



September 13, 2017

Submitted electronically via: e-ohpsca-mhpaea-eatingdisorders@dol.gov

Re: MHPAEA and Application to Treatment for Eating Disorders

Dear Sir or Madam:

The National Business Group on Health is pleased to respond to the Department of Health and Human Services', Department of Labor's, and the Treasury's request for comments regarding how the requirements of the Mental Health Parity and Addiction Equity Act apply to treatment for eating disorders.

The National Business Group on Health represents 415 primarily large employers, including 73 of the Fortune 100, who voluntarily provide group health plan coverage and other health programs to over 55 million American employees, retirees, and their families. Our members employ and provide health coverage under a wide variety of work arrangements, including full-time, part-time, seasonal, and temporary. They often have multiple lines of business in multiple locations and tailor employee work and benefit arrangements to the specific needs of each line of business.

As our members continue to develop group health plan designs and comply with applicable legal requirements, including those under the 21st Century Cures Act and the MHPAEA, primary concerns will be:

- (1) Minimizing the administrative and cost burdens associated with those requirements and
- (2) Having flexibility to provide comprehensive health coverage in the most efficient, cost-effective way possible while ensuring access to providers and facilities that provide high-quality, evidence-based care.

Having flexibility to adapt compliance to current and future work and benefit arrangements will reduce compliance burdens and allow plan sponsors to devote more resources to maintaining and developing high-quality, cost-effective health coverage for employees and their dependents.

I. Need for MHPAEA Guidance

We encourage the Departments to take into account the ongoing challenges that plan sponsors face in MHPAEA compliance, including the following:

- Many mental health benefits are not comparable to medical or surgical benefits. For example, residential treatment for eating disorders often differs substantially (in scope, providers, and treatment) from treatment at a skilled nursing facility or medical rehabilitation facility. Therefore, it is often difficult to determine if a mental health or substance use disorder benefit meets the MHPAEA’s “parity” standard.
- The evidence base for certain mental health and substance use disorder benefits is not as robust as that for many medical and surgical benefits. For example, it is difficult to obtain data from many eating disorder treatment programs regarding short or long-term outcomes for patients, which makes evaluation of the programs’ effectiveness difficult. Meanwhile, plans sponsors and governmental entities such as CMS have placed increasing emphasis on quality outcomes for hospitals and other providers of medical and surgical services.¹ The lack of comparable data for mental health treatment providers is a particular challenge if plan sponsors are to develop plan designs that promote high-quality, efficient care.
- Current MHPAEA regulations and agency guidance require extensive and detailed examination of all mental health and substance use disorder benefits for compliance with parity standards. However, this regulatory structure—by requiring a service-by-service analysis—does not take into account plan participants’ broader need for comprehensive, high-quality, affordable coverage and plan designs that promote high-quality care.

Our members are concerned that without resolving the above issues, MHPAEA enforcement will be inconsistent across plans and states. We therefore recommend that the Departments (1) develop clear implementation guidance and (2) adopt rules that take into account plan sponsors’ good faith compliance before focusing on enforcement efforts.

II. Need for High-Quality, Cost-Effective Care

Our members are committed to maintaining comprehensive health coverage—including mental health and substance use disorder coverage—for employees and their dependents. However, our members are concerned that the MHPAEA, as currently interpreted in agency guidance, may not accommodate plan design features that promote clinical effectiveness, efficiency, and value-based benefit design and may encourage inappropriate, unnecessary, and poor-quality care. This result would run contrary to the goal of controlling the overall costs of health care so employers can continue offering comprehensive employer-sponsored group health plan coverage.

¹ For example, CMS and the Hospital Quality Alliance are reporting 30-day mortality measures for acute myocardial infarction and heart failure (<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/outcomemeasures.html>).

Therefore, we recommend that the Departments focus not only on parity but also on encouraging benefit designs that promote clinical effectiveness, efficiency, and value-based benefit design.

1. Clinical Effectiveness

To prevent health care expenditures for unnecessary, redundant, or ineffective care, we support coverage of services or treatments with demonstrated evidence of clinical effectiveness. To this end, mental health and substance use disorder benefit coverage—including coverage for treatment of eating disorders—should align with generally accepted standards of medical practice and promote clinically appropriate care. For example, when evidence warrants, our members' plans routinely use medical management tools for medical and surgical benefits based on clinical effectiveness such as:

- Step therapies that require employees to try lower-cost treatment options before progressing to higher-cost options;
- Prior authorizations ensuring that only patients adhering to evidence-based clinical guidelines receive certain medications or treatments; and
- Quantity limits for the first time a patient fills a prescription to (1) avoid waste in the event a patient cannot tolerate a medication or (2) minimize the risk of abuse of addictive medications such as opioids.

These benefit designs may not have exact parallels with mental health and substance use disorder benefits. However, applying these types of design features to mental health and substance use disorder benefits will help assure that patients receive the highest-value, safest, and most medically appropriate health care services to meet their individual needs, particularly when access to high-quality mental health and substance use disorder treatment providers remains a challenge. For example, the optimal treatment settings and treatment duration for substance use disorders can vary from brief therapies to residential treatment, depending on the patient and type of disorder.² Plan designs should be able to take into account the evidence base (or lack thereof) for the effectiveness of various treatments.

A focus on clinical effectiveness also helps group health plans maintain the balance between comprehensiveness and affordability of coverage while improving participants' health and access to health benefits. Plan sponsors' efforts to implement plan designs based on clinical effectiveness also are consistent with HHS's efforts to promote evidence-based and value-based benefit designs.

2. Reasonable Limits to Promote Effective Care, Prevent Unnecessary Care, and Keep Benefits Affordable

² See Slavit W, Reagin A, Finch RA. *An Employer's Guide to Workplace Substance Abuse: Strategies and Treatment Recommendations*. Washington, DC: Center for Prevention and Health Services, National Business Group on Health; 2009.

We also strongly recommend that the Departments take into account the significant role of benefit limits in both employer and government-sponsored coverage. Employer-sponsored plans routinely place limits on a number of services, where they make sense clinically, to keep care affordable. Examples include limits on the following: bariatric surgery, chemical dependency treatment, chiropractic benefits, dental benefits, vision benefits, durable medical equipment, hearing aids, home health care and hospice, infertility benefits, out-of-network benefits, and physical and speech therapy. We therefore recommend that future guidance take into account the important role of benefit limits in both mental health/substance use disorder and medical/surgical plan designs.

We believe that the above recommendations, if implemented, will reduce administrative and cost burdens and allow group health plan sponsors much-needed flexibility in complying with the MHPAEA, the 21st Century Cures Act, and other applicable laws.

Thank you for considering our comments and recommendations. Please contact me or Debbie Harrison, the National Business Group on Health's Assistant Director of Public Policy, at (202) 558-3004 if you would like to discuss our comments in more detail.

Sincerely,

A handwritten signature in black ink, reading "Brian J. Marcotte". The signature is fluid and cursive, with a long horizontal stroke at the end.

Brian J. Marcotte
President and CEO