ABHW
Advancing Health Care Policy
for Mental Health and Addiction

June 30, 2020

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Walden:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments for the record on the hearing: "High Anxiety and Stress: Legislation to Improve Mental Health During Crisis".

ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness.

ABHW thanks you for your continued leadership in responding to the COVID-19 crisis. Congress has taken important steps to address the urgent needs facing the health care industry and to deliver relief to families and small businesses. We appreciate the Committee examining legislation and policies to support our nation during this difficult time, recognizing the impact COVID-19 is having on the behavioral health of individuals and communities.

As you move forward, we encourage Congress to advance telehealth policies, enhance the behavioral health workforce, increase access to services, and prioritize suicide prevention. These actions play a critical role in expanding access to MH and SUD services that will be needed as a result of COVID-19 and also will provide long lasting improvements to our nation's behavioral health system. Our comments are below.

Mental Health and Addiction Parity
Since its inception, ABHW has been an active supporter of equitable coverage of MH and addiction treatment. ABHW has worked closely with the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury, to ensure that its member

companies understand the intent of the regulations in order to properly implement the Mental Health Parity and Addiction Equity Act (MHPAEA). We support continued discussions about parity to ensure the law is fully implemented and focused on what it was intended to do. We also recognize there are issues that persist in the system that may be better addressed under a framework other than MHPAEA. The ABHW Issue Brief: Mental Health Parity and Addiction Equity offers additional information and recommendations. As the Committee reviews the Behavioral Health Coverage Transparency Act (H.R. 2874), and the Mental Health Parity Compliance Act (H.R. 3165) we offer the following points for your consideration:

- From a macro perspective, we do not feel additional federal legislation in the parity space is needed, especially given that there is a dearth of guidance from regulators on matters that would help to resolve outstanding parity issues. In this regard, on June 19th, the DOL issued a request for comment on a parity compliance tool per the 21st Century Cures Act which hopefully can provide additional clarity, particularly around nonquantitative limitations (NQTLs).

- Introducing a parity 2.0 bill, while well-intentioned, may serve to derail the progress of various stakeholders with compliance by adding another layer of regulations to an already technical and labor-intensive review process.

- Contrary to various statements, parity has progressed since its adoption in a meaningful way:
    - Routine MH outpatient treatment no longer habitually requires pre-certification or has explicit quantitative treatment limits,
    - Evidence-based levels of care for mental health conditions are no longer subject to blanket exclusions (e.g., residential treatment for eating disorders),
    - Transparency, documentation, attention to medical necessity criteria all have improved, and
    - Access to MH and SUD treatment providers has expanded.

- A focus on improved clarity for the existing MHPAEA framework should occur outside of an additional layer of legislation as follows:
    - Recognition of a parity accreditation standard deeming a health plan "parity compliant" and support consistent interpretation and assessment of parity compliance. The Utilization Review Accreditation Commission (URAC) has kicked-off a detailed parity compliance approach that had input of payers, providers, and advocates.
    - Recognition that National Association of Insurance Commissioners (NAIC) adopted a flexible NQTL standard under its Market Conduct Examination Workgroup which states can adopt to provide uniformity in NQTL analyses. The NAIC model had signoff of payers and

regulators. The NAIC is currently looking at parity further to hone additional suggestions for regulators with regard to templates.

- Recognition of the new DOL self-compliance tool comment cycle, which may continue to clarify some of the confusing aspects of NQTLs for payers, providers, and consumers, which in turn solves some of the issues of the intended legislation.
- Increased focus on the simplification of the NQTL analyses**,** as opposed to adding more granular requirements to an already technically challenging law. The granularity and challenging amount of materials that need to be collected for parity analyses do not per se help consumers achieve better care at affordable rates.

Make Permanent the Use of Telehealth for Mental Health Services
ABHW supports moving forward the Telemental Health Expansion Act of 2019 (H.R. 5201). We appreciate the guidance issued on March 17, 2020, from the Centers for Medicare and Medicaid Services (CMS), temporarily waiving restrictions on how and where individuals can access telehealth services. In the midst of social distancing waiving these restrictions has been vital to the ability to access care and making the changes permanent will help address the growing need for behavioral health services. We support H.R. 5201 which would permanently:

- remove the geographic restrictions on originating sites, and
- add the home as an originating site.

Strengthen and Expand the Behavioral Health Workforce
ABHW recommends recognizing mental health counselors (MHCs) and marriage and family therapists (MFTs) as covered Medicare providers to address the gaps in care for Medicare beneficiaries. Recognition of MHCs and MFTs would increase the pool of eligible mental health professionals by over 200,000 licensed practitioners. Studies have shown that these providers have the highest success and lowest recidivism rates with their patients as well as being the most cost effective.[1] We urge you to advance the Mental Health Access Improvement Act (H.R. 945/ S. 286). This legislation would recognize MHCs and MFTs as covered Medicare providers and help address the critical gaps in care and ensure access to needed services.

Thank you for the opportunity to comment on these important issues. We look forward to working with you to identify solutions and ensure quality, evidence-based MH and SUD treatment in communities across our nation. Please feel free to contact

[1] D. Russell Crane and Scott H. Payne, "Individual Versus Family Psychotherapy in Managed Care: Comparing the Costs of Treatment by the Mental Health Professions," Journal of Marital & Family Therapy 37, no. 3 (2011): 273-289.

Maeghan Gilmore, Director, Government Affairs at gilmore@abhw.org or 202.449.7658 with any questions.

Sincerely,

Pamela Greenberg, MPP
President and CEO

ABHW

ISSUE BRIEF

Mental Health Parity and Addiction Equity

Background

In October 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), P.L. 110-343, was signed into law. MHPAEA requires group health plans and health insurance issuers that provide mental health and/or substance use disorder (MH/SUD) benefits to treat those benefits comparable to medical/surgical benefits. As a result of provisions in the Affordable Care Act (ACA) and MHPAEA, parity applies to employer funded plans, individual and small group plans (including exchanges), Medicaid (managed care and Alternative Benefit Plans), and Children's Health Insurance Program Plans (CHIP). MHPAEA and its accompanying regulations require parity for financial (i.e. copayments), quantitative treatment (i.e. visit limits) and nonquantitative (NQTL) treatment (i.e. preauthorization requirements) limits as well as out-of-network benefits. MHPAEA also includes requirements related to information disclosure.

Since its inception, ABHW has been an active supporter of equitable coverage of mental health and addiction treatment. ABHW has worked closely with the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury, to ensure that its member companies understand the intent of the regulations in order to properly implement MHPAEA. ABHW member companies have teams of people from multiple departments in both physical and behavioral health working diligently on the required parity analyses in order to provide a parity benefit to consumers. Health plans have made changes such as eliminating arbitrary treatment limits and aligning behavioral health copayments with medical visit copayments in order to comply with MHPAEA.

Challenges exist in the implementation and compliance assessment of MHPAEA. As federal and state governments enforce parity, a variety of interpretations of the law have developed, resulting in a lack of uniformity in the documentation required to

demonstrate compliance. Additionally, federal regulatory guidance has gone beyond the intent of the law. This has resulted in complex compliance requirements that don't necessarily benefit consumers and increase compliance burden and costs.

Recommendations

The parity analysis has become a one-way comparison between MH/SUD and medical/surgical benefits with no recognition of the differences between behavioral and physical health. It is critical to recognize these variations to ensure that the best quality, evidence-based care is provided to consumers. Suggested steps to improve understanding and compliance with MHPAEA include:

- Release de-identified information on compliance issues discovered by the regulating agencies and provide examples of parity compliance.
- Develop and implement uniform MHPAEA compliance requirements.
- Issue a model disclosure form that identifies specific documents that health plans could use to respond to enrollee requests for the information required to be disclosed under MHPAEA.
- Clarify NQTL disclosure requirements and that MHPAEA does not require a specific process, strategy, evidentiary standard, or other factor be used in applying a NQTL.
- Address important issues that weren't intended to be parity issues under the law, such as network adequacy and out-of-network usage, outside of the parity rubric.