From:	Deb
To:	E-OHPSCA-FAQ.ebsa
Cc:	Patricia Beauchemin (TCA); cpmcmanus@wswdc.com; Steve Roman; Mike Harle; Greg Heller
Subject:	Comments - FAQs Nov182013
Date:	Tuesday, January 07, 2014 12:05:40 PM
Attachments:	E-OHPSCA-FAQ Nov82013 Comments from DASPOP.pdf

Please see the attached comments submitted by the Drug and Alcohol Service Providers Organization of Pennsylvania in response to request for comments (11/8/13 FAQs "Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation").

Joelen for Deb Beck
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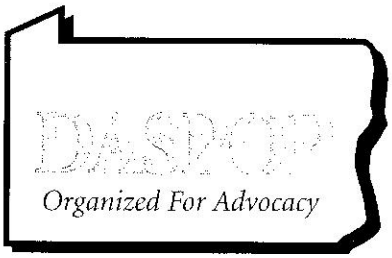

Drug & Alcohol Service Providers Organization of Pennsylvania

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Suite N-5653
Washington, DC 20210
Via Email: E-OHPSCA-FAQ.ebsa@dol.gov

RE: Enforcement of the Affordable Care Act & Mental Health Parity & Addiction Equity Act

The FAQs regarding the Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation (11/8/13) concluded with an invitation to make recommendations and comments on how "to ensure compliance with MHPAEA through health plan transparency, including what other disclosure requirements would provide more transparency to participants, beneficiaries, enrollees, and providers, especially with respect to individual market insurance, non-Federal governmental plans, and church plans."

This is, of course, where the rubber meets the road. Without strong and consistent enforcement, families with addictions will have coverage for treatment of addiction but no access to it and no access to appropriate levels of care and lengths of stay.

For this reason, when we submitted comments on proposed regulations for the Affordable Care Act to the U.S. Office of Personnel Management (RIN3206-AM-47) and to the Centers for Medicare & Medicaid Services (CMS-2334-P) in 2013, we spent a fair amount of time delineating concerns and recommendations regarding enforcement and accountability.

In response to this FAQ invitation regarding enforcement, we are now submitting these recommendations and comments for your review.

Enforcement

Currently, Pennsylvanians have difficulty accessing addiction treatment through self-insured plans and other plans falling under the provisions of MHPAEA. The MHPAEA and the ACA hold out the promise that everyone will be able to get help, including Medicaid populations. However, until strong enforcement is worked out for the MHPAEA, we fear that this will be chimerical – everyone will appear to be covered but no one will be able to get treatment.

In all of our states, people can access all the drugs and alcohol they want all of the time and with very little effort. Sadly, access to treatment for alcohol and drug problems continues to be heartlessly complicated.

This problem can only be solved by strict enforcement of the MHPAEA and the ACA, including Medicaid provisions.

Working out the problems of enforcement of these laws is critical particularly in regard to people with untreated addictions. Immediacy of enforcement here can literally mean the difference between life and death.

For this reason, it is essential that internal and external review processes are available and that they work efficiently and well and reflect the urgency of untreated addiction. The current OPM appeal process is not designed for the urgency and desperation of untreated addiction. (We have seen appeals take as long as eight months to resolve.) We urge you to take a hard look at this process and the resources that are devoted to it with an eye on the often-fatal consequences and always costly delays in provision of addiction treatment.

It is also essential that families keep their rights to seek redress in the civil courts. There is nothing in the ACA that preempts private, State-law claims and the proposed regulations do not (and cannot) eliminate any such claims. Clarification of this could be helpful. Plan issuers should not be allowed to create, out of regulatory ambiguity, immunities that are not established in the law.

Accountability – Need for Special Consumer Protections

Stigma and embarrassment continue to surround alcohol and other drug addiction and keep both the patient and his/her family from speaking out

and insisting on appropriate and timely treatment. For this reason, we can't rely on consumer complaints, nor count on intimidated treatment programs to hold the health plans accountable. Because of this and the horrific cost of untreated addiction to our nation, we recommend the development of strong, transparent accountability systems that are specific to this illness to ensure that health plans actually provide treatment for those in need. Without such specific accountability systems and measures of compliance with law, the treatment component of the nation's War on Drugs will continue to be weak and ineffective.

The regulations refer to accreditation standards, which rely heavily on the Healthcare Effectiveness Data & Information Set (HEDIS) measures. Unfortunately, when it comes to addiction and addiction treatment, these standards are not sufficient. Frankly, the current HEDIS measure for addiction treatment is an extremely blunt instrument. It lumps all addiction treatment together and provides basically no information at all about the type, setting and intensity of care that patients are receiving. The problem is compounded by the private nature of HEDIS standards which ordinary citizens cannot even examine (HEDIS charges hundreds of dollars to every individual who wants to review the standards and see what they really measure!). Simply put – untreated addiction is too important to leave hidden behind a paywall.

Recommendation of a Strong Role for Single State Authorities

As part of ensuring health plans' compliance with the addiction treatment provisions of law, we recommend that states' Single State Authorities on Drug and Alcohol Abuse be empowered and funded to publish – and make widely available – annual reports on each health plan, including such data as the number of people receiving treatment, level of care, length of stay, comparisons to benchmark requirements and to publicly funded treatment, meaningful outcome measures and other data that will provide accountability.

This disclosure of proper provision of addiction treatment for subscribers and their families should become a point of pride for insurers – a demonstration in the public square of their shared commitment to public safety, to saving lives and reducing health care costs.

I also offer one final point, which is a lesson learned from the decades of hard work that our citizens have put in. There are a lot of ways that managed care companies can prevent patients from getting access to needed addiction treatment. Plan design is one way (if a benefit is not in the plan, it won't be covered). But there are also a lot of other ways that managed care plans can stand between patients and care. Creating formal barriers is one way – that is precisely why State laws that formally regulate the method of accessing a benefit are so important. But managed care plans also manipulate patient care through an incredible array of other barriers – unreturned phone calls, lost bills and files, browbeating of treatment facility personnel, episode of care payments that reward inadequate care, manipulating network design, etc. There seems to be no limit to these soft but devastating barriers; they are apparently limited only by the ingenuity of man.

We appreciate this opportunity to make recommendations on enforcement and accountability, keeping in mind that plan design is only one small part of a much larger compliance, healthcare, and public safety challenge.

To reiterate a point made earlier – without specific accountability systems and measures of compliance with the law, the treatment component of the nation's War on Drugs will continue to be weak and ineffective.

Sincerely,

Deb Beck
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January 7, 2014