Depression and Bipolar Support Alliance

July 22, 2020

Secretary Eugene Scalia
U.S. Department of Labor
200 Constitution Ave., NW
Washington, D.C. 20001

RE: Proposed Updates to 2020 MHPAEA Self-Compliance Tool Request for Comments

The Depression and Bipolar Support Alliance (DBSA) appreciates the opportunity to comment on the U.S. Department of Labor's (DOL) proposed updates to the Mental Health Parity and Addiction Equity Act (MHPAEA) Self-Compliance Tool. We comment from the perspective of DBSA's community, the more than 23 million people throughout the United States living with depression and bipolar disorders.

DBSA envisions wellness for people with these disorders. Further, 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 interactive online tools and resources that allow individuals to understand, choose, manage, and evolve their personal wellness. Additionally, we have a network of more than 160 chapters across the country that offer over 500 free support groups. DBSA reaches 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 35 years in existence. It is from this perspective of experience and relationships that we believe DBSA is uniquely positioned to provide comment.

We are committed to working with the Administration on improving the implementation and enforcement of MHPAEA through the Self-Compliance Tool.

Background

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.
- Achieving parity, as envisioned by the MHPAEA 2008 legislation and the Affordable Care Act, will help lower costs and improve health outcomes. The following recommendations are designed to strengthen the MHPAEA Self-Compliance Tool to realize this goal.

Recommendations

Although not required by MHPAEA, an internal compliance plan that promotes the prevention, detection, and resolution of potential MHPAEA violations can help plans and issuers improve compliance with the law. In Section H, "Establishing an Internal MHPAEA Compliance Plan," the Department states successful compliance plans share the following characteristics:

- Training and Education – We are pleased to hear about the training and education materials the Department makes available to plans and issuers. We recommend that plans be required to educate participants as well, because they will not know to file a complaint without knowledge of their rights. DBSA also provides educational materials, webcasts, and in-person workshops that inform participants and beneficiaries of their rights under MHPAEA. People who have taken our training report an average increase of 2.7 points on a 5-point scale on awareness of parity and ability to identify a potential parity issue.
- Internal monitoring and reviews on a regular basis – We encourage the Department to establish minimum timelines for how often plans are expected to conduct internal compliance reviews. We support internal consumer ombudsmen programs to assist participants and beneficiaries in navigating their benefits and elevating their complaints of noncompliance.
- Prompt response to offenses and corrective action – We encourage the Department to establish a timeline for appropriate prompt action when a plan or issuer discovers a violation of MHPAEA, including providing retroactive relief and notice to potentially affected participants and beneficiaries.

- Additionally, we recommend removing the mention of The National Association of Insurance Commissioners (NAIC) Data Collection Tool in the guidelines, as we believe it is not an adequate tool for purposes outlined in these guidelines and would need further review by various stakeholders in order to be appropriate. Giving plans and issuers the freedom to adopt another tool in order to maintain compliance with these new guidelines undermines the opportunity to establish a new measurement to compare information on the non-quantitative treatment limitations (NQTLs) imposed on medical/surgical and MH/SUD benefits and to identify some basic information on their factors, sources, and comparability, and focus further review on NQTLs where noncompliant disparities appear.

DBSA thanks you for your careful consideration of our comments. We would be pleased to discuss these recommendations in greater detail, and we stand ready to serve as a resource to the Administration.

Sincerely,

Michael Pollock
Chief Executive Officer
Depression and Bipolar Support Alliance

55 E. Jackson Blvd., Suite 490 • Chicago, IL 60604 USA
(312) 642-0049 • Toll-free (800) 826-3632 • Fax (312) 642-7243 • DBSAlliance.org