From: Kara Kukfa
To: E-OHPSCA-FAQ.ebsa
Subject: Comments MHPAEA
Date: Wednesday, January 08, 2014 3:50:49 PM
Attachments: FINAL PJK comments 010814.docx

Attached are comments on the final rules for MHPAEA from former Congressman Patrick J. Kennedy.

Best,
Kara

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The Departments request comments on what additional steps, consistent with the statute, should be taken 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.

Please send comments by January 8, 2014 to E-OHPSCA-FAQ.ebsa@dol.gov.

Comments submitted by:

Patrick J. Kennedy
Member of Congress
1st District, Rhode Island
1995 - 2011

As the prime House sponsor of MHPAEA, I was very happy to see the final rule for the Act announced in November, and welcome the opportunity to provide further comments about transparency and disclosure under the statute. I strongly believe that the effective implementation of these requirements will determine the law's ability to achieve the ambitious goals I shared with my colleagues in the House and my late father and his colleagues in the Senate.

In order to have true parity, the first thing we need is much more information about where we are, and what—if anything—has changed in the five years since MHPAEA was signed into law. The only way to know whether insurance coverage for substance abuse and mental health disorders is fully symmetrical with coverage for all other medical problems is if we can gather, analyze, and compare the information generated by insurance plans, service providers, and service users and plan subscribers, as well as those in government who are overseeing implementation of the law and enforcing compliance with it. Transparency and disclosure are our diagnostic tools to determine the health status of parity.

I appreciate that in developing rules for the implementation of MHPAEA, the departments of Labor, Treasury, and Health and Human Services drew on vast ongoing experience with oversight and enforcement of statutory requirements, and I am very pleased with the resulting framework. At the same time, I am acutely aware that we still will need to map this territory as we traverse it, and we must be certain we are using all tools and mechanisms at our disposal to gain and maintain a clear picture of where we are.

One way to improve the final rule, I think, is to provide much more clarity on exactly what information insurance plans must disclose to potential customers before they make decisions, and to clients after they are insured. As someone who talks to a wide range of people representing different perspectives in the field—patients and clinicians, professional groups and advocacy groups, treatment facilities, pharmaceutical companies, think tanks, academic institutions, insurance companies and lawyers who bring cases for

and against all of them—I can say with certainty that when it comes to details of coverage, more is more. Detailed rules requiring greater clarity will help cut down on misunderstandings and the kind of recrimination that too frequently characterizes relations between plans and their subscribers and will help to underscore the common purpose plans share with providers and clients to get the best care to those who need it in the most direct manner.

The rule has admirably clarified plans' obligations in explaining Non Quantifiable Treatment Limits (NQTLs). To build on this, I believe the insurance plans should make information about NQTLs – and the criteria and processes by which they are determined – available to potential subscribers at the time they are considering participating in them. While a requirement of this sort may appear to place a limitation on plans and plan administrators, transparency at this stage would ensure that potential subscribers have the opportunity to fully understand the coverage they will receive.

The final rule acknowledges that the law can only serve its intended purposes if subscribers are provided with descriptions of any and all NQTLs cited in any adverse benefit determination. It is important at the same time for plans to provide descriptions of NQTLs in use for medical/surgical procedures. Such a requirement would enable subscribers and those monitoring plans' compliance with the law to understand whether coverage for mental health and substance abuse services meets the parity standard.

An additional concern repeatedly been brought to my attention has to do with the adequacy of the provider networks assembled by plans in the geographic areas they serve. It is important for government entities and subscribers monitoring compliance with MHPAEA to be able to determine whether or not the number of providers credentialed in mental health and substance abuse service specialties is equivalent to specialists available in other medical/surgical areas of practice. It would be unacceptable for a plan to claim that it is in compliance with MHPAEA if the network it supports cannot meet the service demands of its subscribers or offer a level of provider choice comparable to medical/surgical services. Plans must be able to show that the providers they credential are actually accepting patients for mental health and substance abuse services at the same rate as providers in various medical/surgical specialties. Anything less would not meet the parity standard as I understand it.

And let's not forget that more mental health and substance use treatment occurs in general medical offices than in specialty mental health and addictions settings. In the system for compliance and enforcement that I envision, government monitors will be able to determine whether plans are applying parity standards in all settings. It will be critical to our understanding of the law to know what benefits determinations are being made for treatment delivered in the general sector as well as in specialty offices and facilities. Understanding this complex dynamic will be increasingly important as the Affordable Care Act and overall health reform move practices towards more integrated care for the whole person.

In every way, implementation of the new rule is a learning process. So I would like to see the rule more directly encourage the various federal, state and local departments it governs to make lessons learned from oversight and enforcement as available to the public as possible. Many enforcement actions will result in clarifications of policy or procedure. It is my hope that the departments can bring the benefits of these lessons to the broadest possible audience, perhaps through publication of de-identified FAQs that show how the policies or procedures have been refined through enforcement actions.

We can learn from the actions of other government agencies in this regard. Consider the approach taken by the Internal Revenue Service in the instructions it provides taxpayers, which include examples of what expenses may be acceptable tax deductions under a particular provision. As health plans and their subscribers in communities across the country continue to become familiar with MHPAEA, I expect that we will steadily refine our understanding of its scope in similar ways. At the same time, remember, our nation's health care system is experiencing its greatest transformation in decades. To understand how the law will apply in circumstances we perhaps cannot yet imagine, we need unprecedented levels of transparency, steady, real-time scrutiny and truly aggressive oversight.

Once more, I'd like to thank the departments for their diligent work in producing clear and useful guidance for implementation of this important statute. I look forward to contributing my thoughts as all of us – insurers, providers, health care consumers, legislators, and regulators – work to ensure fair and equitable insurance coverage for mental health and substance use conditions.