Partnership to End Addiction

July 24, 2020

Amber M. Rivers
Director
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

Re: **Proposed Updates to the 2020 MHPAEA Self-Compliance Tool**

Dear Ms. Rivers,

Thank you for the opportunity to provide comments on the Department of Labor's (DOL) proposed updates to the 2020 MHPAEA Self-Compliance Tool.

Partnership to End Addiction (formerly Center on Addiction + Partnership for Drug-Free Kids) is a national nonprofit providing personalized support and resources for families impacted by addiction. With decades of experience in direct services, communications and partnership-building, we mobilize families, policymakers, researchers and health care professionals to more effectively address addiction systemically on a national scale.

One of our policy priorities is to increase access to affordable addiction treatment by reducing insurance barriers. The Mental Health Parity and Addiction Equity Act (the Parity Act) is one of the strongest tools available to improve insurance coverage for addiction treatment, but it continues to be under-utilized due to non-compliance and weak enforcement. We are grateful for the Department's efforts to improve implementation through the issuance of compliance tools. The Self-Compliance Tool clearly articulates the Parity Act's regulatory standards in a user-friendly form and provides important examples of how the law applies in certain situations. We strongly support many of the proposed updates to the 2020 MHPAEA Self-Compliance Tool.

Nonetheless, we are concerned with DOL's recommendation for health plans to adopt a voluntary compliance plan because we believe the Parity Act **requires** health plans and issuers to have an internal compliance plan. Suggesting that an internal compliance plan is not required places an undue burden on regulators and consumers and undermines states' efforts to require plans to report on compliance standards. We are also concerned with DOL's recommendation for plans to use the NAIC Market Conduct template for data gathering and compliance review because the tool is inadequate. Recommending the use of inconsistent guidance and tools to regulators, issuers and plans, and consumers

will further inhibit strong enforcement of the Parity Act. Instead, we urge DOL to identify the MHPAEA Self-Compliance Tool itself for purposes of compliance testing and guidance.

We are particularly supportive of several of the updates to the Self-Compliance Tool, which address a number of common problems and provide important clarifications about the application of the Parity Act.

1. Coverage of Medications for Opioid Use Disorder (MOUD). DOL explains that plan requirements for coverage of MOUD to be contingent on availability or participation in behavioral or psychosocial therapies/services are not permissible under the Parity Act unless the plan uses a comparable process to determine a similar limitation for medical/surgical services. DOL also explains that when prior authorization is required for MOUDs but not comparable medications, it may be a warning sign for a parity violation. While commonly imposed, prior authorization requirements for MOUD are not clinically appropriate, and counseling requirements are not evidence-based.[1] They create unnecessary barriers to life-saving medications. An explanation that such requirements may also violate the Parity Act will help in ensuring health plans do not impose arbitrary requirements on MOUD.

2. Specialist Co-Payment for MH/SUD Providers. We also strongly support DOL's new Warning Sign that the plan's application of a specialist co-payment for mental health and substance use disorder (MH/SUD) providers may violate the Parity Act if the plan only applies the specialist co-payment to some of the medical/surgical benefits in the same classification. We published a review of the 2017 EHB benchmark plans[2] and a follow-up study evaluating a sample of individual market plans sold in each state in 2017.[3] Among the 2017 EHB benchmark plans (which are still in effect in many states), we identified Arkansas, Delaware, Pennsylvania, South Dakota and West Virginia, as requiring the specialist co-payment for MH/SUD providers. In 2017, plans sold in Alabama and Alaska required the specialist co-payment for MH/SUD providers. This Warning Sign is particularly important for consumers because it is easy to identify. The current enforcement framework relies on consumer complaints to identify parity violations, but consumers are often unaware of the law or its protections. It is also difficult for consumers to readily identify Parity Act violations because they often require information that is not available to the consumer. This Warning Sign is straightforward and can be readily identified by consumers.

3. Provider Reimbursement Rates. The updated Self-Compliance Tool also contains important notes, examples and warning signs related to reimbursement rates for MH/SUD providers. While reimbursement rates have long been subject to the Parity Act's requirements for nonquantitative treatment limitations (NQTLs), disparate and discriminatory reimbursement rates for MH/SUD providers continue to be an ongoing issue. In our work examining parity and MH/SUD treatment access issues in five states, low reimbursement issues were

[1] National Academies of Sciences, Engineering and Medicine. (2019). *Medications for Opioid Use Disorder Save Lives*. Retrieved from https://www.nationalacademies.org/our-work/medication-assisted-treatment-for-opioid-use-disorder.
[2] Partnership to End Addiction. (2016). *Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans*. Retrieved from https://drugfree.org/reports/uncovering-coverage-gaps-a-review-of-addiction-benefits-in-aca-plans/.
[3] Partnership to End Addiction. (2019). *Uncovering Coverage Gaps II: A Review and Comparison of Addiction Benefits in ACA Plans.* Retrieved from https://drugfree.org/reports/uncovering-coverage-gaps-ii-a-review-and-comparison-of-addiction-benefits-in-aca-plans/.

frequently cited by provider groups.[4] This is supported by Milliman's research, which found that reimbursement rates for primary care providers are higher than those for psychiatrists for the same services and that such disparities have worsened in recent years.[5] Inadequate reimbursement rates likely contribute to the ongoing shortage of behavioral health providers and must be addressed to increase access to MH/SUD care. Hopefully, the additional information in the Self-Compliance Tool will lead to greater investigation of discriminatory practices and enforcement of Parity Act requirements related to reimbursement rates.

We respectfully request that DOL reconsider the following proposed updates.

1. Compliance Plan. We appreciate DOL's description of common elements of an internal compliance plan and the identification of plan materials that DOL investigators may request in an audit. We are very concerned, however, by the suggestion that an internal compliance plan is ***optional***. We believe health plans and issuers are **required** to have an internal compliance plan to meet the legal obligation to "not sell a policy, certificate, or contract of insurance that fails to comply with [parity requirements with respect to aggregate lifetime and annual dollar limits, financial requirements, and treatment limitations]…".[6] It is well recognized that an enforcement strategy that relies on consumer complaints is not effective because of the complexity of the Parity Act and the lack of access to plan documents and internal decision-making processes. For this reason, a growing number of states are adopting mandatory parity compliance and data reporting requirements to ensure better enforcement of the Parity Act. Any suggestion that federal regulators construe the law as not requiring an internal compliance program could undermine those and future state efforts and hinder uniform implementation of the law. A stronger compliance framework, which requires plans to provide data and information about internal processes to regulators, is needed to shift responsibility to plans to demonstrate compliance with the law. Requirements for plans to implement compliance plans should be mandatory, not voluntary. We urge DOL to remove the phrase "[a]lthough not required by MHPAEA" in the introductory statement to Section H.

2. Data Collection Tool. We urge DOL to delete the suggestion that plans use the NAIC Market Conduct template as a self-compliance tool and instead require plans to utilize the MHPAEA Self-Compliance Tool for internal reviews. The NAIC tool is inadequate because it omits key NQTLs, is not suitable for comparative analyses, and is less rigorous than templates that have been adopted by state regulators.[7] In addition, DOL's endorsement of one tool to the exclusion of others being adopted by state Departments of Insurance in connection with mandatory compliance reporting and those currently under development by the NAIC MHPAEA Working Group B will create confusion and undermine the adoption of more effective tools. **Fundamentally, we believe that the DOL's identification of any particular tool is at odds with the development of the Self-Compliance Tool itself.** The tool constitutes the guidance of the federal regulators that possess authority to enforce the Parity Act

[4] Vuolo, L., Oster, R., & Weber, E. (2018). Evaluating The Promise And Potential Of The Parity Act On Its Tenth Anniversary. *Health Affairs.* Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20181009.356245/full/.
[5] Melek, S., Davenport, S., Gray, T.J. (2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. *Milliman*. Retrieved from https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx.
[6] Parity in mental health and substance use disorder benefits. 29 C.F.R. § 2590.712(h), 2010.
[7] *See, e.g.*, 3 Code Colo. Regs. 702-4:4-2-64 and Appendices (2020).

Thank you very much for your willingness to receive and consider our comments. We also fully support the comment letter submitted by the Legal Action Center and their recommendations for the Self-Compliance Tool.

We applaud DOL's ongoing commitment to implement and enforce 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 for mental health and substance use disorders.

Sincerely,

Lindsey C. Vuolo
Vice President of Health Law & Policy