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Thank you for the opportunity to provide testimony on how Congress can improve access to substance use disorder and mental health treatment in Medicare and private insurance. The Legal Action Center (LAC) is a non-profit organization that uses legal and policy strategies to fight discrimination, build health equity, and restore opportunities for people with substance use disorders, arrest and conviction records, and HIV or AIDS. LAC convenes the Medicare Addiction Parity Project, which seeks to improve Medicare’s coverage of substance use disorder treatment equitably and comprehensively. LAC also works with partners in states and on the national level to fight for fair insurance coverage of mental health and substance use disorder treatment through robust enforcement of the federal Mental Health Parity and Addiction Equity Act and state parity laws.

We applaud the Committee for your commitment to improving coverage of and access to mental health and substance use disorder treatment for all individuals. The dual epidemics of COVID-19 and substance use and mental health disorders have resulted in unprecedented numbers of overdose deaths, with a disproportionate impact on Black communities, and increased rates of depression, anxiety, and suicidal ideation, particularly among youth. America’s compounding crises have revealed longstanding deficiencies in access to substance use disorder and mental health care that require immediate and system-wide reform. **We appreciate the opportunity to identify (I) needed improvements in Medicare to ensure access to all evidence-based substance use disorder treatment at parity with other medical conditions, reforms that will improve critical coverage standards in other payer systems, and (II) rigorous metrics and oversight of health plan networks of mental health and substance use disorder providers to ensure timely access to quality services.**

I. Improving Medicare Coverage of Substance Use Disorder and Mental Health Services

Millions of individuals ages 65 and over cannot access substance use disorder treatment because of significant gaps in Medicare’s coverage. Based on the National Survey on Drug Use and Health, approximately 1.7 million Medicare beneficiaries had a substance use disorder in 2015-2019, and yet only 11% received any treatment (6% of individuals ages 65 and older, 17% of Medicare beneficiaries under the age of 65).¹ Among those who did not receive treatment 38% of beneficiaries ages 65 and older (and 28% of beneficiaries under 65) reported financial barriers, including insurance not covering treatment, as a reason for not getting the needed care.

¹ Parish, W. J., Mark, T. L., Weber, E., & Steinberg, D. (2022). Substance use disorders among Medicare beneficiaries: Insights from analysis of the National Survey of Drug Use and Health. *Working paper*.

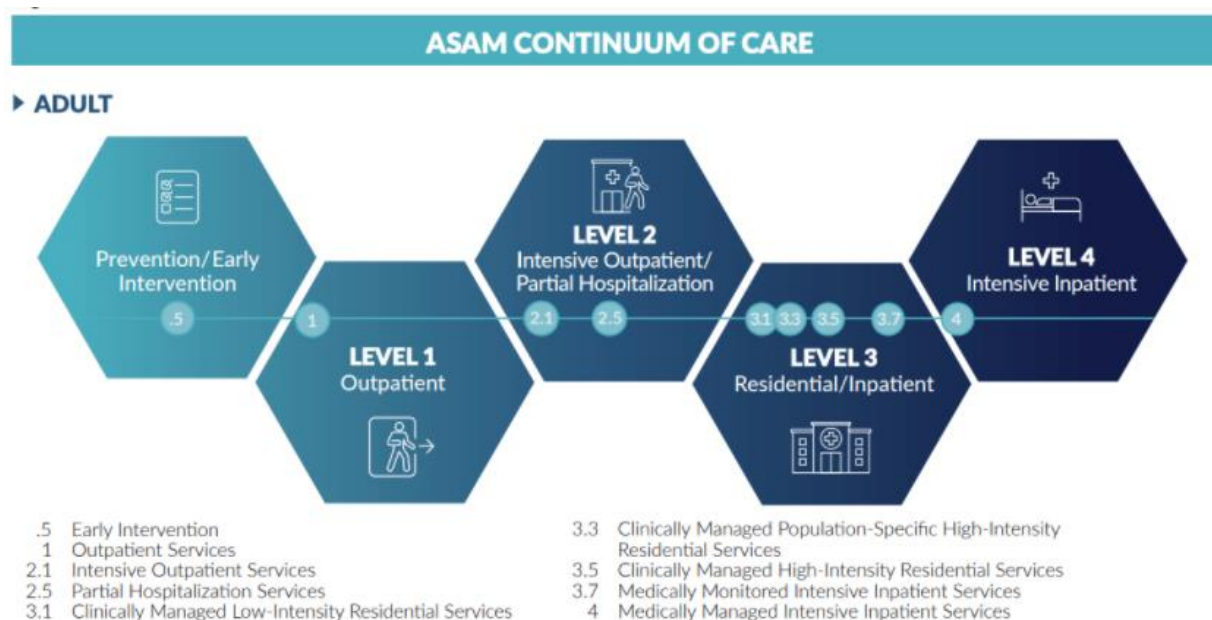
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Over one million Medicare beneficiaries were diagnosed with an opioid use disorder in 2020.² Rates of risky alcohol use are even higher, as approximately 65% of individuals ages 65 and older report high-risk drinking, with more than one tenth of this group currently binge drinking.³ Due to changes in the body and brain and increased use of medications for other health conditions, older adults are often more susceptible to the effects of prescribed and non-prescribed drugs and alcohol, and the related health consequences. Furthermore, the COVID-19 pandemic has made these individuals even more susceptible to increased substance use as they experienced isolation from friends and family, grief and loss over loved ones due to COVID-19, fear from day-to-day uncertainty, financial hardship, and loss of livelihood and routine activities.

This disparity – between those who need care and those who can access it – exists because Medicare fails to cover the full scope of (A) evidence-based services, (B) providers, and (C) settings for substance use disorder treatment, and (D) lacks the anti-discrimination protections in the Mental Health Parity and Addiction Equity Act to ensure comprehensive and equitable access to care.

A. Medicare’s Coverage Gaps – Medicare Does Not Cover the American Society of Addiction Medicine Continuum of Evidence-Based Substance Use Disorder Treatment.

Substance use disorders are treated on a continuum, like other chronic disease models. The American Society of Addiction Medicine (ASAM) has developed a widely used and comprehensive set of guidelines for the levels of treatment that patients need, based on the degree of direct medical management provided; the structure, safety and security provided; and the intensity of the services provided.⁴ These levels include:



² U.S. Dep’t of Health and Human Services, Office of Inspector General, “Many Medicare Beneficiaries are not Receiving Medication to Treat Their Opioid Use Disorder” 1 (Dec. 2021), <https://justthenews.com/sites/default/files/2021-12/OEI-02-20-00390.pdf> [hereinafter “OIG Report”]

³ National Institute on Drug Abuse, “Substance Use Disorder in Older Adults DrugFacts,” <https://www.drugabuse.gov/publications/substance-use-in-older-adults-drugfacts>.

⁴ American Society of Addiction Medicine, “About the ASAM Criteria,” <https://www.asam.org/asam-criteria/about-the-asam-criteria>.

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Medicare covers the least intensive and most intensive types of treatment but fails to cover intermediate levels of care.⁵ This limited “bookend” approach is inconsistent with ASAM’s evidence-based treatment model and with other health care financing systems, including Medicaid and private insurance. Medicare covers early intervention and outpatient services (ASAM Levels 0.5 and 1) and inpatient services (ASAM Level 4), but it lacks coverage for intensive outpatient/partial hospitalization services and residential services (ASAM Levels 2 and 3). These intermediate levels of substance use disorder care are often used as a step down for patients who no longer need to be hospitalized but cannot be discharged safely into their communities, or as a step up for those who need more intensive services and supports.

The Legal Action Center has collected stories from patients, family members, and providers across the country to understand the impact these gaps have in treatment access. Providers have stressed that they cannot help their patients get the treatment they need because Medicare does not cover the required services. One Minnesota health care provider shared:

It was extremely difficult to find a regular IOP [intensive outpatient program] addiction that took Medicare. All I could find were special 65+ Medicare programs which did NOT provide the level of care that the client needed.

A Washington health care provider shared:

I have an increasing caseload of Medicare patients who need [ASAM level] 3.5 inpatient and cannot go because Medicare won't cover it or there is no agencies that take Medicare for 3.5 level of care.

An Oregon provider has also struggled with helping clients who need residential treatment, since, **“Medicare doesn't cover this level of care and therefore clients end up going inpatient which is more costly.”**

Without coverage of the full continuum of substance use disorder services, Medicare beneficiaries cannot receive the most appropriate care in the least restrictive and costly setting, resulting in many individuals getting inadequate, if any, treatment until their conditions become acute enough to require hospitalization. In most of the stories we received, patients ultimately received a higher – and more expensive – level of care because the appropriate level was not available. **As one provider captured the shameful reality: “People die waiting for solutions when they need higher/appropriate levels of care.”**

The Parity Act and ACA standards generally require the full scope of services for qualified health plans and employer sponsored plans and support a full continuum in Medicaid. Thus, Medicare is currently falling behind, and people lose access to treatment when they become eligible for Medicare. **Congress should authorize coverage for the full ASAM continuum to ensure that people have access to the appropriate substance use disorder care they need and prevent unnecessary hospitalizations and deaths.**

⁵ Deborah Steinberg & Ellen Weber, Medicare Coverage of Substance Use Disorder Care: A Landscape Review of Benefit Coverage, Service Gaps and a Path to Reform, Legal Action Center (Feb. 1, 2021), <https://www.lac.org/assets/files/Medicare-sud-coverage-final-formatted-2.12.21-Final.pdf>.

Expanding Medicare Coverage of Substance Use Disorder Treatment
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While Medicare covers outpatient services for beneficiaries with substance use disorders, access to care is severely hampered because Medicare (1) does not cover the full range of providers that offer these services or (2) pays such low reimbursement rates that covered providers cannot afford to participate in the program. The substance use disorder providers who are “missing” from the Medicare providers include Licensed Professional Counselors and Licensed Addiction Counselors, Certified Alcohol and Drug Counselors, and Peer Support Specialists. Certified and/or licensed addiction counselors offer much of the counseling in ASAM Level 1 (outpatient) services, as well as comprise a significant portion of the staff in more intensive levels of substance use disorder care.

Accordingly, many beneficiaries who seek outpatient treatment – a level of care that is covered under Medicare – are unable to find services in their communities. This creates significant continuity of care gaps, as patients lose access to their treatment and trusted providers when they become eligible for Medicare and can no longer receive care from practitioners who are covered under other insurance. One substance use disorder program director shared a story of a patient who had access to the treatment he needed because he was on Medicaid, but who was approaching age 65:

“As this client aged, his number one fear was transitioning to Medicare coverage, because he knew that he would lose all of his medical providers and perhaps most importantly he would lose access to his therapist. This client also knew that the services available to him through traditional Medicare and even through a Medicare advantage plan would not be adequate to his needs.

As we approached this pending transition in his insurance status, this client asked his therapist every week, ‘**Do I still have to transition to Medicare, I don’t want to lose all of my support.**’ The anxiety that this client experienced also prompted significant moral distress for the clinician, as she knew that such a significant drop in support would cause this client significant harm and would also stand to exacerbate his history of trauma and abandonment.”

Other stories from patients and providers have repeatedly captured how, in rural and underserved communities especially, Medicare beneficiaries cannot find substance use disorder treatment providers within a reasonable driving distance. We commend Congress for allowing substance use disorder services to be delivered to Medicare beneficiaries via telehealth in their homes, regardless of geographic location, and the Centers for Medicare and Medicaid Services for authorizing such services to be delivered via audio-only telehealth. Such actions are helping many beneficiaries access treatment that they otherwise could not receive. But while telehealth is the solution for some, it is not appropriate for everyone, and not available for many of the most vulnerable Medicare beneficiaries including those from historically marginalized populations.

In this escalating behavioral health workforce crisis, where more than one-third of Americans live in mental health provider shortage areas,⁶ we need to ensure that all practitioners that are authorized by states to deliver substance use disorder treatment can do so. Representative Mike Thompson’s bill H.R. 432, cosponsored by many Members of this committee, would begin to fill this need by covering Marriage and Family Therapists and Mental Health Counselors. We strongly support this bill, and urge the Committee to also cover the licensed and certified addiction treatment professionals. Representative Judy Chu’s bill H.R. 2767 would further alleviate the provider and support services gaps in Medicare by ensuring coverage of peer support specialists in Medicare for behavioral health integration services.

⁶ U.S. Government Accountability Office, *Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID-19 Pandemic* (March 31, 2021), <https://www.gao.gov/assets/gao-21-437r.pdf>.

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Congress can help address workforce gaps by authorizing the full range of substance use disorder treatment practitioners to receive reimbursement through Medicare and ensuring that appropriate reimbursement rates are established.

Data also reveal that the Medicare practitioners who are authorized to deliver substance use disorder services – psychiatrists, psychologists, and licensed clinical social workers – have low participation rates in Medicare and have among the highest opt-out rates of all practitioners in the program.⁷ Reimbursement rates for these practitioners are often too low to meet the cost of providing their services. Representative Barbara Lee's bill H.R. 2035, which many on this committee have cosponsored, would improve the reimbursement rates for clinical social workers and eliminate a discriminatory rate setting formula. By increasing the reimbursement rates for all of these essential providers, and ensuring non-discriminatory standards for rate setting as well as utilization management and network adequacy in Part C plans (see further discussion below), Congress can expand the behavioral healthcare workforce in Medicare.

C. Medicare's Coverage Gaps – Community-Based Settings of Substance Use Disorder Treatment Are Not Covered Under Medicare

To further compound workforce shortages in Medicare, the program does not authorize community-based substance use disorder treatment facilities, which serve many beneficiaries who have transitioned from Medicaid to Medicare. Congress, thanks to Chair Neal and the other Committee Members, expanded Medicare to cover Opioid Treatment Programs (OTPs). While Medicare's coverage of this benefit is in its infancy (going into effect in January 2020), almost 40,000 Medicare beneficiaries with opioid use disorders received treatment from OTPs in that first year.⁸ **Yet, no other freestanding (non-hospital-affiliated) community-based substance use disorder treatment facility is a Medicare provider.** These facilities deliver the full range of services patients need, including medications and outpatient counseling. The lack of coverage likely contributes to the OIG's finding that only 16% of Medicare beneficiaries received medications for opioid use disorder in 2020 and only half of those received behavioral counseling.

Community-based substance use disorder programs offer multiple services on the ASAM continuum – outpatient, intensive outpatient, partial hospitalization, and residential services – to facilitate the appropriate continuum of care and transitions. Individuals can step up or step down to an appropriate level of treatment while maintaining relationships with their trusted providers. While Congress has expanded access to community-based mental health care for Medicare beneficiaries by covering Community Mental Health Centers (CMHCs), the equivalent setting for substance use disorder treatment is still missing from Medicare coverage. Accordingly, beneficiaries who have co-occurring mental health and substance use disorders can get more of the intermediate, non-acute levels of treatment that they need, but those without a primary mental health diagnosis are often unable to get treatment in their communities.

Failure to cover non-hospital residential substance use disorder services presents significant barriers to cost effective care for older adults who need treatment in a setting similar to a skilled nursing facility following a hospital discharge. One Texas licensed program, La Hacienda Treatment Center, tracked Medicare inquiries over a three-week period for inpatient/residential care (ASAM Levels 3.7 and 4) and, in that short time, 39 individuals were unable to access needed treatment services due to Medicare's exclusion of those levels of care outside of a hospital setting.

⁷ U.S. Government Accountability Office, *CMS Should Provide Beneficiaries More Information about Substance Use Disorder Coverage* (May 2020), <https://www.gao.gov/assets/710/707117.pdf>.

⁸ See OIG report, *supra* note 2.

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One family member of an individual in need of inpatient withdrawal management (detoxification) reported that they:

spent hours and hours on the phone, being passed around, and never found anything that was available within 1 month from then. Placed on long waiting lists, and by the time the services were available, [the Medicare beneficiary] was using again and no longer willing to get treatment.

A caseworker shared that they were looking for detoxification services for a client on Medicare, but no such services were available outside of jails or hospitals because of Medicare's restrictions on settings. **Outrageously, the client ended up receiving his services in jail.**

Congress can remedy this inequity and tragic waste of human and other resources by authorizing Medicare coverage of community-based substance use disorder treatment facilities, in the same way Medicare covers CMHCs and other similar treatment settings.

D. Medicare's Lack of Parity Creates Discriminatory Barriers to Care Based on Inequitable Reimbursement Rate Setting and Medicare Advantage Utilization Management and Network Adequacy Practices.

Medicare accounts for 20% of health expenditures in the United States and yet it is not subject to the Mental Health Parity and Addiction Equity Act (Parity Act). The Parity Act applies to most Medicaid and private insurance plans, ensuring that substance use disorder and mental health services are offered in a comparable way as medical/surgical services. Because Medicare is not subject to the Parity Act, traditional Medicare and Medicare Advantage plans impose a wide range of treatment limitations to substance use disorder and mental health services that do not apply to other medical/surgical services. **Thus, substance use disorder care is not only more limited, but the available services are also unequal to the scope and availability of services for other medical conditions.** As the standard setter for reimbursement rates and network adequacy standards in other payment systems, Medicare's failure to comply with Parity Act standards also has significant implications for rooting out discrimination in Medicaid and private insurance.

Some Medicare limitations are quantitative in nature, such as the 190-day lifetime limit on inpatient psychiatric care. This discriminatory treatment limitation, which does not apply to any other medical condition, prevents individuals from getting the appropriate treatment they need throughout their lifetimes. It disproportionately affects people with disabilities who become eligible for Medicare prior to turning 65 years old and may need multiple episodes of hospitalization due to the severity of their mental health and substance use disorder conditions. **This lifetime limit is especially problematic for people with substance use disorders because, as previously described, the lower levels of care that could keep them out of the hospital are not covered, and thus they are forced to go inpatient for treatment more frequently.** Furthermore, because the appropriate step down services are not covered under Medicare, the lifetime limit prevents beneficiaries from appropriately transitioning to less intensive levels of care and being safely discharged into their communities. **Congress should eliminate the 190-day lifetime limit on inpatient psychiatric care, and any other quantitative treatment limitations that inhibit access to mental health and substance use disorder treatment in a way that are not comparable to those for medical and surgical treatment.**

Other significant limitations to care access are non-quantitative. The Parity Act bars plans from imposing more stringent non-quantitative treatment limitations (NQTLs) for mental health and substance use disorder services than those imposed on medical and surgical services. As described above, the full scope of substance use disorder and mental health benefits across the ASAM continuum are not available to

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Medicare beneficiaries; this is a Parity Act violation when medical services are covered across the continuum of care. Additionally, there are no standardized medical necessity criteria for substance use disorder and mental health services, and network adequacy metrics in Medicare Advantage Plans are insufficient to ensure an adequate network of providers. Furthermore, Medicare Advantage and Part D Plans impose burdensome and unnecessary prior authorization requirements (even though research has demonstrated that removing such requirements for medications for opioid use disorder improves access to treatment and reduces hospitalizations and emergency department visits),⁹ step therapy or “fail first” policies, and dosage limitations that prevent beneficiaries from getting timely access to appropriate services and medications for opioid use disorder. Applying the Parity Act to Medicare would ensure that such practices cannot be more stringent or restrictive than those used for medical/surgical services.

Perhaps the most significant non-quantitative treatment limitation is inequitable reimbursement rate setting practices. For example, Medicare authorizes reimbursement rates for licensed clinical social workers at a set reduced percentage of the rate for psychologists (i.e. 75%). The U.S. Department of Labor and New York Attorney General settled one case against United Healthcare finding that this type of percentage reduction violated the Parity Act in self-funded employer plans.¹⁰

Inadequate Medicare coverage of substance use disorder treatment is a longstanding problem that has been magnified by the COVID-19 pandemic. To ameliorate the dual epidemic, we must start with Medicare to ensure that our most vulnerable communities have access to the substance use disorder treatment they need. The Office of Inspector General's recent data brief demonstrated that Medicare beneficiaries over the age of 65 were three times less likely than those under 65 to receive medications for opioid use disorder than those under 65, and Asian/Pacific Islander, Hispanic, and Black beneficiaries have less access to this evidence-based substance use disorder treatment than white beneficiaries.¹¹ These findings are not surprising, when Medicare does not cover the entire continuum of care, range of providers, and community-based settings for substance use disorder treatment and there are no requirements for Medicare Advantage plans to maintain adequate networks of these life-saving treatment options like opioid treatment programs. Incremental improvements to Medicare are insufficient. **Congress must act now to save the lives of millions and achieve true health equity by closing the substance use disorder coverage gaps in Medicare and applying the Parity Act.**

II. Network Adequacy – Adoption of Strong Quantitative Metrics and Enforcement Standards Will Improve Access to Affordable Mental Health and Substance Use Disorder Care in Qualified Health Plans and Employer Sponsored Plans

Long wait times, limited access to in-network treatment providers and unaffordable out-of-pocket costs are not unique to Medicare. Research by Milliman found that individuals with commercial PPO plans access out-of-network mental health and substance use disorder care at far greater rates than individuals seeking other medical care for outpatient office visits, outpatient facilities and residential services.¹² The

⁹ Tami L. Mark, et al., *Association of Formulary Prior Authorization Policies with Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries*, JAMA (Apr. 20, 2020), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764598>.

¹⁰ U.S. Dep't of Labor, Dep't of Health & Human Services, Dep't of the Treasury, *2022 MHPAEA Report to Congress: Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage* 38, <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf>.

¹¹ See OIG Report, *supra* note 2.

¹² Melek, S., Davenport, S., & Gray, T.J. (2019), *Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement*, Milliman. https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.

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disparity *increased* from 2013 to 2017, notwithstanding (1) the Parity Act's prohibition on discriminatory network admission, network adequacy and reimbursement rate setting practices and (2) the Affordable Care Act's (ACA) requirement that qualified health plans include an adequate number of network mental health and substance use disorder providers to ensure access to services without unreasonable delay. 42 U.S.C. § 18031(c)(1)(B). Milliman described the disparity for substance use disorder treatment as "especially stark" and, over the 5-year period, was accompanied by "declining reimbursement rates to substance use disorder providers."¹³ Although most individuals and families cannot afford non-network behavioral health care, the availability of those services demonstrates that workforce shortages are not the sole cause of limited behavioral health provider networks. **To fully understand and address the deficiencies in carrier networks, Congress should (A) impose additional data collection requirements for network adequacy and plan improvement requirements for inadequate networks, (B) protect consumers from balance billing for non-network mental health and substance use disorder services when networks are inadequate, and (C) authorize civil monetary penalties against issuers and third-party administrators of employer sponsored plans that violate the Parity Act.**

A. Enhanced Network Adequacy Data Collection Requirements for Qualified Health Plans

The Department of Health and Human Services (HHS) has proposed stronger network adequacy metrics for 2023 QHP certification that, if adopted, will impose new quantitative metrics for appointment wait time, travel time and distance, and essential community providers for substance use disorder and mental health provider networks in all states operating on the federally facilitated exchange (FFE).¹⁴ As of 2020, only 5 states – California, Colorado, Maryland, Missouri and New Hampshire – have adopted quantitative metrics for both geographical travel time and/or distance and appointment wait time metrics for mental health and substance use disorder benefits.¹⁵ **The proposed standards would dramatically improve metrics for and tracking of mental health and substance use disorder provider networks in 31 of the 33 states on the FFE platform.**¹⁶ We applaud CMS for establishing a strong foundation for enhanced network adequacy standards.

Congress should build on this foundation and do more to ensure robust substance use disorder and mental health provider networks and identify the true source of deficiencies so that health plans and regulators can effectively resolve them. Congress should take the following steps to encourage CMS to improve compliance metrics and enforcement or, when needed, authorize additional agency oversight:

- Ensure QHPs to have sufficiently available providers and treatment facilities for **both** substance use disorder and mental health care by **requiring metric tracking separately for the two conditions rather than collapsing them into a single data point.**

¹³ *Id.* at 18.

¹⁴ Dept. of Health and Human Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023*, <https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023#citation-345-p680>; Centers for Medicare & Medicaid Services, *2023 Letter to Issuers in the Federally Facilitated Exchange* (Jan. 7, 2023), <https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf>.

¹⁵ Legal Action Center and Center on Addiction, *Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services: Federal and State Regulation and Enforcement of the Parity Act* (May 2020), <https://www.lac.org/resource/spotlight-on-network-adequacy-standards-for-substance-use-disorder-and-mental-health-services>.

¹⁶ As of 2020, 28 states in the FFE had no quantitative metrics for mental health or substance use disorder providers (AL, AK, AZ, AR, FL, GA, HI, IL, IN, IA, KS, LA, MI, MS, MT, NE, NC, ND, OH, OK, SC, SD, TN, UT, VA, WV, WI, WY); 2 states had travel time and/or distance metrics alone (DE, OR); and 1 state had appointment wait time metrics alone (TX). *Id.* at Exh. C.

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- Ensure QHP networks provide and track the availability of **pediatric mental health and pediatric substance use treatment services** separately from adult services to address the dearth of care in this time of crisis for our nation's youth.
- Ensure QHPs identify **and remedy provider shortages in low-income and predominantly BIPOC communities** to ensure individuals receive health services in the community rather than be subjected to criminal legal sanctions and incarceration.
- Ensure QHPs track appointment wait times for **urgent and emergency mental health and substance use disorder services** in addition to the proposed non-urgent behavioral health services and, additionally, track travel time and distance for additional providers of both mental health and substance use disorder care, including opioid treatment programs, as required in some state regulatory schemes.¹⁷ The adoption of uniform methodologies for tracking and reporting metrics will ensure that health plan data are sufficiently detailed and accurate and can be compared across health plans.
- Require QHPs that do not meet network adequacy metrics to demonstrate, in addition to CMS's proposed justification requirement, that **its network adequacy, network admission, provider credentialing and reimbursement rate setting practices comply with the Parity Act**. The recently released Departments of Labor, Health and Human Services and Treasury 2022 Annual Report to Congress on Parity Act Enforcement reinforces what consumers have long known: health plans **flagrantly ignore and violate the Parity Act's non-discrimination standards and compliance review and documentation requirements**.¹⁸ **Network provider admission standards was among the most frequently identified non-quantitative treatment limitation for which an insufficient comparative analysis was submitted**.¹⁹ Additionally, Parity Act violations were identified for imposition of billing restrictions on mental health and substance use disorder providers and credentialing requirements beyond licensure, and exclusions of or limitations on benefits for medications for opioid use disorders, residential treatment and partial hospitalization.²⁰ **These federal law violations prevent consumers from accessing mental health and substance use disorder benefits that they are entitled to receive.**

Heightened network adequacy standards for plans offered on the FFE will invariably improve networks in other health plans. Issuers are often third-party administrators in self-funded plans and frequently rely on the same state provider networks regardless of the health plan sponsor. Additionally, FFE standards serve as a standard-setter for state-based exchanges and, with enhancements, will serve as a better model than Medicare Advantage network adequacy metrics on which some states rely.

B. Protect Consumers from Unaffordable Out-of-Pocket Cost When Networks Fail to Offer Adequate Networks of Mental Health and Substance Use Disorder Providers.

Consumers need a clear and affordable remedy when they cannot access an in-network provider within a reasonable travel time and distance and appointment wait time. Consumers should not pay twice for behavioral health services – both their premium and a bill for non-network services – based on network deficiencies that they cannot control. In such circumstances, the NAIC recommends that the **health plan**

¹⁷ See Legal Action Center, *Network Adequacy Spotlight*, *supra* note 14, Exh. A.

¹⁸ DOL, HHS and Treasury, *2022 MHPAEA Report to Congress, Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage* 8 (Jan. 2022), <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf> (many plans had not started preparing comparative analyses by deadline required under the Consolidated Appropriations Act of 2021, and no plan analysis contained sufficient information).

¹⁹ *Id.* at 13 (DOL) and 27 (CMS).

²⁰ *Id.* at 19.

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issuer should bear the cost of inadequate networks by “hav[ing] a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider...”²¹ Seventeen (17) states, 10 of which operate on the FFE, have adopted statutory/regulatory protections against balance billing in non-HMO plans.²² Medicare Advantage plans also permit beneficiaries to see out-of-network specialists at the in-network cost sharing level when the plan fails to meet network adequacy requirements. *See* 42 C.F.R. § 422.112(a)(3).

Congress should work with CMS to ensure that all plans operating on the FFE provide the same protection against balance billing for individuals seeking mental health and substance use disorder services, and, if needed, adopt statutory protections as it did in the No Surprises Act.

C. Authorize Federal Regulators to Impose Civil Monetary Penalties Against Issuers and Third-Party Administrators for Violations of the Parity Act.

In response to on-going Parity Act violations in employer sponsored plans, DOL has renewed its request for Congressional authority to impose civil monetary penalties on plan sponsors, issuers and third-party administrators responsible for such violations.²³ **We urge Congress to authorize DOL to impose civil monetary penalties and explore with CMS enforcement strategies that will similarly incentivize QHP issuers to comply with the Parity Act and network adequacy requirements.** In the midst of our nation's worst substance use disorder and mental health epidemic, individuals and families should not be forced to fight for their right to evidence-based care as they struggle to survive.

III. Recommendations

Congress can improve access to substance use disorder and mental health treatment in Medicare and private insurance by:

1. Authorizing coverage of the full ASAM continuum of care for substance use disorder treatment in Medicare;
2. Authorizing coverage and appropriate reimbursement of community-based substance use disorder treatment facilities and the full range of substance use disorder practitioners.
3. Applying the Mental Health Parity and Addiction Equity Act to Medicare;
4. Establishing comprehensive and enforceable quantitative network adequacy requirements for both mental health and substance use disorder treatment in Medicare Advantage Plans and Qualified Health Plans and bar balance billing for non-participating provider services in QHPs; and
5. Authorizing the Department of Labor to impose civil monetary penalties on plan sponsors, issuers and third-party administrators that violate the Parity Act and network adequacy standards.

Thank you for your consideration, and we look forward to working with you to improve access to substance use disorder and mental health care in this time of crisis.

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²¹ NAIC, *Health Benefit Plan Network Access and Adequacy Model Act* (2015) at Sec. 5(C)(1), https://content.naic.org/sites/default/files/inline-files/MDL-074_0.pdf.

²² FFE platform states include, AR, DE, HI, IL, MS, MT, NH, SD, TN and WV, and states with this protection (operating state exchanges) include CA, CO, CT, ME, MN, NY and VT.

²³ DOL, *2022 Annual MHPEA Report to Congress*, *supra* note 17, at 52.