The National Center on
Addiction and Substance Abuse

September 13, 2017

Secretary R. Alexander Acosta
Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

Re: Mental Health Parity and Addiction Equity Act (Parity Act) Disclosures

Dear Secretary Acosta,

Thank you for the opportunity to submit comments to the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury in response to the joint request for comments in FAQ 38 regarding the draft model form for consumers to request information from insurers regarding nonquantitative treatment limitations (NQTLs).

The National Center on Addiction and Substance Abuse is a national non-profit research and policy organization focused on improving the understanding, prevention, and treatment of substance abuse and addiction. Last year, we reviewed each state's Essential Health Benefits benchmark plan and published the findings in our report, *Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans*.[1] We found that 18% of the 2017 EHB benchmark plans, the plans that establish the minimum required substance use disorder (SUD) treatment coverage in each state, contained facial parity violations.

We recently completed another report, *Parity Tracking Project: Making Parity A Reality*,[2] in collaboration with the Legal Action Center, Treatment Research Institute and Partnership for Drug Free Kids. In this study we sought to evaluate whether the two groups on the front-lines of Parity Act enforcement – regulators and consumers – could identify Parity Act violations. Regulators typically identify parity violations through the standard regulatory review process known as form review. Consumers must rely on publicly available plan documents to identify benefit and prescription drug coverage, out-of-pocket costs and any restrictions on accessing substance use disorder care, and identify plan design features that raise "red flags" for violations. We found that neither process is sufficient to identify parity violations.

In the course of our research on addiction treatment access and insurance coverage, we have identified several areas where additional guidance, clarification and/or enforcement of the Parity Act are needed. Clarifying and strengthening some of the existing parity framework will go a long way towards helping the millions of Americans suffering from addiction get the care they need. We urge DOL to enhance Parity Act enforcement by shifting the enforcement paradigm away from an individual complaint-driven model to a prospective compliance review model. Based on our studies, we do not believe that an

[1] https://www.centeronaddiction.org/addiction-research/reports/uncovering-coverage-gaps-review-of-addiction-benefits-in-aca-plans
[2] https://lac.org/wp-content/uploads/2017/06/ES_ParityTrackingReport_ASC.pdf

enhanced disclosure form alone would provide adequate protection to consumers, particularly with respect to NQTLs.

Although widely used by insurers, NQTLs are particularly harmful for patients with addiction because the design and application of NQTLs can limit patients' access to necessary, clinically indicated care and undermine treatment. For example:

- *Prior Authorization*. Requirements for prior authorization can add a further barrier to the already complex process of motivating patients to begin and stay in treatment. Addiction affects the parts of the brain associated with motivation, decision making, self-care and impulse control; therefore, engaging and retaining patients in treatment can be difficult. Because a patient's window of motivation to engage in treatment may be narrow and shifting, imposing delays in the initiation of care can result in a failure to follow up or return for subsequent appointments. Failing to retain patients can result in serious consequences for the patient, including returning to substance use, medical complications, overdose and death. Our review found that a majority of the 2017 EHB benchmark plans (33) explicitly require prior authorization for a range of SUD treatment services, including inpatient, outpatient, and intermediate services.

- *Fail-first Policies*. There is no clinical evidence to support the use of fail-first policies in addiction treatment. Clinical practice guidelines call for a comprehensive assessment of each patient to determine the appropriate therapies and level of care given the severity of the patient's addiction and the presence of co-occurring health conditions and other social/environmental factors. Requiring a patient to fail treatment at one level of care or to fail one specific therapy before starting clinically indicated care does not accord with these guidelines. In fact, the application of fail first policies in addiction treatment can negatively impact the timing and efficacy of treatment or deter patients from seeking needed treatment. For example, requiring a patient to fail psychosocial therapy before authorizing pharmaceutical therapy can cause patients to drop out of treatment. Pharmaceutical treatments reduce cravings and keep people in treatment longer; these medications work best when delivered together with psychosocial therapies, which is why the concurrent delivery of these treatments is generally recommended.

  Another example is to require a patient to fail one medication before authorizing another medication. Addiction medications have distinct mechanisms of action and help the patient achieve different outcomes (e.g., for alcohol use disorders, acamprosate is better for maintaining abstinence while naltrexone is better for reducing heavy drinking and craving), they are not interchangeable. The drug that is indicated for the patient should be prescribed first, no other hierarchy is clinically appropriate. The use of fail-first policies in these examples has the potential to compromise health and increase costs to the health plan.

- *Level of Care Exclusions*. Tailoring treatment to the specific needs of the individual patient is an essential component of effective care and can only be achieved when different levels of care are available. For example, when residential care is not available, the patient may seek care at an outpatient setting where his or her needs may not be addressed adequately, or at a hospital inpatient setting where unnecessary care may be provided at a higher cost.

Allowing for access to a range of levels of care, including inpatient, outpatient and intermediate services, may improve patient outcomes by matching patients to the appropriate level of care for their needs and may decrease costs to the health plan in the long-term. Our review identified 14 EHB benchmark plans with an exclusion for residential treatment. We believe level of care exclusions on intermediate SUD services when intermediate medical services are covered violates both the Parity Act and the Affordable Care Act because the exclusion is discriminatorily based on the patient's medical condition.

- *Reimbursing Only for Short-term or Acute Care Services*. Reimbursing only for short-term services is neither clinically appropriate nor consistent with the robust scientific evidence indicating that longer durations of treatment are more effective than short-term treatments for those with addiction. The medically-indicated length of treatment varies depending on the severity and complexity of the patient's disease and other factors. Length of treatment should be flexible and contingent on periodic evaluation of the patient's progress. Blanket limitations on allowed visits or lengths of stay do not accord with best practices for treating cases of addiction that are chronic and relapsing. When plans apply blanket limitations such as visit limits on SUD services only, this also constitutes a parity violation.

In addition to the harm caused by NQTLs, plan documents often lack information about the creation and application of NQTLs, making it difficult to determine whether plans are in compliance with the Parity Act's requirements that the NQTLs placed on SUD benefits be comparable to and applied no more stringently than the NQTLs placed on medical/surgical benefits. In our review of plans for *Making Parity a Reality*, we found that form review provides no information about non-quantitative treatment limitations, with the exception of pre-authorization requirements for specific levels of care.

As detailed in our *Making Parity a Reality* report, we are concerned that compliance and enforcement efforts at both the state and federal level have focused primarily on strategies that are of limited utility to root out parity violations. Discriminatory insurance coverage of mental health and substance use disorder benefits persists because the traditional regulatory approach to compliance review – plan document review, utilization review agent certification, and consumer compliant investigations – will not uncover the vast majority of Parity Act violations. Regulators are not given information that is required for complex analysis of parity compliance; consumers do not have information, capacity or resources to navigate the inefficient appeals process, particularly in the middle of a health crisis; and treatment providers face significant challenges to responding to the worst opioid epidemic in history, leaving little time to challenge the exclusion of medically necessary benefits (e.g., residential treatment and methadone maintenance therapy), excessive prior authorization requirements, denials of authorization or exceedingly short authorization periods. We do not believe that an enhanced disclosure form for consumers will rectify these issues.

We ask the federal government to improve enforcement by adopting a framework based on prospective review. As described in *Making Parity a Reality*, we recommend a prospective parity compliance review requirement, implemented through a Parity Act Transparency Compliance Report tool. Federal and state regulators should require insurers to submit this tool upon plan approval to prevent the sale of discriminatory health plans. This tool would be different from the current tools employed by state regulators

(e.g., market conduct surveys and audit coverage through data reporting) which only allow for limited review of the plan rather than the full scope of plan design features as written and in operation. Further, market conduct examinations occur after a plan is approved for sale and therefore insufficient for ensuring consumers have real-time access to non-discriminatory coverage by their health plans.

Pre-market compliance reports would place the responsibility for demonstrating compliance on the entities that have a legal obligation to offer parity compliant health plans and possess the documentation to demonstrate plan compliance. Other federal consumer health protection standards, such as the health privacy standards under the Health Insurance Protection and Portability Act (HIPAA), rely on an enforcement framework that places the onus on covered entities (including insurers and health care providers) to comply with the law rather than relying on consumer complaints.

The use of prospective review is fully consistent with other regulatory standards on carriers to demonstrate compliance to obtain market approval to sell plans to consumers and thereby create an economic incentive for carriers to address violations. CMS already requires Medicaid managed care organizations and States to demonstrate that their Medicaid programs comply with the Parity Act.[3]

Most important, prospective review would relieve consumers of the nearly impossible burden of identifying Parity Act violations and asserting their right to health care in the midst of a health crisis. The American Medical Association supports this strategy to improve parity compliance.[4] In addition, the President's Commission on Combatting Drug Addiction and the Opioid Crisis recommended the use of a standardized tool to improve compliance with the Parity Act in its interim report.[5] We believe that changing, instead of continuing to build upon, the current enforcement framework would better ensure plan compliance and afford consumers the protections of the Parity Act.

Thank you very much for your willingness to receive and consider our comments. We applaud the federal government's efforts to examine and understand the issues related to parity implementation and enforcement and provide assistance to consumers seeking to enforce their rights under the Parity Act. When properly implemented and enforced, the Parity Act will have a tremendous positive impact on patients seeking medically-necessary and lifesaving care.

Sincerely,

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[3] 42 C.F.R. § 438.920(b).
[4] https://www.ama-assn.org/report-shows-inconsistent-coverage-substance-use-disorder-treatment
[5] https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf