the application of the nonquantitative treatment limitation rule to other features of medical management or general plan design. We are concerned that a strict application of a “medical necessity” standard will result in coverage denials for mental health and substance use disorder benefits that are effective. Reliance on “recognized clinically appropriate standards of care” as described in the regulation is preferable to a “medical necessity” standard that could result in inappropriate coverage denials.

The regulation permits one exception to the requirement that nonquantitative treatment limitations be comparable and applied no more stringently and that is when “recognized clinically appropriate standards of care” permit a difference. There must be adequate requirements for determining when a standard is recognized as clinically appropriate. The process must not be an internal process involving a plan’s own consultants and employees but must include external verification and the involvement by consumers, stakeholders, experts, and

national and local organizations. A standard for determining whether a treatment is experimental, for example, would not be acceptable if it required controlled clinical trials for mental health and substance use disorders but allowed consensus panels for medical/surgical treatments.

As the health care system retools to pay for outcomes, the benefit packages for both medical/surgical and MH/SUD are likely to include a broader array of services to promote health and recovery. Such services could include case management, habilitation, illness self-management and supportive services related to education, employment, and housing. As a basic level of wellness and preventive services are provided on the medical/surgical side, it will be important to develop and cover the behavioral health equivalents to vaccinations and inoculations.

Categorizing mental health providers as specialists

We urge the departments to address in the regulation itself the classification of mental health providers as specialists for the purpose of determining co-pay levels. It is especially important for the copayment for outpatient psychotherapy visits to be comparable to co-pays for visits to primary care physicians. Otherwise, many individuals will forego services and seek services from less appropriate (and possibly more expensive) providers and outcomes will suffer.

Provider Networks

NASMHPD strongly supports the development of standards to ensure the adequacy of providers in the networks. As the demand for services increases as more people obtain insurance coverage under health reform, it will be important to monitor whether networks for both primary and specialty care are adequate to meet the demand.

Formulary Design

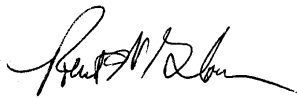
The regulations state that a plan satisfies the parity requirement if it applies different levels of financial requirements to different tiers of benefits based on reasonable factors such as cost, efficacy and generic vs. brand and “without regard to whether a drug is generally prescribed with respect to medical/surgical or with respect to mental health or substance use disorder benefits...” It is important that cost not be the exclusive criteria in coverage determinations. There is some evidence that the coverage standards for brand name drugs for certain mental health and substance use disorders are more stringent than on the medical/surgical side. The regulations should specify that brand name drugs should be available if there is not a comparable generic drug available.

Conclusion

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As parity is implemented, it will be important for the departments to carefully monitor how many plans drop mental health and substance use disorder benefits rather than comply with parity requirements and whether plans exempt coverage for specific conditions or disorders (e.g., schizophrenia). It also will be important to assess the impact of covering mental health and substance use disorders on overall medical costs. NASMHPD appreciates the departments' efforts to date to realize the promise of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Robert W. Glover". The signature is fluid and cursive, with a long horizontal stroke at the end.

Robert W. Glover, PhD
Executive Director
National Association of State Mental Health Program Directors