



**Association for Behavioral
Health and Wellness**

*Advancing benefits and services
in mental health, substance use
and behavior change.*

**WRITTEN STATEMENT OF
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**PUBLIC STAKEHOLDER LISTENING SESSION ON
STRATEGIES FOR IMPROVING PARITY FOR MENTAL
HEALTH AND SUBSTANCE USE DISORDER COVERAGE**

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Introduction

Good Morning. Thank you for the opportunity to speak before you today. My name is Pamela Greenberg, and for the last 19 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 managed behavioral health companies. These payers provide an array of behavioral health services to over 170 million people in both the public and private sectors.

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, and at one point chair, of the Coalition for Fairness in Mental Illness Coverage.

Since passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, our member companies have had numerous meetings with regulators at both the state and federal level to help better understand and operationalize the law's regulations. Our member companies have teams of dozens of people from multiple departments working diligently to exchange information and perform the required parity analyses.

More recently, we have been working with the Clear Health Quality Institute (CHQI) and a diverse group of stakeholders to try and develop standards for a parity accreditation. Our belief is that such an accreditation will be useful to state and federal governments, consumers, providers, and others in knowing whether or not a plan is approaching parity in the correct manner. A parity accreditation will hopefully bring some desperately needed uniformity to MHPAEA implementation.

It's often hard to believe that nine years after passage of the law and over 44 FAQs later we remain focused on parity implementation. This is probably the best indication of how complex, and at times burdensome, the law and accompanying regulations can be.

Federal regulators have been dedicated to the proper implementation of MHPAEA. The regulators have made themselves available to answer our questions and help clarify ambiguities in the regulations. They've also been helpful in working with our member companies and the states when states have had an incorrect interpretation of federal guidance. We appreciate their assistance and have several recommendations on how to improve the federal/state enforcement of MHPAEA.

- 1) Educate states to create consistent understanding and implementation of the law
- 2) Simplify the disclosure requirements
- 3) Change the overly restrictive nonquantitative treatment limit (NQTL) requirements
- 4) Share de-identified information

Educate states to create consistent understanding and implementation of the law

Many states are enforcing parity and each of them has a different enforcement process and understanding of what is intended by the federal regulations. This creates an immense burden on

payers as they seek to comply with disparate state requirements and audits. More uniformity in the interpretation and enforcement of MHPAEA in both the commercial and public sectors would make a world of difference to payers implementing the law.

We are aware that the Department of Health and Human Services (HHS) works with states to educate them about the intent of the federal parity law and responds to their technical questions. We also know that the National Association of Insurance Commissioners (NAIC) is engaged to help ensure that all states have the same understanding of the intent of the parity law and regulations. The Department of Labor (DOL) has issued both a compliance assistance guide, a compliance check sheet, and held multiple regional meetings to assist employers and their advisors with compliance. The Substance Abuse and Mental Health Services Administration (SAMHSA) has also held parity policy academies for 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. ABHW also encourages regulators to be clear and consistent in the guidance they provide. We have seen states incorrectly interpret the examples in the parity compliance warning signs document published by the federal regulators as parity violations, instead of as indications that there might be a problem, or examples in guidance as the only possible correct outcome instead of as one possible outcome.

Many of our members have seen a lack of understanding of MHPAEA at the state level that has led to attempts to incorrectly enforce, or comply with, 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). States have also set artificial limits on services, like treatment for autism or outpatient visits, which violate MHPAEA. This puts plans in a precarious situation of explaining to the state that their benefits are not compliant with MHPAEA.

A recommended federal compliance tool would be of great assistance to plans trying to prove compliance in multiple states. States assess compliance in one or more of the following ways: market conduct exams, state regulatory inquiries, attestations, and audit questionnaires. Right now, in some states, it takes multiple cross disciplinary teams a year to complete the audit process.

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.

Simplify the disclosure requirements

Another area that needs further discussion is disclosure and ABHW intends to comment on HHS's recently released draft optional disclosure request form. Consumer education and understanding was a key 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 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. Existing disclosure documents like the summary plan description (SPD) and the summary of benefits and coverage (SBC) should be examined as vehicles to provide information before creating additional documents and requirements. Some other 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.

Change the overly restrictive nonquantitative treatment limit (NQTL) requirements

Parity in NQTLs was not something envisioned by the legislators when they passed MHPAEA; however, they are included in the regulations. 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. The language included in the interim final rule that allowed clinical guidelines to permit a difference when performing the NQTL analysis should be restored.

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?” One example of an NQTL that is specific to behavioral health is efforts by plans to place limits on out of area destination substance use treatment which has become an area of rampant fraud and abuse that has no corollary in medical treatment and the NQTL rules are inhibiting plans efforts to protect their members from unscrupulous patient brokers and treatment programs. Lack of flexibility in the NQTL analysis impedes payers from imposing more stringent oversight on these fraudulent residential substance use facilities.

Share de-identified information

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 states and other interested parties with a thorough picture of the intent of the final rule and will lead to an overall better understanding of MHPAEA. The data will also help identify parity complaints that are actually about other system issues, like the shortage of mental health providers, and in reality are not parity violations.

Thank you again for the opportunity to speak before you today. We welcome ongoing discussions with you. I believe we all share the same goal of access to quality mental health and substance use disorder care for everyone.