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Deputy Administrator and Director
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services (CMS)
200 Independence Ave SW
Washington, DC 20201

Re: Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces

Dear Mr. Counihan:

On behalf of the American Psychiatric Association (APA), the national medical specialty society representing over 36,000 psychiatrists and their patients, I am pleased to share APA's comments in response to the Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces (the "Letter"). APA member psychiatrists serve patients across all levels of care and in private and public payer programs, including exchange plans. The Affordable Care Act (ACA) has made substantial progress in expanding access to affordable, quality health insurance coverage. Challenges however remain. In the case of psychiatric services for treatment of mental illnesses, including substance use disorders, insurance plans continue to violate provisions of the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) and the related ACA mental health parity sections - collectively referred to as the "parity law". This in turn creates barriers to accessing timely care. These discriminatory practices also violate Section 1557 of the ACA, which bars health care entities, including health insurer issuers and plans in the exchanges, from engaging in practices that discriminate on the basis of race, color, national origin, sex, age, and disability (including mental illness). We cannot overstate the importance of this Letter, because of its potential to ensure that people suffering from mental illness and/or substance use disorders (MH/SUDs) have timely access to needed, high-quality treatment. To ensure meaningful implementation of MHPAEA and Sec. 1557's antidiscrimination protections, we specifically request that the final letter to issuers:

- Explicitly discuss the parity law's application to exchange plans and strengthen associated reporting and compliance requirements.
- Implement a robust network adequacy standard, which includes time and distance standards and timeliness of access to care standards that, within mental health, specifically accounts for medical care delivered by psychiatrists.
- Does not exempt narrow network plans from meeting network adequacy standards.
- Establishes a claims-based analysis to identify phantom networks in provider directories and improve provider contract renewal practices to ensure accurate provider network information.

Need For and Potential Impact of Guidance:

It is well established that adverse or risk selection is an operating reality in health insurance markets. This leaves individuals with MH/SUDs particularly vulnerable to insurance plan discrimination.¹ While the ACA prohibits plans in the state exchanges from adjusting premiums to reflect individuals' expected health care costs, plans still have an incentive to attract the healthiest enrollees and to select against others, including those with mental illness. Previous research suggests that adverse selection is particularly problematic for individuals with mental illness in part because they have higher than average total health care costs, which often include high non-mental health-related medical costs. Costs for treating those patients with chronic medical and comorbid mental health/substance use disorder conditions can be 2-3 times as high as for those who do not have the comorbid MH/SUD condition. The additional healthcare costs incurred by people with behavioral comorbidities were estimated to be \$293 billion in 2012 across commercially insured, Medicaid and Medicare beneficiaries in the US.¹ Moreover, the prevalence of individuals with mental health and substance use disorders presumed to be eligible and/or participating in exchange plans is high. Data from the 2008-2010 National Survey of Drug Use and Health and the 2010 American Community Survey indicate that of uninsured adults with incomes making them eligible for exchange coverage 6% have a serious mental illness, 13.3% have serious psychological distress, and 14.6% have a substance use disorder.²

To minimize the exclusion of patients with high costs, the ACA prohibits exchange plans from imposing preexisting condition exclusions, requires guaranteed issue and renewal of insurance policies, coverage of "essential health benefits" including mental health and addiction treatment, and meeting standards for provider network adequacy. Risk adjustment between plans is then mandated to ensure that plan compensation accurately reflects the expected health care needs of the population covered, including those that attract sicker enrollees. The ACA also extends MHPAEA provisions to exchange based plans. However plans still creatively circumvent these anti-discrimination protections, discouraging enrollment of individuals with MH/SUD especially through the establishment of provider networks and the scope of the benefit offered by the plan.

Parity Law Application to Exchange Plans

This guidance is critical to address the aforementioned Exchange plan operating realities and mechanisms through which plans illegally risk select. While the ACA and MHPAEA address network adequacy and benefit design, we are dismayed by the draft guidance's lack of discussion of the MHPAEA requirements and regulatory tests. It is unclear how compliance with MHPAEA is part of the certification process. Early research on insurance products sold on exchanges substantiates that available benefit design information to consumers is problematic as well as compliance with the requirements of MHPAEA. Plan summaries pointing to unequal requirements and limitations for

¹ Adverse selection can occur in health insurance markets structured like the exchanges, where enrollees have a choice among competing health plans. When individuals choose among plans, those plans offering more generous benefits often attract individuals who are more likely to have high health care costs. If individuals suspect they will use a large quantity of health care services in the subsequent year, they will choose a plan with low cost sharing and more expansive provider networks.

behavioral health services relative to other medical services has the clear potential to affect plan choice decisions among consumers who expect to use behavioral health services; plans which are not compliant or appear to limit the benefit are de facto selecting against these enrollees.³

Recommendation:

The Letter should explicitly detail health plans' obligations under the federal parity law.

Network Adequacy

Plans Manipulate Provider Networks to Risk Select

As you know, federal and state laws require health insurance plans to provide beneficiaries with timely access to a sufficient number of in network providers, including primary care and specialty physicians. Network adequacy, however, is not a reality for far too many patients seeking psychiatric care. It is well documented that most health plan directories of psychiatrist purportedly available to treat plan members are woefully inaccurate and create "phantom networks". For example, a recent Maryland study found that less than 40% of the psychiatrists listed in plan directories were actually accepting that plan's insurance.⁴ A market conduct study in this area resulted in the Maryland Insurance Administration fining five plans for violations of network adequacy requirements. New Jersey studies made similar findings regarding network inadequacies.^{5,6}

While many states have laws defining network adequacy, up until the issuance of your draft Letter, and related regulation, there has been no national standard. Further, comparability of networks for both MH/SUD services and other medical care is a requirement of federal parity law. Because there is little consistency in how network adequacy is defined, how health plan attestations that they possess an adequate network are audited or how provider directories are monitored through real time provider or consumer data consumers are often confused when making purchasing decisions and once making those decisions find that the plan they have purchased does not meet their needs.

Recommendations:

When plans are permitted to attest that their network is adequate without having to actually meet specific standards of adequacy they can hide their efforts to use their network as a tool for selecting the healthiest and least expensive patients to treat, thereby minimizing their risks and costs. For example, plans can narrow the networks that provide mental health care, long term and costly treatment, and in effect discourage patients with mental health care needs from selecting their plans. **Therefore, we applaud CMS's efforts to quantify a network adequacy standard as a first step and we urge further refinements.** CMS has proposed two metrics for quantifying whether plans meet the "reasonable access" standard: (1) time and distance standards and (2) provider to covered person ratio.

- *Time and distance standards vs. ratios*

We urge CMS to adopt a time and distance standard, instead of a provider to covered person ratio, to define network adequacy. Although time and distance standards can have limitations when applied to rural areas, they are better measures of adequacy than a physician to beneficiary ratio. Physicians frequently practice part-time in multiple locations, thereby distorting the physician-to-covered-persons ratio. Either standard must account for a physicians' FTE status, as well whether a physician practices in in-patient settings, therefore not being accessible for outpatient care. Examples of established and well tested geographic access standards include California's, which currently apply to all state-licensed plans.

- *Missing Elements from Table 2-1*

Table 2.1 on page 25 provides CMS' proposed default time and distance standards that will apply in states that do not have a quantifiable metric for reviewing network adequacy. Table 2.1 includes "mental health" as a specialty area. **While we clearly support access to other mental health providers, psychiatry is the medical specialty that diagnoses and treats mental illness with therapy and medication – and should be measured separately from a broader mental health metric.** For example, HHS' Mental Health Professional Shortage Area (MHPSA) designation criteria separately accounts for psychiatrists' availability in addition to total "core mental health professionals". The Medicare Advantage metrics also account for psychiatrists separately. **We urge CMS to add psychiatry as an explicit specialty area for geographic access standards.**

- Table 2.1 lists "Inpatient psychiatric facility services". **While important, this fails to account for the full spectrum of psychiatric care settings beyond private practices and health clinics, for both mental health and substance use disorders. In measuring access to psychiatric facilities, CMS should include the following settings:**
 - Hospital inpatient (psychiatric hospital or psychiatric unit within a hospital)
 - Partial hospitalization
 - Residential treatment
 - Partial residential treatment
 - Outpatient
 - Intensive outpatient, and
 - Substance use disorder facility services.

- *Adding a Timely Access to Care Metric*

Mandating plans to meet time and distance standards does not necessarily go far enough to ensure that patients have timely access to medical care. Patients, particularly those suffering from MH/SUD, need prompt and timely medical care. If plans only have to ensure that providers are within a certain distance and travel time, yet patients have to wait extended periods of time before they can get care, they lack adequate access to care. Providers may not necessarily provide all

covered services that fall within their scope of practice, and just because a plan shows that it contracts with a particular provider does not mean that such provider is accepting new patients. **We urge CMS to adopt appointment wait time standards, such as those provided in California, as an additional measure of network adequacy.**

- *Narrow Network Plans*

CMS has proposed that the new federal default standard be used in states without quantifiable metrics for measuring a plan's network adequacy. However, page 26 states that it is not CMS's intent that these metrics disqualify narrow networks plans from the market. This sentence appears to create a possible exception to exchange plans' obligation to meet network adequacy tests, if a plan is willing to call itself a narrow network plan. **We urge CMS to remove this exception, which could be used as a loophole for all together avoiding compliance with network adequacy standards. All plans sold on the exchange must guarantee consumers with adequate networks of providers.**

- *Provider Contracting Practices*

The actual adequacy of a network may also be negatively affected by plans' provider contracting practices, such as the use of automatically renewing contracts, or renting part or all of another network. **Please see our comments in the provider directory section below for discussion of this important issue.**

Discriminatory Benefit Design and Drug Formulary Outlier Review

Your Letter proposes to perform outlier analyses to identify potential benefit and formulary design issues. This outlier analyses is an inter-plan comparison and any conclusions drawn are on the basis of what would be current market norms. **We are however concerned that market norms will not always yield definitive conclusions about benefit design discrimination. Since individuals with MH/SUDs are subject to adverse selection we are pleased that you include two disorders (schizophrenia and bipolar) as a primary focus for review. Your letter however fails to note that a second standard – MHPAEA – also applies to benefit designs for these conditions. Under MHPAEA the regulatory test requires an intra-plan comparison, rather than the inter-plan comparison yielded by the outlier analysis, in order to identify discriminatory benefit/formulary design.** This intra-plan comparison is essential. There is a clearer built in standard – medical benefits – against which to compare benefits for the persons covered by a specific plan, rather than a contingent standard set by market norms.

Recommendations:

- Because the outlier analysis does not substitute for the MHPAEA regulatory test, the Letter needs explicitly discuss MHPAEA. Review protocols must include the MHPAEA intra-plan analyses.

- In addition urge CMS to use feedback from state regulators, exchange officials, and navigators, as well as analyses of appeals data and information collected under Sections 1311(e) and 2715(A) of the ACA to monitor implementation of non-discrimination standards, assess whether further adjustments are necessary and identify other examples of discriminatory benefit design. The regulations implementing these provisions are codified at 45 CFR 155.1040 and 156.220. These require reporting on the following and this type of data would be substantively useful in ensuring non-discriminatory benefit design:
 - (1) Claims payment policies and practices;
 - (2) Periodic financial disclosures;
 - (3) Data on enrollment;
 - (4) Data on disenrollment;
 - (5) Data on the number of claims that are denied;
 - (6) Data on rating practices;
 - (7) Information on cost-sharing and payments with respect to any out-of-network coverage; and
 - (8) Information on enrollee rights under title I of the ACA.

Decision Support Tools – Provider Directories

Numerous studies have indicated that network directories provided to patients when selecting a plan inflate the number of physicians available to them through the plan, which is misleading to consumers when they are trying to make an informed decision about their health care needs.^{7,8,9,10} The inaccuracy of network directories is a particularly acute issue for psychiatrists and the patients they treat. In APA’s experience, psychiatrists listed as in-network often may not have filed a claim in the past year. Reasons for this vary: including psychiatrists being included without their consent; old, automatically renewing contracts (evergreen contracts) that they do not even know exist; the person listed as a psychiatrist not actually being one, etc.

Recommendations:

We support CMS’ requirement to make up-to-date, accurate, and complete provider directories, including information on which providers are accepting new patients, the provider’s location, contact information, specialty, medical group and institutional information easily accessible to prospective and plan enrollees, the State, the FFMs and CMS. Additionally to ensure accuracy of such directories and rectify discriminatory “phantom networks” we urge CMS to require the following:

- **Exchange plans should be required to publish quarterly reports, by provider listed in the directory by specialty, which include the number of claims submitted by that provider in the past quarter.** Providers who have not submitted a reasonable number of claims in the past quarter should be removed from the provider directory. This will ensure transparency in the marketplace as to who is actually actively involved as part of the network, and as further check that plans do, in fact, have adequate networks for patients MH/SUDs.

- **Plans should also be required to publish on a quarterly basis the number of out-of-network claims and in network claims paid by the plan for each physician specialty.** These reports will help address network adequacy, because:
 - If the out-of-network claims are disproportionate to the in network claims paid, it would indicate that the network itself is not sufficient; and
 - If the number of out-of-network claims for mental health are disproportionate to the non-mental health claims filed, it would require investigation into why mental health treatment is provided on a less favorable basis under the plan. It will also give the health plan beneficiary who must pay for these services accurate information about the likelihood that a particular carrier will be able to meet their health care needs.

- **Many of the health insurers that contract with physicians use evergreen contracts to engage physicians in their networks and/or contracts that permit the insurer to “re-market” their network participants to other payor entities. These contracts contribute to inaccuracies in the network directories in two ways:**
 - When a physician terminates the agreement pursuant to the contract terms, the health carrier often does not remove the physician’s name from the network; and
 - Because of the age of some of these contracts physicians do not even have access to them anymore. Therefore they give notice of termination from the network (perhaps not in accordance with contract time periods without knowing that) and believe they are no longer part of the network, whereas the plan keeps them as part of the network because they did not follow contract termination procedures. Additionally, contracts that allow remarketing of providers result in practitioners having no knowledge that their network participation with one payer has been rented to another with the same fee schedule. Contract with remarketing provisions rarely, if at all, require notice that this has been done. Consequently, patients call the physician and are told that he or she does not participate in the plan. These contract provisions, which confuse the parties, are unfair to both providers and patients.

To resolve these issues, **plans that use automatically renewing contracts, or have rented part or all of another network, should provide notice to the provider (at least 60 days in advance of the notice termination period) that the contract is about to renew or that their services are about to be rented to another network and that failure to terminate by the deadline will result in contract renewal.** Requiring carriers to notify participants of the termination period will help to keep reported network numbers more accurate. The requirement that carriers report claims submission will also help to identify potential problems described above where the carrier and the provider have different views as to whether or not the provider is participating in the network.

Thank you again for the opportunity to comment. We look forward to working with you to ensure meaningful health insurance coverage for exchange plan enrollees. Please contact Nevena Minor,

Deputy Director, Legislative and Regulatory Policy, at 703-907-7800 or nminor@psych.org, if you have any questions or if we can be of assistance.

Sincerely,



Saul Levin, M.D., M.P.A.
CEO and Medical Director

¹ Milliman, Inc. Economic Impact of Integrated Medical-Behavioral Healthcare. April 2014.

² The Substance Abuse and Mental Health Services Administration. Enrollment under the Medicaid Expansion and Health Insurance Exchanges.

³ Berry, Kelsey et al. A Tale of Two States: Do Consumers See Mental Health Insurance Parity When Shopping on State Exchanges? *Psychiatric Services* 66:6, June 2015.

⁴ Mental Health Association of Maryland, Access to Psychiatrists in 2014 Qualified Health Plans. November 2014. Accessed January 10, 2016 at <https://www.mhamd.org/wp-content/uploads/2014/01/2014-QHP-Psychiatric-Network-Adequacy-Report.pdf>

⁵ Mental Health Care Assn. NJ, Managed Care Network Adequacy Report, July 2013. Accessed January 10, 2016 at <http://www.mhanj.org/wp-content/uploads/2014/09/Network-Adequacy-Report-Final.pdf>

⁶ Holstein, Russell et al. 'Phantom Networks' of Managed Behavioral Health Providers: An Empirical Study of Their Existence and Effect on Patients in Two New Jersey Counties. *Hospital Topics*, 2012 Jul-Sep;90(3):65-73. Accessed January 15, 2016 at <http://www.tandfonline.com/doi/abs/10.1080/00185868.2012.714689?journalCode=vhos20&>

⁷ California Department of Managed Care, Non-Routine Survey of Anthem Blue Cross.

⁸ California Department of Managed Care, Non-Routine Survey of Blue Shield of California.

⁹ Malowney, Monica et al. Availability of Outpatient Care From Psychiatrists: A Simulated-Patient Study in Three U.S. Cities. *Psychiatric Services*, January 2015, Vol. 66, Issue 1. Accessed January 16, 2016 at <http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400051>

¹⁰ National Association on Mental Illness. A Long Road Ahead, Achieving True Parity in Mental Health and Substance Use Care. April 2015. Accessed January 15, 2016 at <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf>