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June 22, 2018

Secretary R. Alexander Acosta
Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

Dear Secretary Acosta,

Thank you for the opportunity to submit comments to the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury in response to the joint request for comments on FAQ 39 regarding implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA, or the Parity Act), as amended by the Affordable Care Act, the 21st Century Cures Act, and the Employee Retirement Income Security Act (ERISA).

Center on Addiction (formerly, The National Center on Addiction and Substance Abuse) is a national, non-profit research and policy organization founded in 1992 by Joseph A. Califano, Jr. We are building on our legacy as the country's leading addiction research and policy organization to put our research into action to find, promote and enact the necessary solutions to end our country's addiction crisis. One component of this work involves monitoring substance use disorder (SUD) benefits in commercial health insurance plans in order to improve access to evidence-based treatment. The Parity Act is one of strongest tools available to improve insurance coverage for SUD treatment but it continues to be underutilized due to non-compliance and weak enforcement. We are grateful for the Departments' efforts to improve implementation through the issuance of FAQs and compliance tools.

We strongly support the Departments' "Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)" which clearly articulates the Parity Act's regulatory standards in a user-friendly form. The Self-Compliance Tool offers an important illustration relating to the application of MHPAEA to medication-assisted treatment (MAT), and we respectfully request that the Departments also include this illustration in FAQ 39 and the Model Disclosure Form to increase awareness that disparate coverage of methadone may constitute a violation of the Parity Act.

According to the illustration, a plan that covers methadone for pain but excludes methadone for opioid use disorder (OUD) may violate MHPAEA if the issuer is unable to demonstrate compliance with MHPAEA's non-quantitative treatment limitation test in developing the methadone treatment exclusion (i.e., "the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions"). According to the illustration, plans that cover methadone for pain but exclude coverage for OUD should reevaluate the medical necessity of methadone treatment for OUD and develop medical necessity criteria that "mirrors federal guidelines for opioid treatment programs."



This illustration is critically important because our research demonstrates that methadone for OUD is frequently excluded by commercial insurers. Methadone is a lifesaving and effective treatment that has historically been stigmatized, underutilized and under-reimbursed. There is no medical justification for excluding coverage of methadone for the treatment of opioid addiction. We commend the Departments for recognizing that such discriminatory coverage violates the Parity Act.

In 2016, the Center published a review of the 2017 EHB benchmark plans (the “Benchmark Plans”)¹ and recently completed an evaluation of a sample of individual plans sold on each state’s marketplace in 2017 (the “2017 ACA Plans”). Methadone for OUD was frequently excluded among both the Benchmark Plans and the 2017 ACA Plans. Among the Benchmark Plans, only three states selected a plan that explicitly covered methadone, while seven states selected a plan that explicitly excluded methadone and 41 states selected a plan where the plan documents were silent on methadone coverage. Among plans sold on state marketplaces in 2017, eight states offered at least one plan that explicitly covered methadone, 14 states offered at least one plan that explicitly excluded methadone, one state offered a plan with a possible methadone exclusion, and 28 states offered plans that were silent on methadone coverage. While the number of states with plans that explicitly covered methadone increased among the plans offered in 2017, the number of states that offered plans with explicit methadone exclusions also increased. As the opioid epidemic worsened, more exclusions appeared, despite the fact that nearly 50 years of research demonstrates that methadone is the most effective treatment for opioid addiction.

We reviewed plan formularies for the 2017 ACA Plans and found that every plan formulary included methadone for treatment of pain. As such, the fourteen states (Arkansas, Delaware, Georgia, Idaho, Iowa, Louisiana, Michigan, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, and Wisconsin) that offered at least one plan with an exclusion for methadone for OUD need to be carefully examined for compliance with the Parity Act. We understand that the plans we reviewed are not under the Departments’ jurisdiction, but rather the jurisdiction of state insurance departments. Nonetheless, we suspect that discriminatory coverage of methadone occurs across insurance products. We will also share our findings with state insurance departments. A summary of our findings is attached hereto.

In the midst of an unrelenting opioid epidemic, it is critical to ensure that insurers are not imposing barriers to evidence-based treatment. The illustration provided in the Self-Compliance Tool provides an important clarification that disparate coverage of methadone likely violates the Parity Act. We are grateful to the Departments for providing this illustration and respectfully request that the Departments also include the illustration in FAQ 39 and the Model Disclosure Form to increase awareness that disparate coverage of methadone may constitute a violation of the Parity Act.

Further, we believe that the Self-Compliance Tool will help promote parity because it provides a framework for shifting Parity Act compliance to prospective regulatory review, an enforcement strategy that would require issuers to demonstrate compliance *before* the plan could be offered on the market. Such an approach would relieve consumers of the nearly impossible burden of identifying Parity Act violations and asserting their right to health care in the midst of a health crisis. We detailed our concern with the current Parity Act enforcement framework in *Parity*

¹ Center on Addiction. (2016). *Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans*. Retrieved from <https://www.centeronaddiction.org/addiction-research/reports/uncovering-coverage-gaps-review-of-addiction-benefits-in-aca-plans>.



Tracking Project: Making Parity A Reality,² a report the Center completed in collaboration with the Legal Action Center, Research and Evaluation Group at Public Health Management Corporation (formerly Treatment Research Institute) and Partnership for Drug-Free Kids. In this study, we sought to evaluate whether the two groups on the front lines of Parity Act enforcement – regulators and consumers – could identify Parity Act violations. We found that neither group has sufficient information to identify parity violations and recommended a prospective parity compliance review requirement, implemented through a compliance tool. The Department's Self-Compliance Tool can facilitate prospective review because it sets out a detailed framework for assessing Parity Act compliance.

We also fully support the comment letter submitted by the Coalition for Whole Health and their recommendations for FAQ 39, the Model Disclosure Form, and steps to improve the Departments' authority.

Thank you very much for your willingness to receive and consider our comments. We applaud the Departments' efforts to examine and understand the issues related to parity implementation and enforcement and provide assistance to consumers seeking to enforce their rights under the Parity Act. When properly implemented and enforced, the Parity Act will have a tremendous positive impact on patients seeking medically-necessary and lifesaving care. We believe the illustration regarding methadone will increase access to a life-saving medication for patients with opioid addiction, an important tool that – due to stigma and discriminatory insurance practices – is currently underutilized with fatal consequences.

Sincerely,

Lindsey C. Vuolo, J.D., M.P.H.
Associate Director of Health Law & Policy

² Weber, E., Woodworth, A., Vuolo, L., Feinstein, E., & Tabit, M. (2017). *Parity Tracking Project: Making Parity a Reality*. Retrieved from https://lac.org/wp-content/uploads/2017/06/ES_ParityTrackingReport_ASC.pdf.



**Summary of Findings:
Review of Methadone Coverage in Individual Market Plans**

State	EHB-Benchmark Plan ¹	2017 ACA Plans ²	
		Methadone for OUD	Methadone for Pain
Alabama	Excluded	Silent	Covered
Alaska	Silent	Silent	Covered
Arizona	Silent	Silent	Covered
Arkansas	Excluded	Excluded	Covered
California	Silent	Covered (1) ³ Silent (1)	Covered
Colorado	Silent	Silent	Covered
Connecticut	Silent	Silent	Covered
Delaware	Excluded	Silent (1) Excluded (1)	Covered
District of Columbia	Covered	Covered (1) Silent (1)	Covered
Florida	Silent	Silent	Covered
Georgia	Silent	Excluded (1) Silent (1)	Covered
Hawaii	Silent	Silent	Covered
Idaho	Silent	Silent (1) Excluded (1)	Covered
Illinois	Silent	Silent	Covered
Indiana	Silent	Silent	Covered
Iowa	Silent	Excluded (1) Silent (1)	Covered
Kansas	Silent	Silent	Covered
Kentucky	Excluded	Silent	Covered
Louisiana	Silent	Silent (1) Excluded (1)	Covered
Maine	Silent	Silent	Covered
Maryland	Covered	Silent	Covered
Massachusetts	Silent	Covered	Covered
Michigan	Silent	Covered (1) Excluded (1)	Covered
Minnesota	Covered	Covered	Covered
Mississippi	Silent	Silent	Covered
Missouri	Silent	Silent	Covered
Montana	Silent	Silent	Covered
Nebraska	Silent	Excluded (1) Silent (1)	Covered
Nevada	Silent	Silent	Covered
New Hampshire	Silent	Silent (1)	Covered

¹ The findings from our review of the 2017 EHB benchmark plans were published in *Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans*, available at <https://www.centeronaddiction.org/addiction-research/reports/uncovering-coverage-gaps-review-of-addiction-benefits-in-aca-plans>

Note that we did not review plan formularies for the 2017 EHB benchmark plans and therefore do not have data on coverage of methadone for pain.

² The findings from our review of 2017 ACA Plans has not yet been published. In most states, we reviewed two individual plans offered on each state's marketplace in 2017. In some states, where only one carrier participated on the state's marketplace or where we were unable to obtain complete documentation, we only reviewed one plan.

³ (1) means applies to one plan in the state. If (1) does not appear, applies to all plans reviewed in state.



**Summary of Findings:
Review of Methadone Coverage in Individual Market Plans**

		Covered (1)	
New Jersey	Silent	Silent	Covered
New Mexico	Silent	Silent	Covered
New York	Silent	Covered	Covered
North Carolina	Silent	Silent	Covered
North Dakota	Silent	Silent (1) Excluded (1)	Covered
Ohio	Silent	Possible exclusion (1) ⁴ Silent (1)	Covered
Oklahoma	Silent	Silent	Covered
Oregon	Silent	Silent (1) Covered (1)	Covered
Pennsylvania	Silent	Silent (1) Excluded (1)	Covered
Rhode Island	Excluded	Covered	Covered
South Carolina	Silent	Silent	Covered
South Dakota	Silent	Silent (1) Excluded (1)	Covered
Tennessee	Excluded	Silent	Covered
Texas	Silent	Silent	Covered
Utah	Silent	Excluded (1) Silent (1)	Covered
Vermont	Silent	Silent	Covered
Virginia	Silent	Silent (1) Excluded (1)	Covered
Washington	Silent	Silent	Covered
West Virginia	Silent	Silent	Covered
Wisconsin	Excluded	Excluded (1) Silent (1)	Covered
Wyoming	Silent	Silent	Covered

⁴ The following language appears in one plan's Evidence of Coverage and there is no explicit reference to methadone: "No benefits will be paid under this benefit subsection for services provided or expenses incurred: For medication that is to be taken by the member, in whole or in part, at the place where it is dispensed."