NASMHPD National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302, Alexandria, VA 22314 (703) 739-9333 Fax (703) 548-9517

May 28, 2009

Internal Revenue Service
U.S. Department of Treasury

Employee Benefits Security Administration
U.S. Department of Labor

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

VIA EMAIL: E-OHPSCA.EBSA@dol.gov

RE: Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (published in 74 Fed. Reg.19155 et seq.)

To Federal Agencies:

On behalf of the members of the National Association of State Mental Health Program Directors (NASMHPD), we appreciate the opportunity to submit comments to the three Federal agencies as part of the rule making process for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act signed into law on October 3, 2008.

Under the new law, employers with over 50 employees that offer mental health coverage are required to offer benefits that are on par with medical-surgical benefits. Financial requirements (deductibles, co-payments, coinsurance and out-of-pocket expenses) and treatment limitations (number of visits, scope and duration of treatment) cannot be more restrictive for mental health or substance abuse benefits. However, several issues related to the law are not completely straightforward and as requested in the Federal Register Notice of April 28, NASMHPD welcomes the opportunity to highlight areas of concern surrounding several key issues. In consultation with our members in the states, several questions have emerged that need to be addressed:

- What is the scope of services covered under parity? Is it limited to inpatient hospitalization, office visits or clinic services, partial hospitalization, and prescription drugs or does it include services that are

more specific to treatment of mental illness such as case management, day treatment, rehabilitation services, assertive community treatment, and supports to remain in independent housing? Standards should be established that require plans to include all clinically necessary services provided by practitioners of the healing arts licensed under state law. A narrow medical necessity screen would not provide wellness and recovery-oriented services that are cost-effective and lead to improved health outcomes.

- What are the behavioral health equivalents of vaccinations and inoculations, PSA and PAP tests, and cholesterol lowering drugs and anti-hypertensives? The regulations should assure access to a basic level of wellness and prevention services. Managed behavioral health plans sometimes use a Global Assessment of Functioning (GAF) scale to make medical necessity determinations for services ranging from high intensity inpatient services to no services indicated. The use of this type of scale should not exclude the use of effective "inoculations" for mental health conditions.

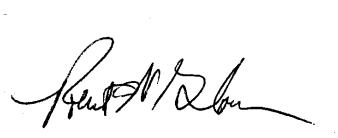
- Are there adequate standards for the network? If credentialed networks are inadequate or do not include needed subspecialties such as child psychiatry, the option to go "out of network" is only available to those with the ability to pay higher copays and deductibles. Networks must include sufficient numbers of both primary and specialty providers to assure access to services.

- Some health plans have lower copayments for primary care doctors (including Ob/Gyn, pediatricians, and internists) than for other specialists. Will the lower co-pays that often apply to primary care services also apply to those provided by psychologists, social workers, and drug and alcoholism counselors? It violates the spirit of parity that an individual participating in substance abuse counseling two or three times a week would have to pay copayments set at the highest rate for medical subspecialties.

- Because the new parity law does not mandate coverage for mental health and addiction services, some employers could choose to terminate behavioral health coverage altogether and provide expanded employee assistance plan (EAP) services instead. Regulations should draw a bright line defining what services EAP can include and what can only be provided through a health insurance policy. Inpatient care, psychiatric visits, and medications should be on the insurance side of that line.

Thank you for the opportunity to raise concerns in this initial stage of the regulatory process. If you have any questions regarding these comments please feel free to contact me or Elizabeth Prewitt, Director of Government Relations at 703-682-5196.

Sincerely yours,



Robert W. Glover, Ph.D.
Executive Director