ABHW
Association for Behavioral Health and Wellness
Advancing benefits and services in mental health, substance use and behavior change.

AN EXAMINATION OF FEDERAL MENTAL HEALTH PARITY LAWS AND REGULATIONS

STATEMENT OF
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Introduction

Good Morning, Chairman Pitts, Ranking Member Green, and distinguished members of the Subcommittee. Thank you for the opportunity to testify before you today on the important issue of mental health parity laws and regulations. My name is Pamela Greenberg, and for the last 18 years I have served as the President and CEO of the Association for Behavioral Health and Wellness (ABHW). ABHW is an association of the nation's leading specialty behavioral health 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 access and health care outcomes for individuals and families.

Since its inception in 1994, ABHW has actively supported mental health and addiction parity and we believe that it is important to diagnose and treat mental health and substance use disorders at an early stage. ABHW was an original member of the Coalition for Fairness in Mental Illness Coverage (Fairness Coalition), a partnership developed to win equitable coverage of mental health treatment. Other members of the Fairness Coalition were the American Hospital Association, American Medical Association, American Psychiatric Association, American Psychological Association, Federation of American Hospitals, Mental Health America, National Alliance on Mental Illness, and the National Association of Psychiatric Health Systems. In the four years prior to passage of the Mental Health Parity and Addiction Equity Act (MHPAEA), ABHW served as the Chair of the Fairness Coalition. 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 MHPAEA's passage in 2008, we have worked closely with the law's three regulating agencies: the Department of Labor (DOL), the Department of Health and Human Services (HHS), and the Department of Treasury, to ensure that our member companies understand the intent of the regulations in order to properly implement MHPAEA. In those dozens of conversations, we also have had the opportunity to

provide information to the regulators on challenges presented by the law, the regulations, and their enforcement.

In my testimony today I will provide a brief overview of MHPAEA, discuss compliance and enforcement, and suggest some next steps as we continue to move forward with parity implementation.

Overview of MHPAEA

MHPAEA expands upon the Mental Health Parity Act of 1996 that created parity for annual and lifetime limits between mental health and physical health benefits. MHPAEA applies to employer plans with over 50 employees that choose to provide coverage for mental health and substance use disorders. MHPAEA does not mandate coverage for mental health and substance use disorders. The law states that financial (copayments, coinsurance, etc.) and treatment limits (day or visit limits) can be no more restrictive than those on the physical side. Additionally, the law requires the disclosure of medical necessity criteria and the reason for a denial, if one is issued. The law also provides that if an out-of-network benefit is offered for physical health, it also needs to be offered for mental health and substance use disorders. ABHW, and many others, supported all of these provisions. The interim final rule issued in 2010 and the subsequent final rule released in 2013 added parity for nonquantitative treatment limitations (NQTLs). Examples of NQTLs are medical management, formulary design, and provider network admission standards. The processes, strategies, evidentiary standards, or other factors used by a health plan to apply an NQTL to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used on the physical side. What is important to keep in mind with NQTLs is that the parity comparison is not a mathematical one. Even though the same process is applied, the results may be different; but this does not mean the plan is noncompliant with MHPAEA. It is equally important to note that parity was not intended to be the panacea for all mental health and addiction issues. For example, parity does not address our workforce shortage issues, nor does it look at the quality of care that is being provided.

The Affordable Care Act extends MHPAEA to small group and individual market plans and requires qualified health plans in the health insurance market place to offer mental health and substance use disorder benefits as part of the essential health benefits and provide these behavioral health benefits at parity with physical health benefits. Additionally, a State Medicaid Director's letter issued in 2013 discussed parity in Medicaid; and in March 2016, a final rule was issued regarding the application of parity to Medicaid. Just last week a final parity rule was issued for TRICARE. At this point, virtually everyone with behavioral health insurance coverage, with the exception of Medicare beneficiaries, should have parity in their mental health and substance use disorder benefit.

Compliance and Enforcement

As with most regulations, the MHPAEA rules have grey areas that are open to different interpretations. Since the Interim Final Rule was issued, ABHW has worked to identify these areas and to seek clarification from the regulators as to their intent. Our member companies have proactively worked 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 from multiple departments in both physical and behavioral health working diligently to exchange information and perform the required parity analyses in order to implement and provide a mental health and substance use disorder parity benefit to their consumers.

The analyses are complex. One member company explained to the regulators that they have to perform analyses with over one hundred health plans for just one of their employer customers. This includes obtaining information on financial, treatment, and nonquantitative limits from each physical health plan, which may or may not be the same company as the behavioral health plan, and performing the financial analysis in the case of quantitative limits or the no more stringent analysis for NQTLs. These analyses need to be completed for each variation of the medical plan offered by our customers. Our member companies' customers can include employers, health plans, and states.

For example, in order to complete the parity analysis, ABHW member companies perform some version of the following with each medical plan:

1. Review summary plan documents of benefit descriptions
2. Review medical necessity criteria and medical policy
3. Review medical management program descriptions
4. Review network-related issues, including credentialing and reimbursement
5. Conduct discussions with group health plan administrator and medical/surgical plan regarding process for development and application of NQTLs
6. Document underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) on this compliance tool as evidence of completion
7. Review findings with the organization's legal team
8. Review findings with stakeholders and recommend changes to benefits or practices (if any)

ABHW members have been audited for parity compliance at both a state and federal level. At a state level this could include one or more of the following activities: market conduct exams, state regulatory inquiries, attestations, and audit questionnaires. In one state, this audit process has taken over one year. The DOL and HHS have also been actively enforcing MHPAEA through investigations and health plan audits. In its January 2016 report to Congress, the DOL reported that since October 2010, the DOL's Employee Benefits Security Administration (EBSA) had conducted 1,515 investigations related to MHPAEA and cited 171 violations. Kaiser Health News reported that HHS found 196 possible violations from September 2013 to September 2014, and all complaints were resolved through voluntary changes by the plans. This means of resolution is a better solution than a lawsuit; as the problem gets resolved more expediently; and tax payer and health care dollars are not wasted on legal fees.

In addition to enforcement, the three federal regulating agencies have issued multiple sets of frequently asked questions (FAQs) that provide both guidance and education as to the intent of the final regulation. This year, President Obama also established a White House Mental Health and Substance Use Disorder Parity Task Force (Task Force) that will "identify and promote best practices for executive departments and agencies (agencies), as well as State agencies, to better ensure compliance with and implementation of requirements related to mental health and substance use disorder parity, and determine areas that would benefit from further guidance." We have met with members of the Task Force on several occasions and hope to see some of our recommendations included in its final report.

To say that parity is not being implemented and enforced is a misrepresentation. The law is complex, and so is the enforcement process. It is important to recognize the strides that have been made and work together to develop best practices to move forward.

Ideas for Next Steps

The parity analysis has become a strict one-way analysis with no recognition of the differences that do exist between behavioral health and physical health. Any flexibility that once existed has been taken away through rules and additional guidance. We believe that a one-way parity analysis does not always lead to the best quality of care for consumers and that there are times when a NQTL should not be imposed in the same manner it is imposed for physical health care. It is critical 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; and 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. Parity should not just be about the correct analysis being done; we should be asking, "Does this comparison result in good care for the patient?"

Another area that needs further discussion is disclosure. Consumer education and understanding was an important principle of the original legislation, and transparency and disclosure of information to

consumers is important. But we also have to keep in mind the results of a new research paper published in the Journal of Health Economics that found that 86% of participants could not define deductible, copay, coinsurance, and out-of-pocket maximum in a multiple choice questionnaire. The study leads us to believe that plan documents will also be difficult for a consumer to understand.

Recent legislative attention in the area of disclosure has contributed to the regulators issuing additional guidance on what information consumers have the right to ask for from their health plan. What is missing from this discussion has been the understandability of these documents once they are disclosed to an individual. We can provide consumers with thousands of technical papers that they may not have time to read and understand, or we can take the time to talk about what is the exact information a consumer needs in order to understand how a decision has been made or how parity has been applied. There needs to be a more concise option for consumers who want to understand how their health plan has implemented parity without burying them with hundreds of documents. We have begun this conversation with the three regulating agencies and members of the Task Force. Some ideas to consider include the development of a document that a plan would use to explain how they have performed the parity analysis; this would help guide the plan as to what information they need to provide and would not over burden the requesting party with an overabundance of documents. Another idea is to provide examples that would include scenarios of questions a consumer might have and documents that a consumer may want to request in order to have their questions answered. Additional information can always be requested but these alternatives would at least not immediately inundate someone, especially at a time that they or a loved one may be in treatment.

A third area that needs additional attention is education. This includes education to consumers, providers, employers and others as to what is and isn't included in MHPAEA, as well as additional education to states that are responsible for MHPAEA enforcement. HHS is working with states to educate them about the intent of the federal parity law and respond to their technical questions; they are engaged with the National Association of Insurance Commissioners (NAIC) to help ensure that all states have the same

understanding of the intent of the parity law and regulations. DOL has issued both a compliance assistance guide and a compliance check sheet to assist employers and their advisors with compliance. The Substance Abuse and Mental Health Services Administration (SAMHSA) also has educational information about MHPAEA on its website and recently issued Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States. We commend these agencies for their work and recommend increasing education and guidance about MHPAEA to state officials who are enforcing the law and its accompanying regulations. Our member companies are currently faced with disparate interpretations by state agencies enforcing the federal law. In some cases, states' interpretations are inconsistent with other states and also with 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. Many of our members 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 to require that a plan use the primary care payment as the only permissible copayment for outpatient behavioral health services (despite the express language of the regulations and clarifying guidance in the form of FAQs laying out a mathematical formula that should be used to calculate copayments). We hope that additional materials, 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.

Furthermore, ABHW supports the release of de-identified information related to compliance issues discovered by the regulating agencies. De-identified information that is released could also include best practice examples where plans have correctly implemented MHPAEA. The availability of this information will allow health plans and managed behavioral health organizations (MBHOs) to reexamine their compliance process to ensure that they are implementing parity according to the full intent of the

regulations. This information will also provide interested parties with a thorough picture of the intent of the final rule and will lead to improved compliance.

As I mentioned earlier, MHPAEA does not, and was not intended to, fix all of the problems impacting behavioral health. In that vein, there are two "parity" issues that I'd like to call your attention to as we look forward to 2017: the lack of parity in access to and disclosure of substance use disorder records (42 CFR Part 2) and the lack of meaningful use incentive payments for several categories of behavioral health providers. The separation of a patient's substance use records from the rest of his or her medical records is not the privacy standard used for any other medical care (including mental health). This law is especially alarming in the current environment where the opioid addiction crisis demands closer coordination between medical providers and substance use treatment. Added to this is the fact that most behavioral health providers did not receive meaningful use incentive payments to encourage the use of electronic health records. As a result, integration of behavioral and physical health records and treatment is further obstructed.

Conclusion

Thank you again for the opportunity to testify before you today. As parity implementation continues, we welcome ongoing discussions with the Subcommittee. I believe we all share the same goal of access to quality mental health and substance use disorder care for all.