



September 12, 2017

U.S. Department of Health and Human Services  
200 Independence Ave., NW  
Washington, DC 20201

U.S. Department of Labor  
200 Constitution Ave., NW  
Washington, DC 20210

U.S. Department of Treasury  
1500 Pennsylvania Ave., NW  
Washington, DC 20220

*Submitted electronically via [e-ohpsca-mhpaea-disclosure@dol.gov](mailto:e-ohpsca-mhpaea-disclosure@dol.gov)*

**RE: Tri-Agency Request for Comments – FAQs About Mental Health & Substance Use Disorder Parity Implementation & the 21<sup>st</sup> Century Cures Act Part 38**

Dear Sir/Madam:

Optum and UnitedHealthcare, under the UnitedHealth Group (UHG) family, are pleased to provide the Departments of Health and Human Services, Labor, and the Treasury (“the Departments”) with the following comments with respect to the FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21<sup>st</sup> Century Cures Act Part 38.

**I. Optum and UnitedHealthcare Overview**

Optum is a leading information and technology-enabled health services business dedicated to helping make the health system work better for everyone. Optum represents over 100,000 employees worldwide who collaborate to deliver integrated, intelligent solutions that work to modernize the health system and improve overall population health. Optum serves over 75 million individuals, more than 80,000 physician practices and health care facilities, more than 67,000 pharmacies, nearly 5,000 hospitals, approximately 300 different health plans, over 150 state, federal and municipal agencies and departments, and more than 400 global life sciences companies. It is this experience that is the basis upon which we offer the following comments.

UnitedHealthcare (UHC) is dedicated to helping people live healthier lives. As a recognized leader in the health and well-being industry, we strive to improve the quality and effectiveness of health care for all Americans, enhance access to health benefits, create products and services that make health care more affordable, and use technology to make the health care system easier to navigate. UHC serves many of the country’s most respected employers, and we are also the

nation's largest Medicare health plan - serving nearly one in five seniors nationwide - and one of the largest Medicaid health plans, supporting underserved communities in 24 states and the District of Columbia.

In these capacities, UHC and Optum provide and/or administer mental health and substance use disorder benefits for over 30 million Americans and are firmly committed to the realization of parity in the provision and administration of these vital services.

## **II. Comments in Response to Questions from the Departments on Mental Health & Substance Use Disorder Parity Implementation & the 21<sup>st</sup> Century Cures Act Regarding Requests for Disclosures**

The Departments requested comments on the following questions as well as a draft model form developed in response to an earlier Request for Comments on these questions. The model form is intended to be used by individuals to request information from a health insurer or group health plan regarding coverage for mental health and substance use disorder benefits. We have provided our comments below in response to each of these questions and the draft disclosure form included with the current Request for Comments:

*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?*

### **Our Comment:**

The use of a model form, such as that included in the Departments' Request for Comments, may have some utility for individuals in limited circumstances. We note, however, a few issues with such an approach for the Departments to consider. Any form developed by the Departments should: (1) be optional not mandatory; (2) not duplicate existing forms and processes; and (3) be streamlined and as consumer-friendly as possible for all stakeholders. With respect to the first item, we note that in the Request for Comments that the Departments have indicated the form is intended as a model and not a mandatory form and we support this approach.

In addition, we believe the form and instructions should alert consumers about existing sources of information regarding the insurer's or plan's terms, conditions and processes such as the summary plan description, member handbook, and evidence of coverage. These existing disclosure documents provide a valuable resource regarding the plan and its provisions including information on medical/surgical benefits and mental health/substance use disorder benefits necessary to address parity issues and concerns. Accordingly, with regard to our second note above, the disclosure request form and instructions should not duplicate existing processes for disclosure of plan information.

Specifically, the Mental Health Parity and Addiction Equity Act (MHPAEA) requires disclosure in three instances: (1) in response to an appeal of a claim denial; (2) in response to an inquiry about the plan and the documents under which it operates; and (3) in response to an inquiry or

examination by state or federal regulators. The draft request form appears to be drafted to address the first of these requirements and in doing so is duplicative of existing forms and processes under federal and state law including the federal claims rules for health insurers and group health plans and state insurance laws which define claims and appeals processes and standards. As a result, the model form may have the opposite effect of that intended and conflict with existing claim and appeals processes which support disclosure of information related to a particular claim. We urge the Departments to include information regarding the existence of these existing processes, consumer disclosure documents, and forms in the instructions and material accompanying these proposed model forms.

With respect to our third point, the draft model disclosure request form is unduly extensive, cumbersome, and internally duplicative. We urge the Departments to simplify the form and avoid duplication of information that is unnecessary. A single page with consumer-friendly language that can be used in hard copy or electronic formats for efficiency and ease of use should be supported. We also suggest the Departments extensively test the model form with consumers to ensure that it is understandable and meets its intended purpose.

Finally, we note that the Departments' draft form exceeds the disclosure requirements of MHPAEA (which only requires disclosure of medical necessity criteria and the rationale for a denial) and includes elements (such as "evidence of compliance") which, in addition to being undefined, are not clearly requirements under any federal law including ERISA. This approach would appear to exceed the Departments' authority in the absence of Congressional action and a proper rule making process.

*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?*

#### Our Comment:

We do not believe different forms are needed. The use of different versions of the form unnecessarily complicates the burden all stakeholders may face regarding which form should be used in a particular circumstance. While the factors used by an insurer or plan to analyze a specific non-quantitative treatment limit (NQTL) may vary, the information available regarding the NQTL and the parity standards, should not.

We note that there are already requirements pre-dating MHPAEA requiring disclosure of medical necessity criteria – under both federal rules and state insurance and utilization review laws – and the requesting and disclosing of these criteria has not been a material issue. In fact, these criteria are publically accessible from UHC and Optum via the internet without an individual even needing to make a request. Adding forms and disclosure standards to existing transparency requirements is simply not necessary.

*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 the model form should 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?*

Our Comment:

We support state regulation of health insurance markets and believe the states do not need a specific form to request information as part of their examination process. However, the Departments can provide additional guidance to states on appropriate implementation of the MHPAEA. In particular, insurers are facing a fragmented and inconsistent approach to state enforcement with each state developing unique surveys and information requests resulting in undue administrative burdens and a varying application of the provisions of MHPAEA. For example, at least one state in developing its survey for MHPAEA compliance is requiring health insurers to classify services as a mental health or medical/surgical benefit consistent with the regulators' interpretation rather than the insurer's definitions based on generally accepted standards and reasonable factors as permitted under MHPAEA.

*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?*

Our Comment:

As noted, from our perspective there is not a need for additional processes and forms for requesting information, but rather better definition of what content and level of detail such informational disclosures must provide when requested.

*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?*

Our Comment:

We offer two items for consideration by the Departments in response to this question: (1) consistent with our response to question (c) above, additional education, model survey tools, and examples of what constitutes a compliant parity analysis and disclosures are needed to avoid the proliferation of multiple approaches across states –a single set of interpretative guidance and guidelines for assessment of parity is absolutely necessary to ensure consistent interpretation and application of the law, but we support the ability and right of states to determine how to collect the information and conduct necessary complaint inquiries, market conduct exams etc. consistent with existing state processes and procedures and (2) the process to develop additional guidance, forms, tools etc. should, consistent with the 21<sup>st</sup> Century Cures Act's emphasis on transparency, engage a cross-section of stakeholders to assist in drafting and developing such guidance, forms and tools etc. with the opportunity for public comment and input prior to publication.

### **III. Request for Comment on Eating Disorders FAQ**

The Departments additionally requested comment on the following new guidance and draft FAQ with respect to parity and eating disorders coverage:

*Section 13007 of the Cures Act requires that if a group health plan or a health insurance issuer provides coverage for eating disorder benefits, the group health plan or issuer must provide the benefits consistent with the requirements of MHPAEA. In light of this provision of the Cures Act, the Departments are issuing the following FAQ and soliciting comments regarding whether any additional clarification is needed regarding how the requirements of MHPAEA apply to treatment for eating disorders.*

***Q1: Does MHPAEA apply to any benefits a plan or issuer may offer for treatment of an eating disorder?***

***Yes. The Departments’ regulations implementing MHPAEA define “mental health benefits” as benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, which must be defined to be consistent with generally recognized independent standards of current medical practice. Eating disorders are mental health conditions and therefore treatment of an eating disorder is a “mental health benefit” within the meaning of that term as defined by MHPAEA.***

*Furthermore, in light of section 13007 of the Cures Act, the Departments request comments on whether any additional clarification is needed regarding how the requirements of MHPAEA apply to treatment for eating disorders.*

#### **Our Comment:**

The proposed FAQ is helpful, however, this language highlights a key issue that we strongly believe does require further clarification and guidance. We ask the Departments to address the problematic definition of mental health benefits under MHPAEA and how that definition is applied to the terms and scope of benefits considered as mental health benefits and therefore subject to MHPAEA.

We agree that eating disorders conditions, such as anorexia nervosa and bulimia, are mental health conditions as generally accepted by the medical community consistent with the definitions of those conditions in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. However, the fact that an individual has such a condition does not mean every service that the patient may receive is a mental health benefit. For example, if an individual is suffering from anorexia nervosa they may have medical complications such as malnutrition or low body weight that could be treated with nutritional counseling or, in extreme cases, a feeding tube in an inpatient setting. Neither of these services is a mental health treatment (e.g., no one describes nutritional counselors or dietitians as behavioral health providers, a feeding tube is not provided by a psychiatrist or psychiatric unit in a hospital).

To address this over-reading of the language of MHAPEA and this proposed FAQ, we would urge the following distinction be included in the guidance. In order to be considered a mental health benefit, the service must be for the treatment of the mental health condition itself directly and not for medical complications (e.g., malnutrition and low body weight) or other conditions or diagnosis the patient may have or which may arise as symptoms or complications of the mental health condition. This approach would be consistent with the language of the proposed FAQ above which relates back to “generally recognized independent standards of current medical practice” which do not treat every service received by an individual with a mental health condition as a mental health benefit.

We would note that this issue is not limited to eating disorders, but arises in relation to other conditions. For example, some stakeholders have argued that limits on physical therapy received by patients with an autism spectrum disorder or pervasive developmental disorders (which are mental health conditions) are not permissible under MHPAEA even though generally recognized independent standards of current medical practice would not view physical therapy or physical therapists as behavioral health services or providers. Accordingly, we urge the Departments to carefully articulate the standard of the scope of the definition of mental health benefits is read and applied consistent with our comments above.

Thank you for your time and consideration of the foregoing comments.

If you have any questions or would like to discuss any of these issues please contact Optum Regulatory Affairs, Deputy General Counsel, Adam R. Easterday, at [adam.easterday@optum.com](mailto:adam.easterday@optum.com) or (503) 603-7395.

Sincerely,



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