

**America's Health
Insurance Plans**

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December 22, 2016

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., NW
Washington, D.C. 20710

Centers for Medicare & Medicaid Services
Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

Internal Revenue Service
U.S. Department of Treasury
1500 Pennsylvania Ave., NW
Washington, D.C. 20220

Re: FAQs About Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation; Request for Comment

Submitted electronically via e-ohpsca-mhpaea-disclosure@dol.gov

Dear Sir/Madam:

America's Health Insurance Plans (AHIP) is writing on behalf of our members in response to the request for comments from the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) regarding disclosures with respect to mental health/substance use disorder (MH/SUD) benefits. AHIP is the national trade association representing health insurance plans. Our members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate the Departments' continuing efforts to provide guidance on implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Our members have worked diligently to ensure compliance with parity requirements – involving clinical and administrative personnel across both medical and behavioral departments to promote understanding and implementation of parity rules. Beyond parity, our members have been leaders in pioneering innovative programs focused on ensuring that patients have affordable access to quality, evidence-based treatments, emphasizing proactive identification and outreach as well as coordination and integration of services.

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In addition, health plans have been strong proponents of transparency and are committed to making information available to consumers that is useful in helping them understand their benefits and make informed decisions regarding their care. The Departments have issued FAQ guidance pertaining to disclosure obligations under the MHPAEA for medical necessity determinations with respect to MH/SUD benefits. Health plans have been meeting those obligations under the MHPAEA standard for the past two years and will continue to assure they provide the necessary disclosures to consumers and clinicians when there are requests or appeals.

We welcome the opportunity to respond to the questions raised in the most recent FAQ regarding the MHPAEA disclosure process with respect to Non-Quantitative Treatment Limits (NQTLs) and the possible use of a model disclosure form. However, it is worth noting that this particular additional guidance may be unnecessary and may inadvertently add to consumer confusion. With the recent signing of the *21st Century Cures Act* (H.R. 34), we recommend that the Departments hold off on additional guidance related to model disclosure forms, given the *Act's* provisions to seek public comment on ways to improve consumer access to documents regarding MH/SUD benefits and the methods that health plans may use to comply with the MHPAEA requirements for disclosures of NQTLs. These provisions, as well as others included in the *Act* that address evaluation and assessment of parity compliance and enforcement, should proceed prior to the imposition of any additional requirements related to a model disclosure form. In addition, any other guidance or documents put forth that are relevant to these issues should be in alignment.

Should the Departments elect to proceed with guidance regarding a model disclosure form at this point or in the future, we would like to offer the following general comment -- While we recognize that the intent of the additional guidance and the possible use of a model disclosure form is to implement existing disclosure requirements, it is imperative that any changes result in the availability of meaningful, consumer-friendly information that helps consumers understand what services may not be covered and the associated reasons. As discussed further below, health plans are developing communications on MH/SUD services that are consumer friendly, and we recommend that any model disclosure form focus on developing in layman's terms general information on processes and tools plans use to make medical policy decisions.

In the FAQs About Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation, the Departments request specific comments on several issues, responses to which are discussed below.

- a) **Whether issuance of model forms that could be used by participants and their representatives to request information with respect to various NQTLs would be helpful and, if so, what content the model forms should include. For example, is there a specific list of documents, relating to specific NQTLs, that a participant or his or her representative should request?**



In previous guidance¹, the Departments clarified the documents a plan must provide upon request, including: the Summary Plan Description; the plan language regarding the imposition of the NQTL; the underlying processes, strategies, evidentiary standards, and other factors considered by the plan in determining the applicability of the NQTL; information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification; the underlying processes, strategies, evidentiary standards, and other factors considered by the plan in determining the applicability of the NQTL to medical/surgical benefits; and any analyses performed by the plan as to how the NQTL complies with MHPAEA.

A model form that accommodates the current disclosure requirements would be preferable, as opposed to separate model forms that request information on each type of NQTL. A single model form makes sense because many consumers, unfamiliar with MHPAEA's technical details, would have difficulty choosing the most appropriate form from a set of different forms. A single communication, that contains as much information as possible about the consumer's issue and request, would help set the stage for an efficient dialogue between the plan and the consumer. To the extent a model form refers to the disclosures that are currently required under federal law, such a form may help provide clarity as to what disclosure is being requested and therefore what is required in response.

We believe that general information on the processes and tools plans use to make medical policy decisions, rather than a list of documents relating to specific NQTLs, would be most helpful to consumers in understanding how coverage determinations are made. Many consumers would benefit from such general information, which would provide them helpful context for understanding their specific coverage determinations. This is particularly true given the already existing requirements in MHPAEA and ERISA for health plans to provide upon request the medical necessity criteria used to make MH/SUD coverage determinations as well as the criteria utilized for medical/surgical decisions and any additional information on processes, strategies, evidentiary standards or other factors considered in applying the NQTLs.

A model disclosure request form that follows a "check list" approach would give consumers useful information regarding what disclosures are currently available and can be requested. Likewise, for group health plans and insurers, a model disclosure request form would provide clarity as to what disclosure is being requested and what should be provided in response. A checklist could include boxes that reference factors used by both MH/SUD and medical/surgical in implementing utilization management such as high variability in adherence to practice guidelines, high utilization relative to benchmark, variability in cost and service, and a high degree of provider discretion in type and length of treatment absent conforming medical evidence. A checklist could also include information about how medical necessity criteria was created for MH/SUD and medical/surgical (e.g., derived from nationally recognized standards of practice utilizing scientific evidence).

¹ Tri-Agency FAQ#31 question number 9. <https://www.dol.gov/ebsa/faqs/faq-aca31.html>



It might be helpful to identify the types of documents currently available that would possibly transcend differing disclosure requirements for individual products and group health plans and that would also be helpful for consumers. For example, the Reporting and Disclosure Guide for Employee Benefit Plans could be supplemented to provide descriptions of where industry-standard documents fall under current disclosure requirements; and, a state based request form could identify these documents when applicable to state disclosure requirements.

In designing a model disclosure request form, the key is to provide consumers with useful information as opposed to complex studies from medical journals. We believe that a more user-friendly analysis in an easily readable format would better serve consumers in understanding whether MH/SUD benefits utilization management practices are on par with those used for medical/surgical benefits.

Lastly, while we would welcome the opportunity to work with the Departments on a model disclosure form that health plans may use to comply with MHPAEA's disclosure requirements when such information is requested (as provided under MHPAEA) by patients or providers, given that health plans are already complying with MHPAEA disclosure requirements and other federal and state disclosure requirements, it is important to maintain that any model form developed would not preclude other ways that health plans may be meeting MHPAEA's documentation requirements. Health plans already utilize multiple avenues of communication with members and clinicians and it is important to recognize the existing communication framework. For example, many plans already have secure, online portals that they encourage members to use when communicating about coverage determinations, benefit design generally, and other concerns. Although a disclosure "template" may be useful in many instances, no one template will be appropriate in all circumstances; hence, it is critical that health plans continue to be allowed the freedom to craft helpful, legally-compliant disclosure responses and not be bound by a "one size fits all" template in all instances.

b) Do different types of NQTLs require different model forms? For example, should there be separate model forms for specific information about medical necessity criteria, fail-first policies, formulary design, or the plan's method for determining usual, customary, or reasonable charges? Should there be a separate model form for plan participants and other individuals to request the plan's analysis of its MHPAEA compliance?

As mentioned above, we believe that one properly structured model request form that accommodates the disclosure requirements currently required under federal law could provide clarity without adding confusion, as opposed to separate model forms for information on each type of NQTL. We strongly believe that using specific NQTLs as the basis for disclosures, rather than the disclosures currently required by law, risks the unintended consequence of further confusion due to a proliferation of additional disclosures. This would effectively undermine the goal to provide stakeholders with clear guidance regarding the disclosures already required under current law.



c) Whether issuance of model forms that could be used by States as part of their review would be helpful and, if so, what content should the model form include? For example, what specific content should the form include to assist the States in determining compliance with the NQTL standards? Should the form focus on specific classifications or categories of services? Should the form request information on particular NQTLs?

In our August 2016 comments to the Mental Health and Substance Use Disorder Parity Task Force², we encouraged federal regulators to provide guidance for states that review compliance with benefits and parity to achieve the goal of consistent interpretation across oversight agencies, provide a level of regulatory certainty, minimize variation in interpretations, and help consumers understand which federal and/or state laws apply to their individual health needs and health care services. A properly structured model request form could provide much needed consistency and clarity in identifying the existing federal disclosure requirements, and it may also be helpful to enable more consistent state interpretation of federal requirements.

Rather than focus on specific classifications or categories of services, we suggest the model form focus on the processes and tools used by health plans. The form could allow a plan to attest when the evidentiary standards used for both medical/surgical and MH/SUD in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) were based on scientific evidence published in peer-reviewed literature, professional society guidelines, or recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved, for example.

d) What other steps can the Departments take to improve the scope and quality of disclosures or simplify or otherwise improve processes for requesting disclosures under existing law in connection with MH/SUD benefits?

For the reasons identified in this letter, we strongly recommend that the content of the form go through the regulatory notice and comment period process to allow for sufficient public input and ensure that the model form does not create any new disclosure requirements or conflict with or confuse existing disclosure requirements.

e) Are there specific steps that could be taken to improve State market conduct examinations and/or Federal oversight of compliance by plans and issuers?

As mentioned above, in our August 2016 comments to the Mental Health and Substance Use Disorder Parity Task Force, we encouraged federal regulators to provide guidance for states that review compliance with benefits and parity. We also suggested that federal regulators could provide more information and expand awareness of federal jurisdiction and state roles as another way of achieving the

² AHIP Letter to Ms. Cecilia Muñoz, Chair, Mental Health and Substance Use Disorder Parity Task Force. August 31, 2016.



goals of consistent interpretation across oversight agencies, more regulatory certainty, less variation in interpretations, and greater consumer understanding of which federal and/or state laws apply to their individual health needs and health care services.

Additional Issues

As the Departments continue to develop additional guidance related to the disclosure of information regarding NQTLs and MH/SUD benefits, we would like to reiterate some of our broader concerns with NQTLs that we have expressed in previous communications with the Departments, should there be an opportunity to revisit these issues.

For example, both the Interim Final Rules and the Final Rules require parity in the application of NQTLs such as medical management standards, formulary designs, network tier designs, and standards for provider admission and reimbursement. In general, insurers and health plans:

may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless . . . any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to mental health or substance use disorder benefits . . . are comparable to, and are applied no more stringently than, the process strategies, evidentiary standards, or other factors used in apply the limitation with respect to medical/surgical benefits . . . (42 CFR §146.136(c)(4))

The Interim Final Rules included an exception to this requirement permitting the application of “more stringent” NQTLs with respect to mental health or substance use disorder benefits, “to the extent that recognized clinically appropriate standards of care may permit a difference.” This exception was deleted from the Final Rules based on the Departments’ claim that the exception was not needed, and, as stated in the Preamble to the Final Rules:

Plans and issuers will continue to have the flexibility contained in the NQTL requirements to take into account clinically appropriate standards of care when determining whether and to what extent medical management techniques and other NQTLs apply to medical/surgical benefits and mental health and substance use disorder benefits, as long as the processes, strategies, evidentiary standards, and other factors used in apply an NQTL to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those with respect to medical/surgical benefits. In particular, the regulations do not require plans and issuers to use the same NQTLs for both mental health and substance use disorder benefits and medical/surgical benefits, but rather that the process, strategies, evidentiary standards, and other factors used by the plan or issuer to determine whether and to what extent a benefit is subject to an NQTL are comparable to and applied no more stringently for mental health or substance use disorder benefits than for medical/surgical benefits. Disparate results alone do not mean that the NQTLs in use do not comply with these requirements. (78 Fed. Reg. 68245)

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Despite additional guidance since issuance of the final rules, the NQTLs continue to be challenging for patients, providers, and health plans. Because there is less information on the quality of behavioral-related providers, facilities, and outcomes, and more gaps in evidence than for many medical/surgical services, medical necessity review can be a particularly important tool in promoting safe, appropriate behavioral health care. For instance, the evidence base for use of atypical antipsychotic medications in younger children is limited and medical necessity reviews can help make sure that these medications are not routinely prescribed in the absence of approved or evidence supported indications. Another example is the suggestion that health care providers should receive the same contracted rate of payment for medical/surgical and for mental health procedures. Even within the medical/surgical provider community, payment rates are not the same for all physician office visits (e.g., a primary care physician will be reimbursed less than a cardiologist); however, this issue is frequently used as a parity concern. It has long been recognized that there are differences with respect to the management and treatment of mental health conditions, substance use disorders, and medical conditions resulting from the underlying nature of the different illnesses. As a result, it may be impractical in many cases to make “apples to apples” comparisons of NQTLs between medical and surgical benefits and mental health and/or substance use disorder benefits. We believe it is important to re-emphasize that “parity” in the context of NQTLs does not mean that the results of application of such limits are the same across all benefits. Rather, the salient issue is whether the health plan is applying clinically accepted, evidentiary standards in the same manner to medical/surgical, behavioral health, and substance use disorder benefits.

Our members recognize that behavioral health conditions, particularly with their often close relationship to chronic medical conditions, have a significant impact on individuals, families, our society, and our economy. For these reasons, our members will continue to implement innovative programs that improve access to quality, affordable, evidence-based care and work with policymakers to remove barriers to further innovations and improvements in meeting the needs of those with behavioral health conditions.

In closing, we would like to reiterate our recommendation that the Departments hold off on additional guidance related to model disclosure forms, given that the recently enacted *21st Century Cures Act* contains several provisions related to parity guidance and enforcement that should be considered, including the requirement to seek public feedback prior to issuing guidance.

We appreciate your time and attention to our comments. Please contact Kate Berry, Senior Vice President of Clinical Affairs and Strategic Partnerships, at kberry@ahip.org with questions.

Sincerely,

A handwritten signature in cursive script that reads "Carmella Bocchino".

Carmella Bocchino
Executive Vice President