Depression and Bipolar Support Alliance

March 6, 2018

Jeanne Klinefelter Wilson
Deputy Assistant Secretary
Employee Benefits Security Administration
Department of Labor
200 Constitution Ave, NW
Washington, DC 20001

RE: Definition of "Employer" under Section 3(5) of ERISA -- Association Health Plans (RIN 1210-AB85)

Dear Secretary Wilson:

Thank you for the opportunity to comment on the Department of Labor's Proposed Rule on the Definition of an "Employer" under Section 3(5) of ERISA related to Association Health Plans.

DBSA is the leading peer-directed national organization focusing on mood disorders: depression and bipolar disorder. Unlike any other organization of its kind, DBSA is created for and led by individuals who themselves live with a mood disorder, with our bylaws stipulating that more than 50 percent of both the governing board of directors and paid professional staff have the lived experience of a mood disorder. This first-person lived experience informs everything that we do.

DBSA envisions wellness for people with mood disorders. And, we believe that an open and collaborative approach to treatment—one that accounts for a person's mental, emotional, and physical health—is what allows people to achieve what they personally define as wellness. DBSA has a long history of providing cutting-edge, interactive online tools and resources that allow individuals to understand, choose, manage, and evolve their treatment plans. Additionally, our network of 235 chapters across the country offer more than 650 free, in-person support groups. Many of our support groups include young people or are for the parents and friends of young people. These programs, enable DBSA to reach over three million people each year with current, readily understandable information about depression and bipolar

disorder; connections to treatment and community resources; and—crucially—the hope that wellness is possible.

Ultimately, we believe that our balanced, person-centered, wellness-oriented approach is what has allowed us to educate, empower, support, and inspire individuals to achieve the lives they want to lead for our more than 30 years in existence. It is from this perspective of experience and relationships that we believe that DBSA is uniquely positioned to provide comment and share stories from our participants.

We are committed to working with the Administration on the prompt, effective implementation and enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA).

SUMMARY OF RECOMMENDATIONS

Please find below the following comments on the Proposed Rule with a focus on areas in which we feel uniquely qualified to comment – Essential Health Benefits (EHBs) and implementation and enforcement of MHPAEA.

As an overarching principle, we believe all Americans must have equitable access to mental health and substance use disorder (MH/SUD) treatment. This is no less true for people living with bipolar disorder as people living with this mental health condition have the highest rate of substance abuse of all the mental health diagnoses.

This is not only the right thing to do, but also yields substantial cost savings in the treatment of other chronic medical conditions. Any changes to the definition of an "employer" and/or "group health plan" must maintain or increase access to lifesaving MH/SUD services.

Essential Health Benefits

> While we appreciate the Administration's goal of allowing employers and other groups to band together as Association Health Plans (AHPs) to increase their negotiating power and lower costs, we are concerned that, without adequate patient protection guardrails, the result could be reduced access to MH/SUD coverage, which would be particularly devastating amid the opioid misuse and overdose and suicide epidemics.
>
> ***Implementation and Enforcement of the Mental Health Parity and Addiction Equity Act***
>
> We ask the Administration to fully implement and enforce MHPAEA and implement the recent important recommendations made by the President's Commission on Combatting Drug Addiction and the Opioid Crisis (the Commission).

ESSENTIAL HEALTH BENEFITS

Given that 25% of people living with bipolar disorder will attempt suicide at least once in their life and that depression is the number one cause of disability in the United States, equitable

access to a full continuum of mental health and substance use disorder treatment services, , must be an essential component of health care coverage. It is also critical that mental health and substance use disorders be covered on par with other medical conditions consistent with MHPAEA.

Ensuring Americans have access to mental health substance use disorders treatment is not only the right thing to do – it's the cost-effective thing to do, yielding a return on investment that will benefit employers and our economy. For example:

- One study found that expanding funding for and access to mental health services reduces government costs for other services and,
- Early intervention reduces the likelihood of costly emergency care which can reduce costs from $13,037 per adult for emergency care to $626 for moderate early intervention care.
- One study found that substance use treatment is associated with a reduction of medical expenses for Medicaid beneficiaries of approximately $2,500 annually.
- Another study found that, "on average, substance abuse treatment costs $1,583 and is associated with a monetary benefit to society of $11,487, representing a greater than 7:1 ratio of benefits to costs. These benefits were primarily because of reduced costs of crime and increased employment earnings."
- Another study found that individuals who received substance use treatment had a 26% reduction in health care costs and had reduced Emergency Department visits and hospitalizations.

Moreover, the cost of the opioid misuse and overdose epidemic is significant. A study released by Altarum in November 2017 found that the economic burden of the epidemic is $95 billion annually. Altarum reported that the federal government alone assumes $29.2 billion of the costs, primarily in the form of lost tax revenue, health care costs and criminal justice related costs.

- **Recommendation:** Association Health Plans must ensure that their MH/SUD benefit is robust and compliant with the Mental Health Parity and Addiction Equity Act. Flexibility in benefit design should be limited and accompanied by strong guardrails that protect individuals with MH/SUD from high out-of-pocket costs and limited covered benefits.

New data from the Centers for Disease Control and Prevention (CDC) found that as of July 2017, 66,972 Americans died of a drug overdose in the previous 12 months. This statistic represents a 14.4% increase in the rate of overdose deaths nationwide as compared to the previous year with some states – Delaware, Florida, New Jersey, Ohio, and Pennsylvania – reporting 30% or 40% increases in their overdose death rates. With 180 Americans a day dying from overdoses, we cannot support allowing plans to offer less access to substance use disorder services.

We are very concerned with the provisions in the Proposed Rule to allow AHPs to expand and be exempt from the Affordable Care Act's (ACA) requirements because we believe plans will likely offer less comprehensive coverage and exclude coverage for MH/SUD. The rule states, "Under this proposal, as noted earlier in this section, AHPs would generally be treated as large employers and accordingly granted access to the large group market (or, alternatively, could self-insure). The large group market is not subject to the same restrictions that apply in the

individual and small group markets. AHPs consequently could offer many small businesses more options than could individual and small group insurance issuers. For instance, AHPs could offer less comprehensive – and hence more affordable – coverage that some employees may prefer."

Historically, mental health and substance use have been subject to insurer exclusions and limitations. For example, prior to the ACA, , 18% of enrollees in the individual market did not have coverage for mental health services and 34% did not have coverage for substance use disorder treatment. Moreover, the Congressional Budget Office (CBO) confirmed in its May 2017 report on the *American Health Care Act* that these services are most likely to be excluded if their coverage is not mandated. CBO states, "Services or benefits likely to be excluded from the EHBs in some states include maternity care, mental health and substance abuse benefits, rehabilitative and habilitative services, and pediatric dental benefits. In particular, out-of-pocket spending on maternity care and mental health and substance abuse services could increase by thousands of dollars in a given year for the nongroup enrollees who would use those services."

Additionally, as MH/SUD comprise a tiny fraction of overall healthcare spending, we do not believe the additional flexibility in plan design and benefit will result in meaningful premium savings for individuals with MH/SUD as intended by the Proposed Rule. An analysis of average insurer spending as projected for 2017 found that "health and substance abuse treatment accounted for 1 percent of per capita insurer spending." In fact, as indicated by the aforementioned CBO analysis, out-of-pocket costs for individuals with MH/SUD are already significantly higher and will likely rise more.

Unfortunately, as a result of cost shifting from the private sector, the public sector is already paying for a substantial portion of mental health and substance use treatment care. A *Health Affairs* study found that in 2014, "the largest share of substance use disorder financing (29 percent) was from state (non-Medicaid) and local governments." Additionally, beyond healthcare costs, state and local governments are also burdened with the collateral costs of the opioid misuse and overdose epidemic. The previously referenced Altarum report found that, "many of 2016 cases of child neglect are associated with parents with an opioid substance use disorder, causing increased child and family assistance spending of $6.1 billion per year. We estimate additional education expenses to be $4.4 billion per year." As such, PIC members caution against any changes that might further burden states and localities.

FULL IMPLEMENTATION AND ENFORCEMENT OF MHPAEA

Unfortunately, as we approach the 10th anniversary of President Bush signing the *Mental Health Parity and Addiction Equity Act* into law on October 3, 2008, our members and the patients and families they serve continue to report barriers to equitable access to mental health and substance use disorder treatment services. As employer-sponsored plans, AHPs are subject to MHPAEA's requirements and we respectfully ask the Administration prioritize enforcement of the law.

One of the primary complaints from our members on behalf of their patients concerns lack of disclosure by health plans, especially concerning the plans' compliance with the parity law as it

relates to non-quantitative treatment limitations (NQTLs) such as medical management techniques, usual and customary reimbursement rates, provider network admission standards, facility-type and level of care exclusions, etc. Consumers and providers are entitled to plan documents and information regarding the development and application of NQTLs that a plan imposes to limit access to benefit coverage and how those limitations are comparable to and no more stringently applied to substance use/mental health benefits than to medical/surgical benefits. However, they consistently report that although they request this type of information, plans are generally non-responsive. Absent this information, consumers and providers are unable to determine whether or not the plan is in compliance with the parity law and its regulations. Thus, enforcement of this vital part of the law remains elusive.

Our anecdotal reporting is supported by the recent Presidential Commission's report which states, "MHPAEA has been the impetus for much progress towards parity for behavioral health coverage; plans and employers have, by and large, done away with policies that are clear violations; provisions such as dollar-limits, visit limits, and outright prohibitions on certain treatment modalities that exist only on behavioral health benefits. However, what remains are violations that are murkier and harder for regulators to discern, for example, non-quantitative treatment limits (NQTLs). These hurdles include medical necessity reviews that are more stringent on the behavioral health side than the medical/surgical side, limited provider networks, and onerous prior-authorization requirements. In reality, it is often difficult to discern when a behavioral health benefit is "on par" with a medical/surgical benefit as different care settings and diagnoses have different policies regarding benefits, providers, and authorizations."

Moreover, a 2017 report by Milliman researchers studied three years of insurer claims data covering 42 million Americans, and looked at inpatient and outpatient services, primary care office visits, and specialist office visits, as well as compared in-network and out-of-network claims in all 50 states and D.C. and found significantly higher use of out-of-network providers by individuals seeking MH/SUD treatment than individuals seeking medical/surgical care. This data suggests lack of enforcement has allowed insurers to continue to limit access to MH/SUD treatment. Nationally, Milliman researchers found that in 2015 on average:

- **31.6%** of outpatient facility behavioral health care was accessed out-of-network; while only **5.5%** of outpatient facility medical/surgical care was accessed out-of-network. In 2013 the out-of-network use of these services was **15.6%**, showing a doubling of access restrictions during three years of parity regulatory oversight.
- **18.7%** of behavioral health office visits were accessed out-of-network; while only **3.7%** of primary medical/surgical office visits were accessed out-of-network.
- **16.7%** of inpatient facility behavioral health care was accessed out-of-network; while only **4.5%** of inpatient facility medical/surgical care was accessed out-of-network.

Additionally, a recent report reviewed if a state regulator could identify potential violations of MHPAEA for substance use disorder services through a common regulatory review process known as form review. Their findings were that, "even with a comprehensive data gathering template, regulators would not be able to accurately assess whether a plan is parity compliant

because required information is not available in the plan documents that regulators receive from carriers prior to approving plans for sale."

We make the following recommendations, many based off recent recommendations in the President's Commission's report, with the goal of increasing access to mental health and substance use disorder treatment.

- **Recommendation**: DOL should use its enforcement authority over AHPs to launch investigations into parity non-compliance and the outcomes of such investigations should be publicized on appropriate federal websites.
  This recommendation is consistent with the Commission's report, which recommended, "that Congress provide DOL increased authority to levy monetary penalties on insurers and funders, and permit DOL to launch investigations of health insurers independently for parity violations."
- **Recommendation**: Federal and state regulators should require plans to use a standardized tool to document and disclose their compliance with MHPAEA's NQTL requirements.

  For further details**,** please see the comments that the Parity Implementation Coalition, of which we are a member, filed with the Departments in response to their June 16, 2017 request for comments on a model form. Included in those comments:

  - Suggested "tracked changes" to the Department's draft form "Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations" as solicited in the June 17, 2016 FAQs;
  - Sample FAQs that expand upon how to comply with the documentation required in the Department's model form;
  - Because specific examples of how various NQTLs are applied is often the clearest way to demonstrate compliant and non-compliant NQTLs analyses, the PIC's comments also include a non-exhaustive group of draft FAQs on a variety of the most common types of NQTLs our members see; and
  - A suggested six-step plan reporting format on application of NQTLs, both written and in operation, and an accompanying spreadsheet. The six-step process for reporting on application of NQTLs to mental health/substance use and medical/surgical benefits, as well as examples of their application to specific NQTLs are intended to be useful tools to the Departments and state regulators as to how a plan could structure its NQTL analysis and report on it to regulators. The sixth step in the process is intended for use by plans, issuers and regulators and not consumers or providers.

  This recommendation for a standardized tool is consistent with the Commission's report, which recommended, "that federal and state regulators should use a standardized tool that requires health plans to document and disclose their compliance strategies for nonquantitative treatment limitations (NQTL) parity. NQTLs include stringent prior authorization and inequitable medical necessity requirements. HHS, in

consultation with DOL and Treasury, should review clinical guidelines and standards to support NQTL parity requirements. Private sector insurers, including employers, should review rate-setting strategies and revise rates when necessary to increase their network of addiction treatment professionals."

Recommendation: Reimbursement and policy barriers to MH/SUD treatment should be eliminated.

This recommendation is consistent with the Commission's report, which recommended, "The Commission recommends HHS/CMS, the Indian Health Service (IHS), Tricare, the DEA, and the VA remove reimbursement and policy barriers to SUD treatment, including those, such as patient limits, that limit access to any forms of FDA-approved medication assisted treatment (MAT), counseling, inpatient/residential treatment, and other treatment modalities, particularly fail-first protocols and frequent prior authorizations. All primary care providers employed by the above-mentioned health systems should screen for alcohol and drug use and, directly or through referral, provide treatment within 24 to 48 hours."

CONCLUSION

DBSA would be pleased to discuss these recommendations in greater detail and we stand ready to serve as a resource to the Administration.

Sincerely,

Phyllis Foxworth

Phyllis Foxworth
Vice President Advocacy
Depression and Bipolar Support Alliance