August 31, 2016

Submitted electronically via: parity@hhs.gov

Mental Health and Substance Use Disorder Parity Task Force

Re: Mental Health Parity

Dear Sir or Madam:

The National Business Group on Health is pleased to respond to the Mental Health and Substance Use Disorder Parity Task Force’s (Task Force’s) request for comments regarding mental health and substance use disorder parity requirements.

The National Business Group on Health represents 420 primarily large employers, including 72 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 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 Mental Health Parity and Addiction Equity Act (MHPAEA), primary concerns are:

(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 regulatory 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. Therefore, we welcome the Task Force’s efforts to incorporate input from key stakeholders such as group health plans.

I. Features of Large, Self-Insured Group Health Plans

We encourage the Task Force, in developing its recommendations and report, to take into account large, self-insured group health plan designs and goals. As noted above, National
Business Group on Health members employ and provide health benefits for employees in a wide variety of industries, locations, and work arrangements. To ensure the efficient, cost-effective plan administration, it is critical that plan sponsors be able to adapt their compliance procedures to current plan structures. Therefore, we recommend that the Task Force take into account the following:

**A. ERISA-Covered Plans and Uniform Plan Administration**

In ERISA’s preemption provision, ERISA § 514, Congress explicitly provided for national, uniform administration of self-insured employee benefit plans. This provision is crucial to the efficient administration of multi-state group health plans such as those maintained by Business Group members. Uniform administration allows our members to offer benefits packages for all employees, streamline administration and communications processes, and reduce costs by negotiating with providers on a multi-state or national basis. Uniform administration also provides much-needed flexibility to tailor plan designs to the features and needs of employers and their employee populations.

**B. 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 Affordable Care Act’s—and our members’—goal of controlling the overall costs of health care so they can continue offering comprehensive employer-sponsored group health plan coverage.

Therefore, we recommend that the Task Force 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 should align with generally accepted standards of medical practice and promote clinically appropriate care. For example, when evidence warrants, our members’ plans routinely use care and medical management tools for medical and surgical benefits based on clinical effectiveness such as:

- “Step therapy” for medications to encourage providers and patients to utilize proven effective drugs that are less costly or risky to patients’ health than new “blockbuster” drugs with less evidence base;
• Radiology management programs to ensure that patients receive appropriate screening for their conditions or stages of treatment and are not subject to excessive radiation exposure or unnecessary scans; and

• Dental plan limits—related to frequency, age, and tooth structure—to provide low cost dental coverage, which has resulted in improved oral health with less than 3% of Americans reaching their annual dental limits. Without internal limits mitigating overutilization, the cost impact of providing oral health care services would rise considerably.

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.1 Plan designs should be able to take into account the evidence base 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. Best Management Practices to Promote Efficiency

In addition to clinical effectiveness, we believe that promoting efficiency through best management practices will help keep group health plan coverage—including mental health and substance use disorder benefit coverage—affordable. Such best management practices include, but are not limited to:

• **Evidence-Based Benefits.** Linking coverage to the effectiveness of treatments and setting cost-sharing, provider selection, and plan payments to support evidence-based care and discourage ineffective care. For example: reducing or eliminating copayments for maintenance drugs where the evidence base for the drugs’ effectiveness is strong.

• **Targeted Evidence-Based Preventive Care.** Providing incentives such as first dollar coverage (or little or no copayment) for evidence-based preventive care services for targeted populations to improve participant health and reduce future health care costs. Offering education programs to improve plan participant awareness of preventive care.

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• **Emphasis on Primary Care.** Paying more for care coordination and patient management and evaluation services. Choosing providers who incorporate the “patient-centered medical home” concept and emphasize primary care coordination.

• **Meaningful Cost-Sharing.** Setting cost-sharing for plan participants at levels that reduce excessive and inappropriate utilization but ensure access to needed medical care when appropriate. Varying cost-sharing based on clinical necessity and therapeutic benefit. For example: Reducing cost-sharing when participants meet requirements fostering evidence-based care such as using medical consultation services and decision supports, participating in disease or case management.

• **Prescription Drug Management.** Managing prescription drug use and pharmacy spending by establishing plan preferences for select generics and brand-name drugs. Considering “step” therapy, generic substitution requirements, or incentives, generic education programs for plan participants and physicians, a separate deductible for prescription drugs, preauthorization for selected drugs, reduced cost sharing for mail order compared to retail purchase, mandatory mail order of maintenance medications, tiered copayments, coinsurance rather than copayments for medications, dose optimization, and quantity-duration protocols for certain medications.

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

   We also strongly recommend that Task Force 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.

**II. Updating Coverage**

In the future, advances in personalized medicine will require a more individualized approach to coverage decisions. In addition, the speed at which new, costly treatments are coming to market will create a need for objective, evidence-based assessments to ensure patient safety, quality, and affordability. Both of these factors highlight the necessity of frequent and regular reevaluation of group health plan benefits, including mental health and substance use disorder benefits. Such reevaluations will identify not only benefits to be added but also existing benefits that may need to be eliminated based on new medical evidence.

Therefore, the National Business Group on Health recommends that the Task Force take into account the need for plan sponsors to continuously evaluate and refine group health plan coverage. These evaluations include evidence-based, clinical reviews of covered
services and providers utilized (with an actuarial cost/benefit analysis) and incorporation of new information based on credible, scientific evidence published in peer-reviewed medical literature. Such evaluation may result in removal of benefits that are no longer supported by such evidence.

III. Need for Flexibility in MHPAEA Implementation

In addition to the above features of large, self-insured plans, we emphasize the ongoing challenges that plan sponsors face in MHPAEA compliance, including the following:

- Many mental health and substance use disorder benefits are not comparable to medical or surgical benefits. For example, residential treatment for mental health conditions or substance use 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 substance use 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. The lack of comparable data for mental health and substance use disorder treatment provider is a particular challenge if plan sponsors are to develop plans design that promote high-quality, efficient care.

- The 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.

IV. Recommendations

Therefore, National Business Group on Health encourages the Task Force, in developing its recommendations and report, to:

(1) Take into account the need for plan design flexibility for group health plan sponsors, provided they make good faith efforts to comply with the MHPAEA and offer an overall benefits package that provides comprehensive health coverage; and

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2 For example, CMS and the Hospital Quality Alliance is reporting 30-day mortality measures for acute myocardial infarction and heart failure (https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinitiatives/outcomemeasures.html).
(2) **Focus on the need for group health plan designs based on clinical effectiveness, efficiency, and value-based benefits.**

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

Again, thank you for considering our comments and recommendations regarding mental health parity. Please contact me or Steven Wojcik, the National Business Group on Health’s Vice President of Public Policy, at (202) 558-3012 if you would like to discuss our comments in more detail.

Sincerely,

Brian J. Marcotte
President and CEO