



December 18, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016

Dear Administrator Tavenner:

Thank you for the opportunity to comment on a proposed rule on Benefit and Payment Parameters for 2016.

The Parity Implementation Coalition (the Coalition) is an alliance of addiction and mental health consumer and provider organizations. Its members include the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine, Cumberland Heights, Faces and Voices of Recovery, Hazelden Betty Ford Foundation, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Addiction Treatment Providers, National Association of Psychiatric Health Systems and The Watershed Addiction Treatment Programs, Inc. In an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders, these organizations advocated for more than fourteen years in support of parity legislation and are committed to the full implementation and enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA).

BACKGROUND

Prevalence of Mental and Addictive Disorders

Addiction and mental illnesses are chronic diseases that can be prevented and treated effectively. However, access to treatment is often lacking. For example, only 41% of the 17.9 million adults with any mental illness received mental health services in the last year; and only 2.5 million of the estimated 22.7 million people suffering from an alcohol and/or drug use disorder received treatment, leaving 20.2 million Americans in need of treatment for an alcohol or drug use problem, but not receiving it.^{1,2} A robust essential health benefit (EHB) is essential to remedying this treatment gap and increasing access to addiction and mental health prevention, treatment and recovery support services for millions of American and their families.

Moreover, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that up to a third of the 30 million Americans who may gain access to health insurance through the Affordable Care Act will have a mental or substance use disorder. It is critical that individuals have meaningful access to the EHB's mental health/substance use disorder (MH/SUD) benefit so the full potential of the law can be realized.

No Health Without Mental Health

Treating mental health and addiction is not only the right thing to do – it is the cost effective thing to do. For example:

- Mental health and substance use disorders cost employers \$17 billion annually in absenteeism and lost productivity³
- Illicit drug use costs America \$193 billion annually - over \$11 billion in health costs, \$61 billion in crime-related costs, and \$120 billion in lost productivity. This exceeds the annual direct and indirect costs of diabetes⁴
- In one study, middle-aged and older adults who received “collaborative care” for depression had significantly reduced healthcare costs compared to those in usual care, with a \$522 initial investment yielding cost savings of \$3,363 per patient⁵

SUMMARY OF RECOMMENDATIONS

As organizations who have collectively worked on the implementation and enforcement of parity for over a decade, please find below the following comments on the Proposed Rule and recommendations for inclusion in a Final Rule with a focus on areas in which we feel uniquely qualified to comment:

1. Essential Health Benefits

- a. Allow States to select a 2015 plan as their new base-benchmark for 2017 plan years
- b. Ensure that all EHB-benchmark plans meet federal parity requirements and provide adequate mental health and substance use disorder services for all persons who depend on coverage through Qualified Health Plans (QHPs) and provide guidance on supplementation requirements if the base-plan does not meet the requirements of § 156.110
- c. Require plans to report on quantitative and non-quantitative treatment limits

2. Discriminatory Benefit Design

- a. Identify a non-discrimination standard, describe a detailed process for federal oversight and outline penalties for non-compliance

3. Network Adequacy

- a. Ensure consumers have access to equitable mental health and addiction treatment provider networks
- b. We support the proposal to require QHPs to update directory information at least once a month and make the information available without an individual having to create an account or use a policy number
- c. We support the clarification that out-of-network providers cannot be counted towards determining network adequacy

4. Enforcement

- a. HHS should aggressively and transparently enforce the MHPAEA and EHB compliance requirements. Outcomes of EHB and MHPAEA compliance investigations should be made available on Department of Health and Human Services and Department of Labor websites

1. ESSENTIAL HEALTH BENEFITS

Recommendation: Allow States to select a 2015 plan as their new base-benchmark for 2017 plan years

The Proposed Rule would allow states to select a new base-benchmark for the 2017 plan year. While we thank HHS for acknowledging that base-benchmark plans need to be updated to reflect 2014 market reform requirements, including MHPAEA, the Coalition is very concerned that allowing the selection of 2014 plans will not provide consumers with the protections afforded to them by the MHPAEA Final Rule (FR). For the majority of plans, the FR goes into effect for plan years beginning January 1, 2015. (The FR effective date was for plan years beginning on or after July 1, 2014; however, most plans renew by calendar year.) Therefore, the selection of a 2014 plan means consumers may not have the important protections and rights afforded to them by the MHPAEA FR. As such, we recommend States be permitted to select a 2015 plan as the new base-benchmark.

The MHPAEA FR strengthened provisions from the MHPAEA Interim Final Rule (IFR) and we are hopeful that full implementation and enforcement of the FR will eliminate some of the barriers consumers have continued to face since MHPAEA was signed into law in 2008. For example, the Final Rule makes it clear that the range and types of MH/SUD services have to be comparable to the range and types of medical/surgical services within each classification of benefits. The net effect of this provision is that parity requirements (as clarified by the FAQs issued by the Department of Labor with the rule) extend to intermediate levels of MH/SUD care and that such services must be treated comparably under the plan.

Over the last two years, the Parity Implementation Coalition with former Congressmen Patrick Kennedy and Jim Ramstad hosted a series of field hearings on the implementation of MHPAEA across the country. At the January 2013 Denver, Colorado field hearing Milliman actuary Steve Melek testified about the lack of clarification around scope of service in the Interim Final Rule. Melek stated, “Another issue that is not well defined within MHPAEA is the scope of services that are required to be included for covered mental health conditions and substance use disorders. The IFR is clear that a plan must provide MH/SUD benefits in every class in which medical/surgical benefits are provided. What has not been clear, and what we believe the FR rectifies, is how broad these benefits need to be. For example, is providing inpatient detoxification benefits for substance use disorder sufficient to meet parity requirements without covering inpatient rehabilitation benefits for the same disorder, assuming the medical benefit contains a comparable continuum? Can a plan exclude benefits for residential treatment services entirely, both those provided in hospitals and non-hospitals and still be parity compliant? Can a plan limit the types of behavioral healthcare providers that it will include in covered outpatient benefits?”

The Coalition is both hopeful and anticipatory that when the Final Rule fully takes effect next month, many of the outstanding questions, including those around scope of service, that allowed barriers to treatment to continue following the release of the IFR, will have been removed. While strong enforcement of the FR will be required to ensure its protections are fully realized, we believe allowing the selection of 2015 plans, fully covered by the MHPAEA Final Rule and its

strengthened provisions, will afford individuals with MH/SUDs the consumer protections they are entitled to.

Recommendation: HHS should ensure that all EHB-benchmark plans meet federal parity requirements and provide adequate mental health and substance use disorder services for all persons who depend on coverage through QHPs and provide guidance on supplementation requirements if the base-plan does not meet the requirements of § 156.110.

The Proposed Rule seeks comments on how to address situations in which a State has few potential base-benchmark plans that meet the requirements of § 156.110 from which to choose. We thank the Department for recognizing that States may need to supplement a benchmark in order to meet the requirements, but we remain concerned that little guidance exists for States on what would meet the minimum standard for supplementation. In particular, if a State’s mental health and substance use disorder benchmark plan is absent or out of compliance with MHPAEA, how should a State supplement the benefit?

We urge HHS to include additional provisions under §156.110(b) as follows:

- ...
- (4) *Supplementing EHB-Benchmark Plans that do not meet Parity, Non-Discrimination and Balance Requirements:*
- (i) *If the state determines that an EHB-benchmark plan does not meet the requirements of mental health and substance use disorder parity under §146.136 of this subchapter, the state must supplement the base-benchmark plan to meet parity requirements, including the six classifications of benefits rule.*
 - (ii) *If the state determines that an EHB-benchmark plan does not meet the requirements of non-discrimination as defined in §156.125 of this subpart, the state must supplement the base-benchmark plan to meet non-discrimination requirements.*
 - (iii) *If the state determines that an EHB-benchmark plan does not meet the requirement that an EHB have an appropriate balance among the EHB categories, in accordance with Section 1302(b)(4)(A) of the Affordable Care Act, the state must supplement the base-benchmark plan to meet balance requirements.*
 - (iv) *Any benefits supplemented to meet the provisions of §156.110(b)(4)(i)-(iii) of this subpart will not be considered “additional required benefits” under §155.170(a) of this subpart. A state is not required to make payments under §155.170(b) of this subpart to defray the cost of any benefits supplemented to meet the provisions of §156.110(b)(4)(i)-(iii) of this subpart.*

In addition, several of the 10 statutory EHB categories include two or more sub-components. For example, the category of “maternity and newborn care” under §156.110(a)(4) includes two components: (1) *maternity care*; and (2) *newborn care*. As Congress was careful to include both

of the terms “maternity” and “newborn” under this statutory category, we believe that every EHB benchmark plan must include coverage under both of these sub-components. This also applies to mental health and substance use disorder services.

We believe that a base-benchmark plan cannot meet the statutory definition for an EHB-benchmark plan if it does not provide items and services for *every* sub-component of the statute’s listed categories. We believe supplementation should be required when an EHB-benchmark plan offers only mental health services, but not substance use disorder services, or vice versa. Likewise, if a plan offers newborn care, but not maternity, or rehabilitation without habilitation, supplementation should be required.

Modifying the supplementation methodology to provide for supplementation when sub-categories are insufficient would be easy for states to administer and for HHS to oversee. Furthermore, this interpretation ensures that items and services that may be at risk of being left out of the benchmark – such as substance use disorder services or habilitative services – will be included in base-benchmark plans in accordance with the expressed intent of the statutory language. We urge HHS to add the following language (written below in bold) to the supplementation methodologies in §156.110(b) and (c) to address this issue:

§156.110(b)(1): General supplementation methodology. A base-benchmark plan that does not include items or services within one or more of the categories – or sub-component thereof – described in paragraph (a) of this section must be supplemented by the addition of the entire category – or sub-component thereof – of such benefits offered under any other benchmark plan option...

§156.110(c): Supplementing the default base-benchmark plan. A default base-benchmark plan as defined in §156.100(c) of this subpart that lacks any categories of essential health benefits – or sub-component thereof – will be supplemented by HHS in the following order...

Recommendation: Require Plans to Report on Quantitative and Non-Quantitative Treatment Limits

The proposed rule solicits comments on the benchmark plan data that must be provided to HHS. We are recommending that the definition of “treatment limits” be expanded to include both quantitative and non-quantitative treatment limits (NQTLs). Currently, only data on quantitative treatment limits must be submitted. As set forth in the MHPAEA Final Rule, an illustrative list of NQTLs includes:

- A. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- B. Formulary design for prescription drugs;
- C. For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- D. Standards for provider admission to participate in a network, including reimbursement rates;

- E. Plan methods for determining usual, customary, and reasonable charges;
- F. Refusal to pay for higher-cost therapies until it can be shown that a lower cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- G. Exclusions based on failure to complete a course of treatment; and
- H. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

Consumers and providers have now had ample experience post MHPAEA IFR with insurers as they apply NQTLs to MH/SUD benefits. The Coalition has seen considerable disclosure issues as well as noncompliance in the application of NQTLs in one or more of four specific areas:

1. Nondisclosure of how and to what degree NQTLs are comparably applied to medical/surgical spending;
2. Refusal by plans and insurers to respond at all to requests for medical/surgical criteria and/or spending (and on occasion refusal to provide MH/SUD criteria as well);
3. Statements by plans and insurers that they may apply an NQTL to any proportion or all of the MH/SUD benefit regardless of what proportion of the medical/surgical benefit that NQTL is applied to; and
4. Unilateral statements by plans that an NQTL is justified based on the plan's internally recognized clinically appropriate standards, with no details or support given.

At the field hearings, patients, physicians and other providers testified that while discriminatory quantitative limits such as higher co-pays and visit limits have been largely eliminated, patients are still finding discriminatory barriers to their addiction and mental health benefits. For the sake of brevity, just two of these examples include:

- A patient from Virginia testified about his plan requiring that he “fail first” at outpatient treatment before the plan would pay for inpatient addiction treatment. The plan did not have a similar requirement on its medical/surgical benefits.
- A physician from California testified about the barriers he and his colleagues encounter. He stated, “There are a seemingly endless number of obstacles that insurers utilize to evade providing mental health and substance use services. Roadblocks we face include vague medical necessity standards, lengthy approval processes that result in attrition, bureaucratic stonewalling of service requests, appeals processes that require an advanced degree to navigate and so on. I encounter these obstacles every day in my work.”

Given these difficulties, we believe it is critical that plan data on NQTLs be submitted to HHS. As recognized by the MHPAEA Final Rule, NQTLs, just like quantitative treatment limits, limit the scope or duration of mental health and substance use disorder benefits and should be transparently measured.

2. DISCRIMINATORY BENEFIT DESIGN

Recommendation: Identify a non-discrimination standard, describe a detailed process for federal oversight and outline penalties for non-compliance

The Coalition's consumer and provider organizational members have significant experience in confronting the discrimination that occurs in health insurance coverage. As discussed above, despite enactment of state and federal parity laws and regulations, there continues to be a well-documented history of insurance discrimination against individuals with MH/SUDs.

While we recognize that the Department is attempting to remedy some of the issues that have plagued exchange plans by allowing States to select a 2014 base-benchmark plan for the 2017 plan year (which we urge to be changed to a 2015 base-benchmark plan), we are concerned that absent stronger consumer protections, discriminatory benefits will continue to be offered to consumers.

We strongly urge HHS to clearly identify a non-discrimination standard, and provide examples below of what would constitute violations. For example, HHS might set the following standards describing discrimination:

- Offering limited coverage within an EHB category is discriminatory
- Making specific coverage exclusions without regard to generally accepted medical necessity is discriminatory
- Offering a full array of medical benefits and limited MH/SUD benefits is discriminatory

We also recommend HHS require qualified health plans to be transparent regarding the terms and conditions of the plan on both medical and behavioral benefits in order to prevent discriminatory practices and allow for parity compliance testing.

HHS must describe a detailed process and timeline for federal oversight over state implementation of a non-discrimination standard so that consumers can be assured that discriminatory plans will not find their way into the exchange.

We also strongly urge the Department to include in the final rule language outlining clear and strong federal enforcement provisions and penalties for violations.

3. NETWORK ADEQUACY

Recommendation: Ensure consumers have access to equitable mental health and addiction treatment provider networks

The Proposed Rule states HHS is planning to wait for NAIC to finish its Model Act before proposing significant changes to network adequacy requirements. We have serious concerns about networks maintaining adequate access to mental health and substance use disorder providers.

In 2007, prior to the introduction of MHPAEA, former Congressmen Patrick Kennedy and Jim Ramstad held 14 field hearings around the country seeking input on what issues needed to be

addressed in parity legislation. One issue that was raised repeatedly and continued to be voiced by providers and consumers at the 2012 – 2014 field hearings was inadequate networks and phantom networks. “Phantom networks” are a phenomenon whereby plans list providers in their networks who are not really available to treat patients, are no longer in existence, or have long since ceased being an in-network provider. For example, a Maryland psychiatrist reported to the Coalition just last month that consumers call his office because he is listed on their plan’s network when he has actually not contracted with the plan.

At the California parity field hearing Dr. Marcy Forgey, on behalf of the California Academy of Child and Adolescent Psychiatry, testified, “Network provider lists provided by insurance companies are frequently out of date. Families will sometimes have to call 30 – 40 providers before they can find one that is actually taking new patients. They may not be able to find a provider at all or are matched with one who does not have the skill set they require. Waiting lists for mental health treatment may be months long for a provider in network or families may have to drive long distances to access care.” **To address these long-standing and discriminatory barriers to care, we support the Proposed Rule’s proposal to require QHPs to update directory information at least once a month and make the information available online without an individual having to create an account or use a policy number.**

We support the clarification that out-of-network providers cannot be counted towards determining network adequacy. Plans generally have fewer providers in their MH/SUD networks than they do in their medical/surgical networks due to a number of factors, and consequently, a higher percentage of MH/SUD patients are treated by out-of-network providers as compared to medical/surgical patients. One of the factors that can be attributed to a lack of network adequacy is that MH/SUD physicians and other providers are generally paid lower reimbursement rates than medical/surgical providers. MH/SUD facilities are also generally reimbursed at lower rates. A study of a national reimbursement fee schedule on what were the average allowed costs paid to in-network, outpatient medical/surgical providers compared to in-network, outpatient behavioral health providers documented this discrepancy.

Particularly given that the Proposed Rule would permit, but not require, plans to count out-of-network cost sharing towards the annual limitation on cost sharing, it is essential MH/SUD consumers have access to in-network providers in order to avoid higher out-of-pocket costs.

4. ENFORCEMENT

Recommendation: HHS should aggressively and transparently enforce the MHPAEA and EHB compliance requirements. Outcomes of EHB and MHPAEA compliance investigations should be made available on Department of Health and Human Services and Department of Labor websites

The Proposed Rule states that HHS will use a “good faith compliance policy” for QHPs through the end of calendar year 2015 for Federally Facilitated Exchanges (FFE).

We are very concerned that problems with MHPAEA and EHB non-compliance will continue absent strong enforcement. HHS should provide aggressive oversight and enforcement in the area of EHB and MHPAEA compliance. HHS should periodically (but no less than annually)

sample plans for compliance with EHB requirements—including parity compliance-- and make these results publically available. At the Maryland parity field hearing University of Maryland law professor Ellen Weber testified, “The federal government’s enforcement actions directly influence the level of voluntary compliance by employers and the effectiveness of enforcement efforts by those on the ground. One Maryland treatment provider captured the importance of enforcement, noting that the law determines ‘whether our patients get care and whether we get paid.’”

HHS should develop and directly enforce reporting requirements and apply appropriate penalties for plan non-compliance. All enforcement actions and compliance correction plans should be made public on appropriate federal and state websites. Absent public reporting, we see the same issues with different plans arise around the country.

If the Department cannot or will not publicly identify the plan involved in the enforcement action, we ask for disclosure of corrective actions taken without identification of the plan. Anonymous disclosure would, at a minimum, provide some guidance to other plans, providers and stakeholders on what is or is not permissible.

CONCLUSION

Thank you for the opportunity to provide comments; these issues are critical to ensuring millions of Americans have access to life-saving mental health and addiction treatment. We appreciate your careful consideration of our comments and look forward to working with you further on EHB and parity implementation. Please contact Coalition Co-Chairs Sam Muszynski (IMuszynski@psych.org) or Carol McDaid (cmcaid@capitoldecisions.com) if you have any questions or if we can be of further assistance.

Sincerely,



Irvin L. Muszynski, JD

Co-Chair, Parity Implementation Coalition



Carol McDaid

Co-Chair, Parity Implementation Coalition

¹ Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

² Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (September 4, 2014). *The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings*. Rockville, MD.

³ Hertz RP, Baker CL. The impact of mental disorders on work. *Pfizer Outcomes Research*. Publication No P0002981. Pfizer; 2002.

⁴ National Drug Intelligence Center. 2011. *The Economic Impact of Illicit Drug Use on American Society*. Washington D.C: United States Department of Justice.

⁵ Unutzer et al., "Long-term Cost Effects of Collaborative Care for Late-life Depression," *The American Journal of Managed Care* Vol. 14, No. 2 (Feb. 2008) (online at http://www.ajmc.com/media/pdf/AJMC_08feb_Unutzer_95to100.pdf)