Parity Implementation Coalition

September 27, 2013

Leon Rodriguez
Director
Office of Civil Rights
Department of Health and Human Services
ATTN: 1557 RFI (RIN 0945-AA02)
509F
200 Independence Ave, SW
Washington, DC 20201

Re: Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities

Dear Mr. Rodriguez:

The Parity Implementation Coalition (PIC) is pleased to respond to the Department of Health and Human Services' Request for Information regarding nondiscrimination in certain health programs or activities.

The Parity Implementation Coalition is an alliance of addiction and mental health consumer and provider organizations. Its members include the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine, Betty Ford Center, Cumberland Heights, Faces and Voices of Recovery, Hazelden Foundation, MedPro Billing, Mental Health America, National Alliance on Mental Illness, National Association of Psychiatric Health Systems, National Association of Addiction Treatment Providers, TeenScreen at Columbia University, and The Watershed Addiction Treatment Programs, Inc.

UNDERSTANDING THE CURRENT LANDSCAPE

RFI Question 1. The Department is interested in experiences with, and examples of, discrimination in health programs and activities. Please describe experiences that you have had, or examples of which you are aware, with respect to the following types of discrimination in health programs and activities: (a) Race, color, or national origin discrimination; (b) Sex discrimination (including discrimination on the basis of gender identity, sex stereotyping, or pregnancy); (c) Disability discrimination; (d) Age discrimination; or (e) discrimination on one or more bases, where those bases intersect.

RFI Question 2. There are different types of health programs and activities. These include health insurance coverage, medical care in a physician's office or hospital, or home health care, for example. What are examples of the types of programs and activities that should be considered health programs or activities under Section 1557 and why?

Coalition Response to RFI Questions 1 and 2: The Coalition's consumer and provider organizational members have significant experience in confronting the discrimination that occurs in health insurance coverage including in hospital, non-hospital, residential and office based settings. PIC members also confront discrimination against individuals with MH/SUD in

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federally qualified health centers, patient centered medical homes, accountable care organizations, and peer and recovery community organizations. Over the last twenty years, federal and state policymakers from both sides of the aisle have recognized systemic health insurance discrimination for those with mental health and substance use disorders (MH/SUD) and responded with the passage of state and federal legislation and regulations aimed at equalizing medical and behavioral benefits:

- An analysis of state parity laws by the National Alliance on Mental Illness (NAMI) documents that all but 2 states have some form of mental health parity laws.
- NAMI has also summarized federal parity protections which include parity for federal employees, the 1996 Mental Health Parity Act and the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA). The Department of Labor (DOL) summarized the 1996 and 2008 parity laws in a 2012 report to Congress.
- Most recently, Section 1557 of the Affordable Care Act (ACA) also clarifies that individuals may not be discriminated against based on disability (among other things) and "disability" has been codified in federal law to include those with mental impairments and those with substance use disorders who are not actively using (see Section 504 of the Rehabilitation Act of 1973 (29 U.S.C 794)).

Despite enactment of state and federal law and regulation, there continues to be a well documented history of insurance discrimination against those with MH/SUD. Even since the passage of MHPAEA, major insurance carriers frequently set the following discriminatory restrictions on plan enrollees, such as:

- Requirement that persons with mental health or addition have to "fail first" at certain interventions before qualifying for higher level of treatment. "Fail-first policies" may require that a person with mental illness take an older, less effective medication. Only after failing on that drug, which might trigger a serious relapse, may that person be approved for a newer, more expensive – but more effective – medication.
- Requirement of prior authorization for outpatient MH/SUD services. According to a February 2012 report by the RAND Corporation and commissioned by HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), requiring prior authorization for mental health and addiction treatment is *"not clinically appropriate, as this may unnecessarily delay clinically appropriate services, and inhibit access to appropriate clinical services."*[i]
- Limiting coverage for mental health conditions that cannot be "cured."
- Imposition of more stringent out-of-network provider limitations such as only covering facilities in the state where the carrier is headquartered or excluding coverage of any care provided at certain facility types such as residential facilities.

In the absence of full implementation of MHPAEA, this discrimination has continued and remains evident in some of the limited information HHS has provided about state benchmark plans. While specific behavioral health plan information remains unavailable for most state marketplaces, based on what is readily available, we see that 14 base benchmark plans specifically exclude substance use disorder treatment in non-hospital residential inpatient settings despite offering these levels of care for other medical conditions. A Government Accountability Office (GAO) study of commercial plans found 33.3% of plans exclude court ordered treatment. Given the high rates of criminal justice involvement for individuals with

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MH/SUD, these exclusions serve as a discriminatory barrier that we see persisting in state marketplaces absent a clear federal discrimination standard. Examples of insurance discrimination that occur regularly today can be found in the attached report summarizing the findings from 11 parity field hearings held around the U.S. in 2012 – 2013 that were convened by former Representatives Patrick Kennedy and Jim Ramstad.

We are also concerned about Americans suffering from mental illness and/or substance use disorders encountering discrimination even before they become beneficiaries of a health care plan. Thus far, the rules HHS has promulgated for benchmark plans, essential health benefits, and health exchanges make clear plans will be sanctioned if they engage in benchmark plan design, as well as implementation of benchmark plans, whether intended or not, in which the effects result in discrimination against plan beneficiaries as a function of their health status.

However, we do not see anything currently in HHS's rules that will deter health plan issuers from acting in a way so as to discourage persons suffering from mental illness or substance use from purchasing their products. A myriad of studies have confirmed incidents of adverse selection among health plans as they enroll persons suffering from mental illness or substance use and a recent study stated, that the ACA's regulations, "are unlikely to fully address selection problems." And "that plans will have strong incentives to under provide care to persons with some chronic illness" including mental health and substance abuse. The way a health insurance plan advertises its mental health/substance use disorder benefits or goes about signing people up for particular health plans can be a powerful instrument in directing persons suffering from these disorders to enroll in one plan type over another. We want to work with HHS to better ensure exchange health plans are not being promoted so as to foster adverse selection against persons suffering from mental health and/or substance use disorders. Statistics suggest a great percentage of the uninsured, as well as under-insured population, has no access to mental health services. HHS's efforts to enroll all Americans in health care coverage without attention being directed to their health care status necessitates promotional tactics that will not foster health care insurers' adverse selection of the mentally ill.

RFI Question 3. **What are the impacts of discrimination? What studies or other evidence documents the costs of discrimination and/or the benefits of equal access to health programs and activities for various populations? For example, what information is available regarding possible consequences of unequal access to health programs and services, such as delays in diagnosis or treatment, or receipt of an incorrect diagnosis or treatment? We are particularly interested in information relevant to areas in which Section 1557 confers new jurisdiction.**

Coalition Response to RFI Question 3: The cost impact of discrimination in coverage for those with MH/SUD is staggering. In 2007, 12 million visits made to hospital emergency department (ED) involved individuals with a mental and/or substance use disorder. 35.6% of substance-use related ED visits were billed as uninsured, according to a report from the Agency for Healthcare Research and Quality (AHRQ). Medicare was the largest single payer for mental health-related ED visits (37.2%).

This disproportionate number of mental health related emergency department visits persists despite evidence of the efficacy of less expensive non-emergent mental health treatment. A recent study found coordinated depression treatment for patients age 60 or older yielded $3,363 in savings per patient for an investment of $522 a patient.

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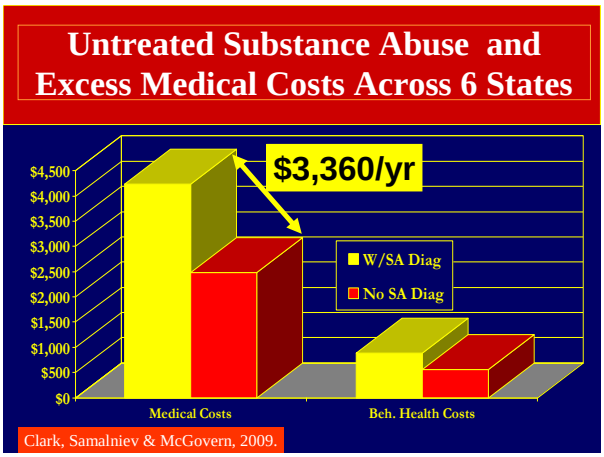
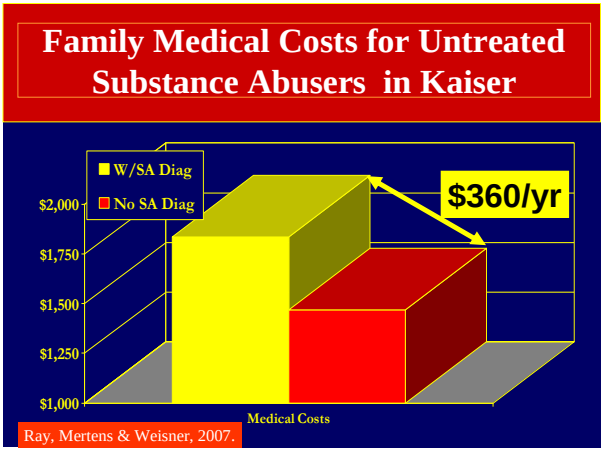
Significant cost savings could also be achieved through non-discriminatory SUD care. UCLA researcher Dr. Suzette Glasner-Edwards noted that "The Medicaid system absorbs a disproportionate share of the healthcare costs associated with SUD. Whereas approximately 9% of the general population has an SUD, nearly 13% of the population that qualifies for Medicaid because of disability has an SUD, and Medicaid patients with SUDs have medical costs that are about twice as high as those who do not."[ii,iii]

Recent studies have demonstrated the cost savings associated with treatment. For example, a study of the Washington State Medicaid program on the effect of access to SUD/MH treatment found that:

- Medicaid costs were reduced by 5% ($4,500 less over a five-year follow up period).[iv]
- Inpatient and emergency department costs declined by 39% following treatment.[v]
- Total medical costs per patient per month went from $431 to $200.[vi]





The consequences of discriminatory access to MH/SUD services have also been well documented in the 2013 parity field hearing report and behavioral health literature. Some of the devastating costs to individuals and families as a result of discriminatory access to mental health and substance use disorder care include:

- Death rates nearly 27 years earlier than those without untreated severe MH/SUD
- Higher suicide rates
- Higher co-morbidities of other chronic health conditions
- Higher out-of-pocket spending
- Higher unemployment rates
- Disproportionate representation in our nation's jails and prisons; 80% of the growth in the federal prison population in the last five years is attributed to those with SUD. Even more startling is the fact that the Los Angeles County Jail is the largest mental health facility in the country today.

Providers and facilities that treat those with MH/SUD are also seriously disadvantaged by this discrimination. The attached Milliman, Inc study found that MH/SUD providers are reimbursed on average 20% below other medical providers based on national average Medicare rates.

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Arbitrary medical management techniques are imposed on MH/SUD providers at greater rates than other medical providers and behavioral health networks are more limited.[vii] Plans often send all of the successfully denied appeal payments to the subscriber instead of also paying the provider that expended resources on the treatment, thereby jeopardizing those clients adversely affected by large sums of cash that can trigger relapse and leaving the provider to collect the treatment costs from patients who may have already spent the reimbursement.

Facility level exclusions for behavioral health facilities are common. This limits access to services for individuals and families with MH/SUD because this eliminates certain types of full service facilities from getting reimbursed for *any* level of duly licensed care that facility provides. Out-of-network behavioral health providers often undergo more restrictions than other medical providers even when a plan participant is paying higher premiums for a plan that permits out-of-network care.

Since HHS has not made available sufficient information on plans operating in state marketplaces or providing Medicaid alternative benefits plans, it is impossible to fully assess the potential impact of discriminatory MH/SUD practices with state marketplace plans, one of the areas in which Section 1557 confers new jurisdiction. However, in the limited information provided, we did identify some discriminatory practices. For example, some plans impose more stringent prior authorization practices on psychiatric visits; Vermont's base benchmark plan required prior-approval for inpatient and outpatient treatment but did not have the same across-the-board requirement on comparable medical/surgical benefits such as inpatient hospitalization and outpatient office visits. Others exclude certain types of addiction medications such as methadone or buprenorphine. The base benchmark plan for California, for example, excluded coverage of methadone except for pregnant women. We believe that many of the discriminatory treatment limitations or exclusions that are predominant in health plans today will persist in state marketplaces and alternative benefit plans, therefore persisting in many essential health benefit and Medicaid plan offerings nationwide.

COMPLIANCE AND ENFORCEMENT APPROACHES

RFI Question 7. Section 1557 incorporates the enforcement mechanisms of Title VI, Title IX, Section 504 and the Age Act. These civil rights laws may be enforced in different ways. Title VI, Title IX, and Section 504 have one set of established administrative procedures for investigation of entities that receive Federal financial assistance from the Department. The Age Act has a separate administrative procedure that is similar, but requires mediation before an investigation. There is also a separate administrative procedure under Section 504 that applies to programs conducted by the Department. Under all these laws, parties also may file private litigation in Federal court, subject to some restrictions.

(a) How effective have these different processes been in addressing discrimination? What are ways in which we could strengthen these enforcement processes?

(b) The regulations that implement Section 504, Title IX, and the Age Act also require that covered entities conduct a self-evaluation of their compliance with the regulation. What experience, if any, do you have with self-evaluations? What are the benefits and burdens of conducting them?

(c) What lessons or experiences may be gleaned from complaint and grievance procedures already in place at many hospitals, clinics, and other covered entities?

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Coalition Response to RFI Question 7: Parity Implementation Coalition members are concerned that without the development of a federal standard to determine whether coverage complies with non-discrimination requirements in Section 1557, behavioral health discrimination in commercial, alternative benefit plans and marketplace coverage will persist. As discussed above, absent full monitoring and enforcement of plan compliance with MHPAEA, we continue to hear of health plans that are applying non-quantitative treatment limitations, like significantly reduced payment rates for mental health/substance use disorder providers or requiring fail first drug therapies, prior authorization, or differentiated medical necessity criteria to the plan's mental health benefits in a manner that suggests the analytical test required for comparing medical/surgical benefits to mental health benefits, as mandated by MHPAEA, is not being carried out and/or are being applied haphazardly.

Non-discrimination protections are critically important to individuals with MH/SUD and to others with other chronic health illness and disabilities. The final rule must include: 1) a non-discrimination standard, 2) a process to identify discriminatory benefit design and 3) bring it into compliance and provide transparent enforcement mechanisms and fines for non-compliant plans. A final rule must also include examples of what would constitute non-discrimination violations. HHS might set the following standards describing discrimination:

- Offering limited coverage within an EHB category is discriminatory
- Making specific coverage exclusions without regard to generally accepted medical necessity is discriminatory
- Offering a full array medical benefits and limited MH/SUD benefits is discriminatory
- Requiring qualified health plans to be transparent regarding the terms and conditions of the plan on both medical and behavioral benefits

There are currently no guidelines or criteria for plans to establish a process to bring discriminatory benefit design or implementation into compliance with the law. HHS must describe a detailed process and timeline for federal oversight over state implementation of a non-discrimination standard so that consumers can be assured that discriminatory plans will not find their way into the marketplaces.

A final rule must describe the process for enforcement of the non-discrimination standard. We strongly urge the Department to include in the final rule language outlining clear and strong federal enforcement provisions and penalties for violations.

Accreditation of Qualified Health Plans

Section 1311(c)(1)(D)(i) of ACA directs a health plan to "be accredited with respect to local performance on clinical quality measures…by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria." Qualified health plans must receive accreditation within a period established by a marketplace.

HHS has recognized NCQA and URAC as accrediting entities for the purposes of qualified health plan certification. The final essential health benefits rule released in February 2013 also established a process for allowing additional accrediting entities to apply to be recognized as accrediting entities and HHS stated there would be an opportunity for public comment on the applications being considered for recognition.

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We urge HHS to require that the parity requirements contained in URAC's Version 7 standards for accreditation of health plans be a mandatory minimum standard applied by all accrediting bodies for accreditation purposes. These standards incorporate the federal parity law (MHPAEA) and the regulations (IFR) that govern the statute. Importantly, these standards require that:

- *A plan must conduct a detailed internal audit and analysis of each medical management (non-quantitative) intervention applied to behavioral health treatments to assure that these interventions are "comparable to and no more stringent than those applied to medical treatments. These audits must be overseen by the compliance officer and will be reviewed by URAC.*
- *A plan must assure that any mental health or substance use disorder (MH/SUD) services contractor (e.g., a managed behavioral health organization) is in full compliance with MHPAEA.*
- *A plan is required to document that they have disclosed key aspects of the behavioral health benefit to consumers and employers, such as how compliance with parity is achieved and any restrictions or exclusion on the behavioral health benefit.*
- *The standards define utilization management (UM) protocols as "any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits" not just medical necessity criteria.*
- *To fulfill network adequacy standards, a plan must document that it has provided parity between medical and behavioral health treatment services in certain levels and types of care, such as emergency care, pharmacy, and inpatient and outpatient treatment.*
- *URAC will review and audit appeals about health plan decisions and a consumer can make a complaint directly to URAC regarding the actions (or lack thereof) surrounding compliance with parity.*

URAC is the only organization to specifically build compliance with the parity law into its standards for accreditation and makes clear that plans must do an analysis of parity compliance and share that analysis. If plans use NCQA or other accrediting bodies for accreditation, those plans may be less likely to comply with parity. We are concerned about HHS' capacity to oversee all plans for parity compliance. Setting strong accreditation standards for parity is one way to help assure that plans offer appropriate levels of MH/SUD benefits for consumers.

CONCLUSION

The Parity Implementation Coalition lauds the Department for requesting additional comments on non-discrimination requirements that are critical for individuals suffering from substance use and mental health disorders and the providers who treat them. We stand ready to work with you on the development and implementation of effective non-discrimination standards, a process to identify discrimination in benefit design, processes for compliance and transparent enforcement mechanisms and penalties.

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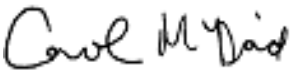
Please contact Coalition Co-Chairs Sam Muszynski (IMuszynski@psych.org) or Carol McDaid (cmcdaid@capitoldecisions.com) if you have any questions or if we can be of further assistance.

Sincerely,

Irvin L. Muszynski, JD
Co-Chair, Parity Implementation Coalition



Carol McDaid
Co-Chair, Parity Implementation Coalition

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[i] Ridgely, MS, Pacula , RL, and Burnam, MA, Short-Term Analysis to Support Mental Health and Substance Use Disorder Parity Implementation. RAND Corporation. February 8, 2012. Available at: http://aspe.hhs.gov/daltcp/reports/2012/mhsud.shtml

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[iii] Boyd, C., Leff, B., Weiss, C., Wolff, J., Hamblin A., & Martin, L. (2010). *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations: Faces of Medicaid Data Brief*. Hamilton, NJ: Center for Health Care Strategies.

[iv] Luchansky, Bill & Longhi, Dario, "Cost Savings in Medicaid Medical Expenses: An Outcome of Publically Funded Chemical Dependency Treatment in Washington State," Washington State Dept. of Social and Health Services, June 1997.

[v] Parthasarathy, S. et al. *Association of Outpatient Alcohol and Drug Treatment with Health Care Utilization and Cost: Revisiting the Offset Hypothesis* Division of Research, Kaiser Permanente Medical Program, 2001.

[vi] Parthasarathy, S., et al., "Utilization and Cost Impact of Integrating Substance Abuse Treatment and Primary Care." *Medical Care*, 41(3):357-367, March 2003.

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