



**Association for Behavioral
Health and Wellness**

*Advancing benefits and services
in mental health, substance use
and behavior change.*

September 12, 2017

U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20710

Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

U.S. Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

**RE: FAQ ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY
IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 38**

To Whom It May Concern,

I am writing on behalf of the Association for Behavioral Health and Wellness (ABHW) to provide comments on FAQ Part 34 (we also provided comments on January 3rd, 2017) as requested by FAQ Part 38 and on the *Form to Request Documentation From an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations*, also included in FAQ Part 38.

Background

ABHW is an association of the nation's leading behavioral health and wellness companies. These companies provide an array of services related to mental health, substance use disorders, employee assistance, disease management, and other health and wellness programs to over 170 million people in both the public and private sectors. ABHW and its member companies use their behavioral health expertise to improve health care outcomes for individuals and families across the health care spectrum.

For the last two decades, ABHW has supported mental health and addiction parity. We were an original member of the Coalition for Fairness in Mental Illness Coverage (Fairness Coalition), a coalition developed to win equitable coverage of mental health treatment. ABHW served as the Chair of the Fairness Coalition in the four years prior to passage of the Mental Health Parity and Addiction Equity Act (MHPAEA). We were closely involved in the writing of the Senate legislation that became MHPAEA, and actively participated in the negotiations of the final bill that became law.

Since the Interim Final Rule (IFR), and subsequently the final rule, was issued, ABHW member companies have worked vigorously to understand and implement MHPAEA. We have had numerous meetings with the regulators to help us better understand the regulatory guidance and to discuss how plans can operationalize the regulations. Our member companies have teams of dozens of people working diligently to implement and provide a mental health and substance use disorder (MH/SUD) parity benefit to their consumers.

Comments on FAQ Part 34

We recognize the importance of transparency and disclosure of information to consumers and are aware that consumer education and understanding was an important principle of the original legislation. However, we are very concerned that recent disclosure requirements (Part 31, FAQ 9) and the Consumer Guide to Disclosure Rights document released by the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Substance Abuse and Mental Health Services Administration (SAMHSA) do not have the intended effect and fail to recognize existing sources for parity information. In particular, the *Consumer Guide to Disclosure Rights: Making the Most of Your Mental Health and Substance Use Disorder Benefits* includes overly detailed, prescriptive, disclosure examples, and requires an overabundance of information to be disclosed. An updated version of the guide should be issued so the requirements do not overload consumers with information and overburden health plans with onerous requirements.

A research [paper published in the Journal of Health Economics](#) found that 86% of participants could not define deductible, copay, coinsurance, and out-of-pocket maximum in a multiple choice questionnaire. Given this, we question the value to consumers in providing documentation of all of the specific underlying processes, strategies, evidentiary standards, and other factors considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit. There are better ways to inform consumers about how their plan is implementing parity without overwhelming them with thousands of pages of documentation.

Before any additional guidance documents are issued we encourage you to determine whether or not existing guidance and practices already address some of these disclosure issues; continue to share draft guidance and solicit feedback from interested parties; and, consider whether or not output from these requirements will be meaningful information to consumers or simply an additional regulatory burden on health plans. ABHW supports a transparent process where subject matter experts, including payers, develop general templates (both for participants and for states) that can be released for public comment. We do not believe payers should be mandated to use model forms. We support keeping the disclosure requirements at a level where consumers

will understand the information they receive and will not be overwhelmed with a U-Haul truck of complex information.

We do not recommend different types of model forms for different scenarios. This will further complicate the disclosure issue for consumers and payers and add an unnecessary administrative burden. A voluntary model form should be general and descriptive in nature so that an individual does not have to spend days reading and interpreting the information disclosed to them. It is important to recognize that not every disclosure inquiry necessitates disclosure of all documents that are available to be disclosed in order to answer the question.

If a model form is developed for states to use in their review of a plan we support the same process as outlined above, a transparent process where subject matter experts, including payers, develop the form and then the public is given the opportunity to comment on the form.

Comments on Draft Model Form to Request Documentation

ABHW believes that use of a model form should be voluntary and not mandated and should keep in mind the comments above, overloading a consumer with a large amount of information or technical methods and analyses will not be beneficial to the individual and will be overly burdensome to the health plan. The draft form needs to be simplified and we suggest that a pilot is conducted to test the effectiveness of the form before it is finalized. The form should also include a cover sheet or addendum that explains the terminology that is used (i.e. medically necessary, prior authorization, drug formulary, etc.)

Instead of the four broad requests for information listed toward the end of the form we suggest the form take a check list approach. This would be easier to comprehend and would still help the consumer get an understanding of whether or not their plan is parity compliant. The checklist could include factors considered to determine whether or not a certain medical management technique is used. An indication of parity compliance would become apparent fairly easily by looking at where the check marks are for behavioral health and where they are for physical health. A similar checklist could be developed for how behavioral and physical health medical necessity criteria was developed. We believe this format is more user friendly, gives insight into the parity analysis, and provides information to indicate parity compliance. More information can be requested if needed but in many cases this information would suffice. This type of form could also be pilot tested by the federal agencies.

The form should also make clear that a denial of a service or a prior authorization requirement does not mean that the plan has violated MHPAEA. Additionally, clarification is needed so that consumers do not think that submitting this form is part of the appeals process. Information provided to the consumer may inform their appeal but the submission of the form is separate from an appeal, this needs to be made crystal clear on the form.

The form also needs to note that if the form is submitted by an authorized representative, the health plan may need documentation showing that the individual is the consumer's authorized representative.

Additional Areas for Consideration

Increase Education to States

We know that federal regulators are working with the states to educate them about the intent of the federal parity law. ABHW recommends increased education about MHPAEA to state officials who are enforcing the law and its accompanying regulations. Consistent interpretation is necessary to provide regulatory certainty and help consumers better understand parity. Our member companies are currently faced with each state enforcing the federal law in a different manner. In some cases, states' interpretations are inconsistent with other states and the express guidance issued by the federal departments. Often times, states are asking parity compliance questions that in reality will not inform the state as to whether or not the plan is properly implementing parity. Managed behavioral health organizations (MBHOs) have also seen a lack of understanding at the state level that has led to attempts to incorrectly enforce the law. For example, at least four states have at various times interpreted the federal regulations (despite the express language of the regulations and clarifying guidance in the form of FAQs) to REQUIRE that a plan use the primary care payment as the only permissible copayment for outpatient behavioral health services. We hope that additional education and training will lead to more consistent enforcement across the states and ensure that all Americans are provided with the parity benefit that Congress and the federal regulators intended for them to have.

Parity Accreditation

ABHW encourages you to support the creation of a parity accreditation standard that would deem a plan parity compliant. Recognition of such an accreditation by consumers, federal and state governments, employers, and providers would support consistency of interpretation and assessment of parity compliance. If such recognition were to exist, ABHW and its member companies are willing to work with others to help develop this process.

Recognize Appropriate Clinical Differences

The interim final rule (IFR) recognized that there are times when a direct comparison between physical health and MH/SUD does not make clinical sense and is not appropriate for the consumer. We encourage the regulators to recognize that differences do exist between behavioral health and physical health in order to ensure that the best quality, evidence based care is being provided to consumers. Parity is important, but so is quality, we have to make sure that we are not so rigid with our implementation of parity that we end up compromising on quality care for consumers.

There are times when a nonquantitative treatment limitation (NQTL) should not be imposed in the same manner it is imposed for physical health care. There are differences between behavioral and physical health and the regulations should allow for some reasonable variation that is consistent with, and accommodates, those differences. Additionally, guidance needs to take into account the existence of different payment methodologies (i.e. diagnostic related groups (DRGs) exist for physical health but not for behavioral health) and how they impact management of the benefit.

ABHW members are responsible for paying for, and delivering, quality care. Yet this strict NQTL comparison to medical care that is in the regulations ties our hands and results in

elimination of terms and conditions being applied to behavioral health that are necessary and appropriate to ensure quality of care.

Recognize that Network Adequacy is not a Parity Issue

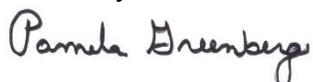
There needs to be recognition that the parity law was not intended to address behavioral health network adequacy issues. Behavioral health networks are influenced by a lot of factors that are external to plans, such as: lack of behavioral health providers in certain geographic areas, unwillingness of providers to contract with managed care, and a shortage of behavioral health providers. The network adequacy issue needs to be addressed but parity is not the right vehicle and comparing a physical health network to a behavioral health network is not an apples to apples comparison.

Bring Substance Use Confidentiality Laws into Parity with Physical and Mental Health

The parity laws do not include parity regarding access to and disclosure of substance use disorder records. This puts substance use disorder patients at greater risk and inhibits integrated care for these individuals. The 42 CFR Part 2, or Part 2, regulation authorized by a 40-year-old outdated law, separates a patient's substance use records from the rest of his or her medical records and treats them differently from records for any other medical or behavioral condition. Currently, only with signed authorization(s) from the patient, can substance use information be shared with providers and care coordinators. This is not the privacy standard used for any other medical care (including mental health). There is no parity in this area, and as a result, many individuals with a substance use disorder are receiving substandard, uncoordinated care. Part 2 is especially alarming in the current environment where the opioid addiction crisis demands closer coordination between medical providers and substance use treatment. This is fundamentally a parity issue, the Part 2 regulations should revert to the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment, and health care operations.

Thank you for the opportunity to comment again on disclosure and other issues related to parity implementation and enforcement. ABHW's member companies and I look forward to continuing to work with you.

Sincerely,



Pamela Greenberg, MPP
President and CEO
Association for Behavioral Health and Wellness