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July 24, 2020

Jeanne Klinefelter Wilson
Acting Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Suite S-2524
Washington, DC 20210

Re: Department of Labor Proposed Updates to 2020 MHPAEA Self-Compliance Tool: Request for Comments

Dear Acting Assistant Secretary Wilson:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to offer comments in support of the U.S. Department of Labor (DOL) amendments to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Self-Compliance Tool. This tool was designed to help group health plans, sponsors and administrators, group and individual market health insurance issuers, state regulators, and other stakeholders determine whether a group health plan or health insurance issuer is in compliance with MHPAEA and its implementing regulations. A self-compliance, tool, however, only works effectively if it is used. **Therefore, the AMA strongly urges DOL to not only adopt the proposed amendments to the Self-Compliance Tool, but also to take further action to require health insurance companies and others to prospectively attest to DOL and state regulators that it has been used.** We explain further below.

When the MHPAEA was enacted in 2008, policymakers came together to address shortcomings in the way care was provided for those with mental health and/or substance use disorders. The law's much-needed reforms improved opportunities for care and reduced the stigma of having a mental health or substance use disorder. Yet, an overwhelming number of people needing treatment for an addiction are not receiving it. The 2017 National Survey on Drug Use and Health found that 92 percent, or 19.7 million people, with a substance use disorder receive no treatment, and 57 percent, or 46.6 million people, with a mental illness receive no treatment.

We also see that health insurance companies are regularly found to violate the MHPAEA. These exams typically involve reviewing claims from previous years to determine if a health insurance company provided mental health and substance use disorder benefits in parity with medical and surgical benefits. The AMA strongly supports the use of these exams, but we note that a market conduct exam reviews *past behavior* by a health insurance company. That is, an exam conducted in 2020 would likely review claims for benefits (not) provided two or three years prior. The importance of the DOL Self-Compliance Tool is that it could be used to **prospectively require** health plans to demonstrate compliance at the time of rate and form filing rather than the current system in which accountability is delayed by several years.

The AMA believes that the obligation of demonstrating compliance with the law is something payers can and should do. Because the MHPAEA is a comparative law, payers should do the comparisons to analyze whether they are in compliance with the law. Requiring prior comparative analysis can help streamline oversight, can help payers identify gaps, and most important—can help ensure patients have the coverage required by the law. It is clear that plans simply are not conducting the type of internal self-compliance that DOL has urged. The Self-Compliance Tool is an important tool, but if plans generally disregard using it, patients will continue to bear the brunt of parity violations, and states and DOL will be at a disadvantage in measuring compliance.

Specific to the proposed amendments, **the AMA strongly supports DOL’s focus on providing increased guidance on enforcing the MHPAEA, including the thoughtful examples and illustrations of what may or may not be an MHPAEA violation.** In the current tool, there is the illustration regarding when plans use prior authorization to deny or delay benefits for mental health and substance use disorder (MH/SUD) benefits: “To come into compliance, the plan could ensure that any additional levels of scrutiny are imposed on both medical/surgical and MH/SUD benefits comparably, including by establishing standards for when a peer review has adequately evidenced efficacy and that the qualifications of the plan’s experts are similar for both MH/SUD and medical/surgical benefits.” **We support the additional examples of how a plan can come into compliance,** such as when the DOL proposes the following language:

- “The Plan could come into compliance by covering outpatient services for MH/SUD benefits both in- and out-of-network in a manner comparable to covered medical/surgical outpatient in- and out-of-network services.”
- “The plan could come into compliance by removing the day and visit limits for mental health services.”
- “The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment.”

The AMA also appreciates the “warning signs” inclusions. **We further suggest that DOL consider providing in an appendix or web links to examples previously found by state regulators—and that plans have agreed to correct.** This would not necessarily suggest that all plans violate MHPAEA in the same manner but having access to the enforcement actions and exam findings would highlight common areas for regulators to focus on. Examples of these exams, violations, and settlements include:

- [The GAO in December 2019](#) reported “For example, DOL reported citing 113 violations of MH/SU parity requirements through its reviews in 2017 and 2018.”
- Pennsylvania—examples include recent findings by the Pennsylvania Insurance Department of violations by [Independence Blue Cross](#) as well as [United Healthcare](#).
- Massachusetts—the Massachusetts Attorney General found [parity and other violations](#) by Harvard Pilgrim Health Care and United Behavioral Health d/b/a Optum; Fallon Community Health Plan and Beacon Health Strategies; AllWays Health Partners; Blue Cross Blue Shield of Massachusetts (BCBS); and Tufts Health Plan.
- Rhode Island—the Rhode Island Office of Health Insurance Commissioner found [significant parity and other violations](#) by Blue Cross Blue Shield of Rhode Island.
- Illinois—the Illinois Department of Insurance just [last week released violation findings](#) from several health insurance carriers, including Cigna and United Healthcare.

The AMA also supports inclusion of the warning signs for “Prior authorization for medication for opioid use disorder,” “Denying all drug screening tests for those with SUD,” and “Different medical necessity review requirements.” These are particularly important markers as they feature prominently in market conduct examinations and in reports from physicians and patients.

The AMA also notes that there are several mentions of the need for plans to provide data to help determine compliance, including a new proposal for providing “specific data” to help determine if there is a violation for a non-quantitative treatment limitation. **The AMA strongly supports requiring plans to not only provide the data upon request, but to require plans to review their own data at the rate and form filing process.** As discussed above, because MHPAEA is a comparative law, the only meaningful way for plans to know if they are in compliance is to review their own data. That is the essence of the Self-Compliance Tool, but **we urge DOL to go one step further and require plans to attest that they actually have performed the analysis.** After nearly a dozen years, it is reasonable to expect plans to do this prospective work given the massive lack of access to MH/SUD services. In support of this goal, the AMA, American Psychiatric Association, and American Society of Addiction Medication (ASAM) joined together last year to develop an “[Enhanced Attestation](#)” tool that not only is based on DOL rules, but would also provide the type of assurance that plans have completed the self-compliance requirements under MHPAEA.

We are pleased to see discussion of *Wit v. United Behavioral Healthcare* (UBH), a case in which UBH was found to have placed its own financial interests over the safety and well-being of patients from 2011-2017 across four states, i.e., Connecticut, Illinois, Rhode Island and Texas. While not a parity case, per se, the case highlighted the damage to patients who were denied coverage by UBH for residential treatment for serious mental illness and substance use disorder. Coverage was also denied by UBH for outpatient mental health treatment. Five of the most important takeaways from the Court’s findings included:

1. UBH’s self-created guidelines dictating what would be covered for mental health illness and substance use disorders did not meet generally accepted standards of care in the commercial and self-insured health insurance markets;
2. UBH committed facial violations of state law in four states for not providing patients the standard of care;
3. The generally accepted standard of care was defined by guidelines developed by medical societies, including the ASAM criteria;
4. Patients’ benefits contracts stipulated consistency with the generally accepted standard of care and UBH could not alter that requirement through the adoption and application of medical necessity criteria that did not meet that standard; and
5. **UBH’s actions were essentially a mitigation strategy in response to the federal MHPAEA.**

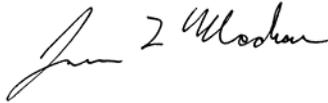
The AMA strongly supports DOL’s proposed language that “Plans should be prepared to disclose their medical necessity criteria and should ensure that, to the extent the plan document specifies a specific treatment guideline, it follows that as well.” **The AMA urges that the disclosure—and compliance—requirements be provided up-front** to avoid egregious situations such as found in *Wit*.

Lastly, the AMA also supports the new DOL section regarding creation of an internal compliance plan. We caution, however, that an internal compliance plan must also include an attestation that the plan has been completed. That is, while it is positive for plans to say that they have the documentation as spelled out by DOL, it is more beneficial for the plans to attest that they have used the data and other information to specifically demonstrate compliance.

Jeanne Klinefelter Wilson
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Thank you for your consideration of the AMA's comments. If you have any questions please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or at (202) 789-7409.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jim L. Madara".

James L. Madara, MD