November 27, 2017

Seema Verma, 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 2019 (CMS-9930-P)

Dear Administrator Verma:

Thank you for the opportunity to comment on the HHS Notice of Benefit and Payment Parameters for 2019 proposed rule.

The Parity Implementation Coalition is an alliance of substance use disorder and mental health consumer and provider organizations. Members include the American Society of Addiction Medicine, Depression and Bipolar Support Alliance, Hazelden Betty Ford Foundation, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, National Association of Addiction Treatment Providers, and Young People in Recovery. In an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders, many of these organizations have advocated for more than nineteen years in support the passage of parity legislation and issuance of regulations and enforcement of both. We are committed to working with the Administration on the prompt, effective implementation and enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA).

SUMMARY OF RECOMMENDATIONS

Please find below the following comments on the Proposed Rule and recommendations for inclusion in a Final Rule with a focus on three areas in which our members feel uniquely qualified to comment – Essential Health Benefits (EHBs), implementation and enforcement of MHPAEA, and Network Adequacy.

As an overarching principle, we believe all Americans must have equitable access to mental health and substance use disorder (MH/SUD) treatment. This is not only the right thing to do, but also yields substantial cost savings in the treatment of other chronic medical conditions. Any changes to the marketplace rules must maintain or increase access to lifesaving MH/SUD services.

800 Maine Ave, SW • Suite 800 • Washington, DC • 20024

Essential Health Benefits

While we appreciate the Administration's goal of providing flexibility to states, we are concerned that too much flexibility without adequate patient protection guardrails could result in reduced access to coverage and increased burdens on the public sector, which would be particularly devastating amid the opioid misuse and overdose and suicide epidemics.

Implementation and Enforcement of the Mental Health Parity and Addiction Equity Act

We ask the Administration to fully implement and enforce MHPAEA and implement the recent important recommendations made by the President's Commission on Combatting Drug Addiction and the Opioid Crisis (the Commission).

Network Adequacy

We have concerns about the proposal in the Proposed Rule to delegate enforcement over network adequacy standards requirements to the states. The Department of Health and Human Services (HHS) should maintain strong federal oversight over network adequacy requirements.

ESSENTIAL HEALTH BENEFITS

In the face of the opioid overdose and suicide epidemics, equitable access to a full continuum of mental health and substance use disorder treatment services, including medications to treat substance use disorders and mental illness, must be an essential component of health care coverage. It is also critical that substance use disorders and mental illness be covered on par with other medical conditions consistent with MHPAEA.

Ensuring Americans have access to substance use and mental health treatment is not only the right thing to do – it's the cost-effective thing to do, yielding a return on investment that will benefit employers and our economy. For example:

- One study found that substance use treatment is associated with a reduction of medical expenses for Medicaid beneficiaries of approximately $2,500 annually.
- Another study found that, "on average, substance abuse treatment costs $1,583 and is associated with a monetary benefit to society of $11,487, representing a greater than 7:1 ratio of benefits to costs. These benefits were primarily because of reduced costs of crime and increased employment earnings."
- The recent Surgeon General Report on Alcohol, Drugs and Health found that every $1 spent on addiction treatment saves $4 in health care costs and $7 in criminal justice costs.
- Another study found that individuals who received substance use treatment had a 26% reduction in health care costs and had reduced Emergency Department visits and hospitalizations.

Moreover, the cost of the opioid misuse and overdose epidemic is significant. A study released by Altarum in November 2017 found that the economic burden of the epidemic is $95 billion annually. Altarum reported that the federal government alone assumes $29.2 billion of the costs, primarily in the form of lost tax revenue, health care costs and criminal justice related costs.

- **Recommendation:** Any changes to the Essential Health Benefit (EHB) requirements must ensure that the MH/SUD benefit is robust and compliant with the Mental Health Parity and Addiction Equity Act. Flexibility in benefit design should be limited and accompanied by strong guardrails that protect individuals with MH/SUD from high out-of-pocket costs and limited covered benefits.

800 Maine Ave, SW • Suite 800 • Washington, DC • 20024

New data from the Centers for Disease Control and Prevention (CDC) found that as of April 2017, 65,669 Americans died of a drug overdose in the previous 12 months. This statistic represents a 17.7% increase in the rate of overdose deaths nationwide as compared to the previous year with some states – Indiana, Ohio, Pennsylvania, Delaware, Maryland – reporting 30%, 40% or even 50% increases in their overdose death rates. With 180 Americans a day dying from overdoses, we cannot support providing flexibility at the cost of decreasing access to substance use disorder services.

Historically, mental health and substance use have been subject to insurer exclusions and limitations. For example, prior to the Affordable Care Act (ACA), 34% of enrollees in the individual market did not have coverage for substance use disorder treatment, and 18% did not have coverage for mental health services. Moreover, the Congressional Budget Office (CBO) confirmed in its May 2017 report on the *American Health Care Act* that these services are most likely to be excluded if their coverage is not mandated. CBO states, "Services or benefits likely to be excluded from the EHBs in some states include maternity care, mental health and substance abuse benefits, rehabilitative and habilitative services, and pediatric dental benefits. In particular, out-of-pocket spending on maternity care and mental health and substance abuse services could increase by thousands of dollars in a given year for the nongroup enrollees who would use those services."

As such, we are very concerned with the level of flexibility in plan benefit design in the Proposed Rule. As stated in the rule itself, the result of allowing significant state flexibility in benchmark selection, may be that "depending on the selection made by the state in which the consumer lives, consumers with less comprehensive plans may no longer have coverage for certain services."

An analysis of average insurer spending as projected for 2017 found that "health and substance abuse treatment accounted for 1 percent of per capita insurer spending." Given that MH/SUD comprise such a tiny fraction of overall healthcare spending, we do not believe the additional flexibility in plan design and benefit will result in meaningful premium savings for individuals with MH/SUD. In fact, as indicated by the aforementioned CBO analysis, out-of-pocket costs for individuals with MH/SUD are already significantly higher and will likely rise more.

Additionally, the Proposed Rule encourages states to consider the "spillover effects," which could include "increased used of emergency services or increased use of public services provided by the State or other government entities, when a certain service is no longer covered by insurance." Unfortunately, the public sector is already paying for a substantial portion of mental health and substance use treatment care. A *Health Affairs* study found that in 2014, "the largest share of substance use disorder financing (29 percent) was from state (non-Medicaid) and local governments." Additionally, beyond healthcare costs, state and local governments are also burdened with the collateral costs of the opioid misuse and overdose epidemic. The previously referenced Altarum report found that, "many of 2016 cases of child neglect are associated with parents with an opioid substance use disorder, causing increased child and family assistance spending of $6.1 billion per year. We estimate additional education expenses to be $4.4 billion per year." As such, PIC members caution against any changes to the marketplace rules that might further burden states and localities.

- **Recommendation:** Substitution between the mental health and substance use disorder benefit and other categories should not be permitted.

  We are also very concerned with the proposal to allow substitution between benefit categories as such a change could 1) make it difficult, if not impossible, for a state to ensure that each of the Essential

800 Maine Ave, SW • Suite 800 • Washington, DC • 20024

Health Benefit categories are equally weighted as required by law and 2) put a significant burden on consumers.

The Proposed Rule acknowledges both concerns. The rule notes that, "by allowing substitution between categories, States may encounter difficulties in ensuring that all categories are filled in such a way that amounts to EHB." We concur that allowing substitution between categories could undermine the intent of the law and result in reduced access to MH/SUD treatment that is not compliant with the underlying statute. Additionally, as noted above, historical discrimination against MH/SUD makes it particularly likely that coverage for these benefits would be limited as compared to other medical/surgical benefits.

Moreover, as the Proposed Rule notes, "This proposal would increase the burden on consumers who choose between plans offered in the individual and small group markets as they would need to spend more time and effort comparing benefits offered by different plans in order to determine what, if any, benefits have been substituted and what plan would best suit their health care and financial needs."

We believe it is unreasonable to put such a burden on consumers, particularly when health literacy is often low. For example, enrollees often have limited knowledge of their rights and benefits under the parity law. A survey by the American Psychological Association found that only 4% of Americans said they were even aware of MHPAEA. Additionally, even the most educated of consumers may select a plan to then later be caught off guard by a mental health or substance use disorder crisis in his or her family. For these reasons, substitution of the mental health and substance use disorder category with other categories should not be permitted.

- **Recommendation**: The definition of a "typical employer plan" should not rely solely on the number of enrollees.

  An option outlined in the Proposed Rule would allow states to "select a set of benefits to become its EHB-benchmark plan, provided that the new EHB-benchmark plan does not provide more benefits than a set of comparison plans and is equal to the scope of benefits provided under a typical employer plan, as required by the PPACA" and defines, for the purposes of this option a "typical employer plan" as any plan that covers at least 5,000 enrollees.

  We are concerned that using only the number of enrollees to define a "typical employer plan" could result in the selection of benchmark plans that do not in fact provide benefits that are "typical." It seems quite plausible that a state could select a plan that covers 5,000 enrollees that is "a-typical" in the benefits it covers, which could result in very limited coverage. At a minimum, a definition of a typical employer plan for this purpose should be limited to plans that already cover all 10 EHB categories.

FULL IMPLEMENTATION AND ENFORCEMENT OF MHPAEA

Unfortunately, as we approach the 10th anniversary of President Bush signing the *Mental Health Parity and Addiction Equity Act* into law on October 3, 2008, our members and the patients and families they serve continue to report barriers to equitable access to mental health and substance use disorder treatment services.

One of the primary complaints from our members on behalf of their patients concerns lack of disclosure by health plans, especially concerning the plans' compliance with the parity law as it relates to non-quantitative treatment limitations (NQTLs) such as medical management techniques, usual and customary reimbursement rates, provider network admission standards, facility-type and level of care exclusions, etc.

800 Maine Ave, SW • Suite 800 • Washington, DC • 20024

Consumers and providers are entitled to plan documents and information regarding the development and application of NQTLs that a plan imposes to limit access to benefit coverage and how those limitations are comparable to and no more stringently applied to substance use/mental health benefits than to medical/surgical benefits. However, they consistently report that although they request this type of information, plans are generally non-responsive. Absent this information, consumers and providers are unable to determine whether or not the plan is in compliance with the parity law and its regulations. Thus, enforcement of this vital part of the law remains elusive.

Our anecdotal reporting is supported by the recent Presidential Commission's report which states, "MHPAEA has been the impetus for much progress towards parity for behavioral health coverage; plans and employers have, by and large, done away with policies that are clear violations; provisions such as dollar-limits, visit limits, and outright prohibitions on certain treatment modalities that exist only on behavioral health benefits. However, what remains are violations that are murkier and harder for regulators to discern, for example, non-quantitative treatment limits (NQTLs). These hurdles include medical necessity reviews that are more stringent on the behavioral health side than the medical/surgical side, limited provider networks, and onerous prior-authorization requirements. In reality, it is often difficult to discern when a behavioral health benefit is "on par" with a medical/surgical benefit as different care settings and diagnoses have different policies regarding benefits, providers, and authorizations."

Additionally, a recent report reviewed if a state regulator could identify potential violations of MHPAEA for substance use disorder services through a common regulatory review process known as form review. Their findings were that, "even with a comprehensive data gathering template, regulators would not be able to accurately assess whether a plan is parity compliant because required information is not available in the plan documents that regulators receive from carriers prior to approving plans for sale."

We make the following recommendations, many based off recent recommendations in the President's Commission's report, with the goal of increasing access to mental health and substance use disorder treatment.

- **Recommendation**: HHS should use its enforcement authority over qualified health plans to launch investigations into parity non-compliance and the outcomes of such investigations should be publicized on appropriate federal websites.

  This recommendation is consistent with the Commission's report, which recommended, "that Congress provide DOL increased authority to levy monetary penalties on insurers and funders, and permit DOL to launch investigations of health insurers independently for parity violations."

- **Recommendation**: Federal and state regulators should require plans to use a standardized tool to document and disclose their compliance with MHPAEA's NQTL requirements.

  For further details**,** please see the comments we filed with the Departments in response to their June 16, 2017 request for comments on a model form. Included in those comments:

  - Suggested "tracked changes" to the Department's draft form "Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations" as solicited in the June 17, 2016 FAQs;
  - Sample FAQs that expand upon how to comply with the documentation required in the Department's model form;
  - Because specific examples of how various NQTLs are applied is often the clearest way to

800 Maine Ave, SW • Suite 800 • Washington, DC • 20024

demonstrate compliant and non-compliant NQTLs analyses, the PIC's comments also include a non-exhaustive group of draft FAQs on a variety of the most common types of NQTLs our members see; and

- A suggested six-step plan reporting format on application of NQTLs, both written and in operation, and an accompanying spreadsheet. The six-step process for reporting on application of NQTLs to mental health/substance use and medical/surgical benefits, as well as examples of their application to specific NQTLs are intended to be useful tools to the Departments and state regulators as to how a plan could structure its NQTL analysis and report on it to regulators. The sixth step in the process is intended for use by plans, issuers and regulators and not consumers or providers.

This recommendation for a standardized tool is consistent with the Commission's report, which recommended, "that federal and state regulators should use a standardized tool that requires health plans to document and disclose their compliance strategies for nonquantitative treatment limitations (NQTL) parity. NQTLs include stringent prior authorization and inequitable medical necessity requirements. HHS, in consultation with DOL and Treasury, should review clinical guidelines and standards to support NQTL parity requirements. Private sector insurers, including employers, should review rate-setting strategies and revise rates when necessary to increase their network of addiction treatment professionals."

Recommendation: Reimbursement and policy barriers to MH/SUD treatment should be eliminated.

This recommendation is consistent with the Commission's report, which recommended, "The Commission recommends HHS/CMS, the Indian Health Service (IHS), Tricare, the DEA, and the VA remove reimbursement and policy barriers to SUD treatment, including those, such as patient limits, that limit access to any forms of FDA -approved medication assisted treatment (MAT), counseling, inpatient/residential treatment, and other treatment modalities, particularly fail-first protocols and frequent prior authorizations. All primary care providers employed by the above-mentioned health systems should screen for alcohol and drug use and, directly or through referral, provide treatment within 24 to 48 hours."

NETWORK ADEQUACY

Network adequacy remains a significant concern for mental health and substance use disorder treatment patients and their family members. Due to serious provider shortages, persons seeking care for mental health and substance use disorder services may not have access to providers who can address their health needs. While shortages of other types of health care providers and specialists exist, plans generally rectify these workforce shortages with aggressive recruitment and increases in rates. As a result, too often patients are forced to see higher cost providers out of network because the network just does not have contracts with an adequate level of mental health and substance use disorder providers. The shortage of mental health and substance use disorder providers may be particularly acute in certain states, for certain conditions and populations such as children and adolescents.

A study in the *Journal of American Medicine* found that exchange plan networks of providers were consistently inadequate for certain types of illnesses or disabilities, including mental illnesses. Moreover, a recent study from *Health Affairs* of exchange plans found that, "On average, plan networks included 24.3 percent of all primary care providers and 11.3 percent of all mental health care providers practicing in a given state-level market."

800 Maine Ave, SW • Suite 800 • Washington, DC • 20024

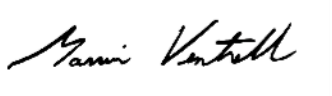
- **Recommendation:** HHS should maintain strong federal oversight over network adequacy requirements. The Proposed Rule proposes to eliminate requirements for State Based Exchanges on the Federal Platform to enforce Federally-facilitated exchange standards for network adequacy and essential community providers. The rule would instead allow states to establish their own standards. We are concerned about this proposal and the extent to which HHS is relying on states to provide oversight to ensure network adequacy. Absent strong federal oversight, narrow networks that result in limited access to MH/SUD treatment will continue and consumers will continue to have to pay more for out-of-network care.
- **Recommendation**: HHS should ensure that qualified health plans set their rates to appropriately cover MH/SUD treatment. This recommendation is consistent with the Commission's report, which recommended, "The Commission recommends HHS review and modify rate-setting (including policies that indirectly impact reimbursement) to better cover the true costs of providing SUD treatment, including inpatient psychiatric facility rates and outpatient provider rates." We support this recommendation and ask that HHS ensure qualified health plans also set their rates to appropriately cover MH/SUD treatment.

CONCLUSION

The PIC would be pleased to discuss these recommendations in greater detail and we stand ready to serve as a resource to the Administration. Our Coalition Coordinator, Carol McDaid, may be reached at cmcdaid@capitoldecisions.com.

Sincerely,

Mark Covall
Co-Chair
Parity Implementation Coalition



Marvin Ventrell
Co-Chair
Parity Implementation Coalition