July 17, 2024

The Honorable Rachel Roberts
House Minority Whip, Commonwealth of Kentucky
Chair, NCOIL Joint State-Federal Relations & International Insurance Issues
National Council of Insurance Legislators
616 Fifth Avenue, Suite 106
Belmar, NJ 07719

RE: NCOIL Mental Health Parity Model Act

Dear Representative Roberts:

As national trade organizations representing health insurance plans, the Blue Cross Blue Shield Association (BCBSA), Association for Behavioral Health and Wellness (ABHW) and America's Health Insurance Plans (AHIP) thank you for focusing on this important issue. We know that the nation faces a mental health crisis. Less than half of Americans with mental health conditions are receiving treatment, and when they do, initiation of treatment is often delayed.[1] This access challenge is heavily driven by the limited availability of appropriate providers coupled with an increased demand for mental health services. More than one-third of Americans live in areas with far fewer mental health specialists than the minimum needed to meet the demand.[2] There is a shortage of behavioral health sub-specialists, especially in rural areas, as well as a shortage of behavioral health professionals that are culturally relevant.

Our member plans are committed to ensuring that patients have robust and affordable access to mental health and substance use disorder (MH/SUD) services to improve their health and keep them well. We appreciate the opportunity to provide comments to the National Council of Insurance Legislators (NCOIL) on the Oct. 17, 2023, NCOIL draft Mental Health Parity Model Act.

We have been supportive of the Mental Health Parity and Addiction Equity Act (MHPAEA) since its inception. MHPAEA has had positive impacts on MH/SUD coverage as a tool to promote parity in benefit design between MH/SUD and medical/surgical (M/S) services. With consistent and transparent guidance, health plans will be better able to ensure compliance with existing laws and continue to enhance access to care for members, fully realizing the potential of MHAPEA to ensure parity.

However, as currently drafted, NCOIL's Mental Health Parity Model Act (Model Act) conflates MH parity with MH benefits mandates. As you continue your discussion of the Model Act, we respectfully recommend that NCOIL remove the references to MHPAEA and focus the Model Act on behavioral health wellness. As the U.S. Departments of Health and Human Services, Labor and Treasury work to finalize the newest requirements for MHPAEA, it is particularly prudent to avoid advocating for new state-level requirements which may not be aligned with

[1] FACT SHEET: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union | The White House
[2] https://data.hrsa.gov/topics/health-workforce/shortage-areas

these new, and likely highly substantive, requirements. We would note that once the federal MHPAEA regulations are finalized, we look forward to augmenting the feedback and recommendations provided in this letter.

We appreciate NCOIL's interest in ensuring access to MH wellness screenings as they are an important tool to increase early identification and treatment of behavioral health conditions. Specific to the Section 6 Mental Health Wellness Examinations requirements, we recommend that NCOIL refine the language to ensure it results in broader access to meaningful MH screenings:

- **NCOIL should broaden the requirement that a mental health professional perform the wellness exam to allow any qualified clinician to administer the screening.** As currently drafted, the language excludes primary care providers who already manage many mild behavioral health conditions as part of their patients' care. Primary care visits increasingly address mental health concerns,[3] and primary care physicians provide nearly four out of ten patient visits for depression and anxiety.[4] As primary care is often the earliest point of contact for behavioral health care, these providers are well positioned to expand access to MH screenings. This also supports behavioral health and primary care integration by better enabling primary care providers to screen for behavioral health conditions, which can reduce barriers to access and expand whole-person care.

  In addition, many existing mental health screening tools are designed to be administered by a range of different clinician types and settings, including both primary care and MH providers.[5] Excluding qualified clinicians who are not MH professionals would likely unduly limit access to these screenings, resulting in patients with behavioral health needs continuing to go unidentified and untreated.

- **NCOIL should align its wellness exam requirement with the U.S. Preventive Services Task Force (USPSTF) existing standards for behavioral health screenings.** USPSTF has focused its mental health preventive services recommendations on screening adults for depression and anxiety following a close examination of the current evidence base by clinical experts. As plans and issuers are already required to cover items and services recommended with an "A" or "B" rating by the USPSTF without cost sharing, we recommend that NCOIL not go beyond or contradict those federal coverage requirements.

  As such, the behavioral health exam required in the NCOIL Model Act does not need to be framed as a separate visit and, instead, should be included as a behavioral health screening. This would broaden access to the screening by allowing its integration as part of existing primary care visits and increase certainty for patients that it will be covered without cost-sharing by aligning it with more established preventive care coverage.

  In addition, while we recognize that the current USPFTF language is specific to adults, we appreciate the current state of youth MH across our country. Before the COVID-19 pandemic, behavioral health challenges were a leading cause of disability and poor life

[3] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00705
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8202306/
[5] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults

outcomes in children, with up to one in five struggling with their MH.[6] The prevalence of child and adolescent depression and anxiety symptoms worsened during the pandemic.[7] Although evidence on the efficacy of screening tools for youth and adolescents is not well understood, we are not proposing that NCOIL limit the exam requirements to adults. We encourage NCOIL to consider advocating for additional research to better understand these tools and how they can best be tailored to younger audiences.

- **NCOIL should remove the required visit length component of the mental health wellness exam.** Removing this component supports access to these exams as part of existing primary care visits. Flexibility on the length improves providers' ability to schedule and administer these exams, further supporting access to the screening. We are supportive of the approach taken in Kentucky state bill H.B. 339 to support this flexibility. While requiring health plan coverage of an annual mental health wellness examination, the bill does not specify a visit length requirement. The Model Act should be consistent with the Kentucky bill and similarly remove the required visit length component.
- **NCOIL should not require a discussion of medication options during the mental health wellness exam.** This requirement could compel a discussion of medication when it is not recommended for the patient, leading to confusion or compromising the patient's quality of care. This requirement could also restrict MH wellness exams to only those conducted by providers for whom prescribing is within their scope of practice. We recommend that NCOIL modify the Model Act language to say that the exam may include this element but is not required to do so.

With these changes, the wellness exam will be accessible to a wider range of patients, increasing early identification and treatment of behavioral health conditions. Behavioral health conditions are easier to treat if identified early, and incorporating screenings increases the chance that early warning signs will be identified.[8] Early identification of conditions aids in connecting people to needed services and support and reduces the likelihood of additional mental health problems developing.[9]

We appreciate your consideration of our comments and look forward to continuing to work with NCOIL on this topic and other MH recommendations. We further appreciate you pausing additional discussion on these issues, pending the release of federal guidance. We stand ready to help review those rules together once they are released.

If you need additional information or have any questions, please do not hesitate to reach out to Randi Chapman (BCBSA) at randi.chapman@bcbsa.com; Kathryn Cohen (ABHW) at cohen@abhw.org, or Miranda Motter (AHIP) at mmotter@ahip.org.

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[6] https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

[7] Global Prevalence of Depressive and Anxiety Symptoms in Children and Adolescents During COVID-19: A Meta-analysis | Adolescent Medicine | JAMA Pediatrics | JAMA Network

[8] https://www.mentalhealthfirstaid.org/2021/06/the-importance-of-early-intervention-for-people-facing-mental-health-challenges/

[9] https://www.mhanational.org/issues/early-identification-mental-health-issues-young-people