NAADAC
THE ASSOCIATION FOR
ADDICTION PROFESSIONALS

1001 N. Fairfax Street, Suite 201, Alexandria, VA 22314
703/741-7686 800/548-0497 • FAX: 703/741-7698 800/377-1136
World Wide Web: www.naadac.org

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May 3, 2010

Department of Labor
Employee Benefits Security Administration

Department of Health and Human Services
Centers for Medicare & Medicaid

Department of the Treasury
Internal Revenue Service

Re: Request for Comment on Interim Final Rules for the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008

Dear Secretaries Solis, Sebelius and Geithner:

On behalf of NAADAC, the Association for Addiction Professionals, we thank you for the opportunity to submit comments in response to the Interim Final Rules (IFR) for the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

With nearly 10,000 members, NAADAC is the primary professional association for addiction-focused counselors, nurses, educators and other health professionals. We have affiliate organizations in 48 states and several territories and foreign countries. NAADAC's mission is to lead, unify and empower addiction focused professionals to achieve excellence through education, advocacy, knowledge, standards of practice, ethics, professional development and research.

We applaud the Departments for issuing an IFR that is consistent with the legislative intent of the MHPAEA. The goal of the MHPAEA is clear: ensure that health plans provide mental health and substance use disorder (MH/SUD) benefits that are at "parity" and provide "equity" with the medical/surgical benefits offered by the plan. The MHPAEA was passed in response to the long-standing discrimination by health plans against people with MH/SUD conditions, despite the overwhelming scientific consensus that MH/SUD conditions can be treated effectively.

This discrimination has not only had devastating consequences for individuals and families—even those with insurance—affected by mental health conditions or substance use disorders. It has also exacerbated public policy challenges, including the significant social costs resulting from an under-provision of MH/SUD treatment (addiction alone is estimated to cost governments at the local, state and federal level over $460 billion each year, according to a 2009

estimate by the National Center on Addiction and Substance Abuse at Columbia University) and a cost-shift from private insurance plans to public systems. Over half of addiction treatment services are funded by public sources *other than* Medicare and Medicaid (compared to just over 10 percent for health spending as a whole), and private health plans only pay for between 10 and 20 percent of addiction treatment.

Given this treatment funding landscape, we are grateful that the IFR so thoroughly seeks to create "parity" and "equity" for MH/SUD benefits, both as plans are written and how they are put into practice.

Please accept our following comments:

I. Non-Quantitative Treatment Limitations

NAADAC applauds the IFR for recognizing that "treatment limitations," which are expressly discussed in the MHPAEA legislation, include a broader range of practices than merely caps on total treatment limits or restrictions on the frequency of visits. There are a broad range of treatment limitations that cannot be expressed numerically yet severely restrict plan participants' ability to receive mental health and substance use disorder benefits at parity with medical benefits. These non-quantitative treatment limitations, including unequal applications of "fail-first" requirements, utilization management standards, prior authorization requirements and the arbitrary classification of certain treatments as experimental, are frequently applied unequally to mental health and addiction treatment benefits. To ensure parity in benefits by requiring parity in treatment limitations, as well as to comply with the clear intent of the MHPAEA (i.e. to prohibit health plans from offering more restrictive mental health and substance use disorder benefits than those offered for medical benefits), it is essential that non-quantitative treatment limitations remain included in the Final Rule. To require parity merely "on paper" (i.e. in a benefit plan), which is then wholly undermined by benefits management practices that are different from or more stringent than those applied to medical/surgical benefits, is not real parity.

II. Medicaid Managed Care Plans

We urge the Centers for Medicaid and Medicare Services (CMS) to issue guidance that confirms that Medicaid managed care plans must abide by the IFR. Since there is no ambiguity about whether Medicaid managed care plans are covered under the MHPAEA, they should follow the IFR as issued. There is nothing about Medicaid managed care plans that would justify using a different parity standard for those plans than the one applied to other health plans. The Final Rule should give specific instruction on when and how Medicaid managed care plans should apply the provisions of the IFR.

III. Scope of Services

The IFR says that it does not aim to address a scope of services that must be provided in order for a health plan to comply with the MHPAEA. Yet the IFR also discusses in detail the fact that plans must provide parity with respect to non-quantitative treatment limitations: It seems clear that *certain* practices related to scopes of service meet the non-quantitative treatment limitations

standards addressed in the IFR. For example, it seems highly unlikely that a plan should be able to reduce all of its MH/SUD benefits to a single level or type of treatment (only primary care physician visits, for example) and still comply with the MHPAEA. This kind of arbitrary exclusion of entire classes of services goes against the clear intent of the MHPAEA and IFR.

The IFR says that non-quantitative treatment limitations for MH/SUDs must be comparable (both as-written and in practice) to those used to limit medical/surgical care. When comparing the extent of services offered, it is clear that there is not always *precise* correlation between the kinds of services most commonly used for medical/surgical conditions and those used for MH/SUDs; this should not be surprising, since it is the very fact that led to separate benefit packages for MH/SUDs in the first place. Therefore, the MHPAEA cannot reasonably be interpreted to say that parity need only be provided when there is an exact correlation between a medical/surgical service and a MH/SUD one.

Several common and evidence-based services for SUDs—including detoxification, residential treatment, and intensive outpatient services—may not have precise analogues in a package of medical/surgical benefits. Nevertheless, they are not so different from common medical/surgical services that reasonable analogues can be found and used as points of comparison. If a given level of care is provided in a plan's medical/surgical package, then its analogue should be included in the MH/SUD package as well (unless there is compelling clinical or research-based evidence to justify its exclusion).

In any circumstance, parity is at risk of being rendered hollow if plans are arbitrarily allowed to exclude standard, evidence-based levels of care for MH/SUDs that they cover for medical/surgical conditions. Now that parity has tied MH/SUD and medical/surgical benefits together, it makes no more sense to exclude a level of care for MH/SUD because it does not have an exact analogue in the medical/surgical package than it would to exclude a level of care for medical/surgical because it did not have an exact analogue in the MH/SUD package.

IV. Six classifications of benefits

There is no question that the six classifications of benefits outlined in the IFR—inpatient, in-network; inpatient, out-of-network; outpatient, out-of-network; pharmacy; and emergency care—are intended to be fully comprehensive. Therefore, there can be no benefits offered outside of these six classifications (and thereby evade the parity requirements). We request that this conclusion be stated explicitly in the IFR.

V. Information Sharing

The IFR's requirement that reasons for denial must be disclosed to beneficiaries provides a vital tool for ensuring that parity is being properly put into practice. It would be helpful to include more information outlining the requirements that must be met (for example, the time limit plans have to issue a reason for denials).

VI. State Preemption

The MHPAEA specifically protects the rights of states to enforce MH/SUD parity laws that are "stronger" than the federal legislation. A re-statement of this fact in the Final Rule would aid state legislators and insurance commissioners as they seek to enforce state parity laws.

VII. Defining MH/SUDs

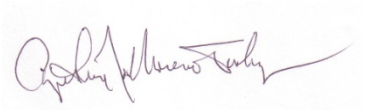
The IFR leaves insurance plans the option to choose what set of conditions will qualify as a MH/SUD according to the plan. At the same time, health plans should not be able to choose only a small, arbitrary list of MH/SUD to cover. The set of conditions included under the category of MH/SUD benefits should reflect an independent, clinically-based or state-regulated guideline. For a health plan to say that it will only consider, for example, depression as its MH/SUD offering is to subvert the clear intent of the MHPAEA. While the MHPAEA and IFR are clear that a plan need not provide MH/SUD benefits, but if they do provide such benefits they must meet the parity standards outlined in the IFR. To adopt arbitrary standards apart from independent, widely recognized clinical categories would subvert the aims of the MHPAEA. It would create an unequal—and insurmountable—treatment limitation that applies to MH/SUDs that does not apply to medical/surgical benefits.

VIII. Single Deductible

We agree with the IFR that it is more consistent with the MHPAEA's intent to apply a single deductible for all medical/surgical and MH/SUD benefits than to have two separate deductibles, even if they are equal. In the specific context of deductibles, it is more in keeping with the goal of providing inclusive, equivalent MH/SUD benefits to require a single deductible than two "separate but equal" ones.

Thank you for the opportunity to share our comments, and do not hesitate to contact us if we can be of further assistance.

Sincerely,



Cynthia Moreno Tuohy, NCAC II, CCDC III
Executive Director