



July 24, 2020

U.S. Department of Labor
U.S. Department of the Treasury
Department of Health & Human Services

Via email to e-ohpsca-MHPAEA-SCT-2020@dol.gov

Re: Comments on the Proposed Updates to 2020 MHPAEA Self-Compliance Tool: Request for Comments

Dear Sir or Madam:

We appreciate the opportunity to provide feedback on the proposed updates to 2020 MHPAEA Self-Compliance Tool. Viva Health, a health maintenance organization founded in 1995, is one of the largest health insurers in the state of Alabama. We administer plans for over 56,000 fully-insured and self-funded lives in the small group and large group health markets as well as nearly 50,000 lives on our Medicare Advantage plans.

We do have a few concerns, some significant, regarding MHPAEA enforcement outlined in the proposed self-compliance tool. Specific comments, suggestions, and concerns are outlined below by topic.

Section B. Coverage in all Classifications

The proposed self-compliance tool includes an update regarding coverage in all classifications that specifies:

If a plan or coverage excludes all other benefits for a particular mental health condition or substance use disorder, but nevertheless covers formulary prescription drugs for that condition or disorder, the plan would be covering mental health or substance use benefits in one classification (prescription drugs). Therefore, the plan would be required to provide mental health or substance use benefits with respect to that condition or disorder for each of the other five classifications for which the plan also provides medical/surgical benefits.

This is extremely troublesome for many reasons. First, it is common for plans to exclude the medical treatment for certain mental health/substance use disorder (MH/SUD) conditions but cover the pharmaceutical treatment for them. This is usually because the treatment under the medical/surgical (med/surg) benefit is unproven and/or cost-prohibitive but the drug treatment is both proven and/or affordable. Similar situations exist with medical conditions. For example, surgical treatment of obesity is often excluded while weight loss drugs are covered. Requiring plans to cover a medical treatment if the drug treatment is covered would almost certainly lead to plans opting to exclude the drug treatment in order to avoid coverage of the costly and/or unproven medical treatment. This enforcement only serves to harm members.

Second, it is often difficult to determine what the diagnosis is that is associated with the covered drug as one drug may be approved for the treatment of multiple conditions, some covered on the med/surg side



and some not. Drug claims do not include an ICD-10 diagnosis code as a matter of routine filing practice. To comply with the requirement, a health plan would need to require diagnosis codes before a drug is dispensed, inevitably delaying access to the medication at the point of sale and increasing administrative burden and expense, which would be passed along to members in the form of premium increases. It is more difficult to get mental health medical records or for a pharmacist to have phone-based communications with a mental health provider to attempt to resolve issues due to enhanced privacy restrictions around accessing these records. Further, patients may already be concerned about stigma and privacy when filling these medications at the pharmacy. Additional barriers at the point of care will likely increase adherence problems.

Finally, if a plan opts to remove drug coverage for MH/SUD diagnoses, it would be nearly impossible to discern whether the drug should be covered or not when a mental health condition has a medical component. For example, if a person is at risk for seizures due to drug use or detox and must be prescribed medication to prevent that, is the diagnosis seizure prevention, a covered medical benefit, or for narcotic maintenance therapy, a commonly excluded medical benefit?

It should also be noted that it is not uncommon for plans, especially self-funded plans, to have their medical benefit with one carrier and drug benefit with another. In these instances, coordinating the exclusion of diagnoses across benefits is much more difficult.

Section F. Non-quantitative Treatment Limitations

The proposed self-compliance tool includes an update regarding parity in provider reimbursement. It states that in order to comply with MHPAEA, “a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates” for in-network med/surg and MH/SUD providers. However, it is not uncommon for a plan to “rent” its MH/SUD network from a third party, which handles the credentialing. In these situations, it is the third party that negotiates the reimbursement rates. This would certainly be a different process than what is used to determine med/surg provider reimbursement, but whether it was “comparable” would be subjective and difficult for a plan to prove or disprove.

General Comments

While we appreciate the Departments’ efforts in taking steps to clarify compliance with regard to non-quantitative treatment limitations, we fear that the more stringent these clarifications become, the less plans are able to make reasonable interpretations, resulting in reduced benefits for members overall, rather than adding benefits that were previously non-covered.



Thank you in advance for your consideration of our concerns and the opportunity to provide comments and feedback on the proposed self-compliance tool. If you have any follow-up questions or comments, please don't hesitate to contact me directly at smasdon@uabmc.edu or (205) 558-7641.

Sincerely,

A handwritten signature in black ink that reads "Samantha Davis".

Samantha Davis
Associate Director of Regulatory Affairs & Strategic Development
Viva Health, Inc.