May 27, 2009

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
Attention: MHPAEA Comments

Re: Mental Health Parity and Addiction Act of 2008 (MHPAEA)

To Whom It May Concern:

The New Jersey Association of Mental Health Agencies (NJAMHA) is grateful for the opportunity to submit comments for your consideration in advance of the issuance of rules and regulations related to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

NJAMHA is a statewide association of 125 nonprofit community behavioral health providers. Annually, these organizations collectively serve an estimated 400,000 adults and children with serious mental illnesses and serious behavioral disorders.

NJAMHA has long advocated for the passage of federal legislation that would assure parity between physical and mental health coverage for plans that cover both. NJAMHA is optimistic that the MHPAEA will address the dire economic and social consequences of untreated mental illness.

An estimated 25 percent of Americans –one in four adults – suffer from a diagnosable mental illness in any given year, or close to 60 million adults on a nationwide basis. Untreated mental illness significantly reduces productivity in the workforce and materially drives up health care costs.

Studies have shown that recovery from mental illness is possible with treatment and support. However, for far too many people with limited mental health plan coverage, the costs associated with treatment, including medications, is cost prohibitive. NJAMHA is

optimistic that with expanded insurance coverage for mental illness, more people will seek treatment, and more providers will be able to render the care needed.

Following are NJAMHA's comments on the priority areas requested:

- *Types of treatment limits plans currently impose*
  Panel of Providers and Accessibility: Often plans limit the panel of behavioral health providers and maintain unacceptable geo-access criteria presenting barriers to service, especially among persons who reside in remote or rural localities. In reality, treatment is not sought solely due to these limitations.

  Limits on Service Array: The full continuum of behavioral health services is often not offered by plans, regardless of medical necessity, as compared to the wide array of physical health services that are covered, as dictated by medical practice guidelines. The eventual regulations must prohibit artificial limitations on the scope of services medically indicated for symptom reduction and recovery.

  Utilization Management: Parity in states has sometimes increased the application of utilization management techniques to restrict behavioral health care, especially with reference to effective antipsychotic medications, which tend to have a higher cost. Also, plans tend to step up the use of prior authorization processes when parity laws are established in states. Federal regulations must safeguard against the overuse and inappropriate application of utilization management tools. And for states that control for excessive utilization management, there must be no exemptions of state laws for those that provide a higher level of consumer safeguards.

  Fail-First Policies: In contrast with physical health policies, plans tend to choose to adopt fail-first policies. This means that behavioral health treatment options known to have been effective for particular consumers, will be unavailable until less costly methods have been employed. This certainly would not be tolerated for patients undergoing cancer treatments, for example.

- *Terms in the statute that require additional clarification to facilitate compliance*
  Pre-Existing Conditions: This is a conundrum, which continues to frustrate practitioners and consumers, will require federal guidance. In that behavioral health issues often begin at an early age, discordant policies between physical health and behavioral health tend to be all too obvious and in dire need of correction.

- *Current disclosure practices by plans regarding medical necessity determinations* and denials of mental health benefits.
  Mystery of Medical Criteria: Medical necessity criteria for behavioral health are often cloaked. Families and consumers are not routinely advised of medical necessity criteria and are all too frequently denied on the basis of requirements that frequently change and are not routinely shared on a routine basis. Most

commonly, consumers become aware of the criteria through an Explanation of Benefits (EOB) that informs of a denied claim. There does not seem to be a consistent standard by which medical necessity criteria, that all too frequently do not comport with best practices, is promulgated, particularly with respect to behavioral health. Frequently behavioral health benefits are separated out from physical health and administered by another entity, which creates additional confusion and access hurdles.

Medical Necessity: The term "clinical necessity" better describes the basis of authorization for behavioral health services due to the different models of mental health interventions, including rehabilitative support services.

Denials: Expedited reviews of the request for psychiatric emergency services, or for critical psychiatric medications, by practitioner certification, should be of highest order. The parity regulations and guidelines must so indicate. For persons with behavioral health issues, the denial of access to services may be catastrophic. This is equivalent to physical health care where an emergency situation is defined as life threatening.

Notification of Denial Decisions and Appeal Processes: For behavioral health consumers, it is absolutely necessary to assure that plan policies and procedures include capturing information about consumers' representatives. This is routinely done through health advance directives. Twenty-five states now have Psychiatric Advance Directives laws, and this number is growing through the Wellness and Recovery movement across the country. The appointed representative, especially in times of crisis and destabilization, must be aware of plan decisions and appeal processes.

NJAMHA looks forward to the delineation of rules and guidelines that protect consumers of behavioral health services and place their treatment benefits on par with traditionally more expansive physical health benefits.

Once again, thank you for this opportunity to voice our suggestions and concerns to assure that the final rules and guidance best serve behavioral health practitioners and the consumers they serve.

If you have any questions on these comments, please do not hesitate to contact me at (609) 838-5488, extension 292.

Sincerely,
Debra L. Wentz, Ph.D.
CEO

Cc: NJAMHA Board of Directors
NJAMHA Public Policy Committee