

# NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

815 16<sup>TH</sup> STREET, N.W., WASHINGTON, D.C. 20006 • PHONE 202-737-5315 • FAX 202-737-1308



**MICHAEL D. SCOTT**  
EXECUTIVE DIRECTOR  
E-MAIL: [MSCOTT@NCCMP.ORG](mailto:MSCOTT@NCCMP.ORG)

June 22, 2018

US Department of Labor  
Employee Benefits Security Administration  
Office of Health Plan Standards and  
Compliance Assistance  
200 Constitution Ave., NW  
Washington DC 20210

*Submitted Electronically at:* [E-OHPSCA-FAQ39@dol.gov](mailto:E-OHPSCA-FAQ39@dol.gov)

Dear Ladies and Gentlemen:

The National Coordinating Committee for Multiemployer Plans (the “NCCMP”) appreciates the opportunity to respond to proposed additional frequently asked questions (FAQs) regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act, the 21st Century Cures Act (Cures Act), and the Employee Retirement Income Security Act (ERISA), prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, “the Departments”).

## **Background on the NCCMP and Multiemployer Plans**

The NCCMP is the only national organization devoted exclusively to protecting the interests of the job creating employers of America and the more than 20 million active and retired American workers and their families who rely on multiemployer retirement and welfare plans. The NCCMP’s purpose is to assure an environment in which multiemployer plans can continue their vital role in providing benefits to working men and women.

The NCCMP is a non-partisan, nonprofit, tax-exempt social welfare organization established under Internal Revenue Code (the “IRC” or the “Code”) Section 501(c)(4), with members, plans and contributing employers in every major segment of the multiemployer universe. Those segments include the airline, agriculture, building and construction, bakery and confectionery, entertainment, health care, hospitality, longshore, manufacturing, mining, office employee, retail food, service, steel, and trucking industries. Multiemployer plans are jointly trusted by management and labor trustees.

Generally, multiemployer health plans are subject to the MHPAEA because they are considered group health plans (with limited exceptions, such as retiree-only plans). Multiemployer health plans tend to be self-insured and many are also self-administered. These plans may also use a wide variety of service providers to perform claims administration, utilization review, behavioral health, and pharmacy benefit manager services. In many cases, plan sponsors have conducted extensive

review of plan operations and documents to assure compliance with the MHPAEA, but plan sponsors continue to be dependent on service providers to also be compliant. Consequently, it is helpful to have as much practical guidance as possible on MHPAEA to allow plan sponsors to monitor their plan's service providers.

The NCCMP appreciates the guidance the Departments have provided on MHPAEA, and have the following comments on the proposed FAQs

1. Prospective Applicability of FAQs

We applaud the Departments' efforts to continue to provide greater clarity related to implementing MHPAEA and particularly the non-quantitative treatment limitation (NQTL) rules, as required under the 21<sup>st</sup> Century Cures Act. We appreciate that the Departments have issued this FAQ guidance on a proposed basis, providing stakeholders the opportunity to comment before the guidance is finalized. The opportunity for comment is significant as these FAQs include guidance on topics that are highly specific or in some instances, such as FAQ 2 that discusses the applicability of MHPAEA to autism and applied behavior analysis (ABA) therapy, address issues regarding which the Departments had previously been silent.

As these FAQs address novel issues, we believe prospective applicability of any final FAQs would be most appropriate. Prospective applicability will give plan sponsors time to review their current plan terms and practices and ensure that all necessary changes are made to reflect full compliance with the new guidance provided by these FAQs.

2. FAQ 2 Addressing Autism Spectrum Disorder

FAQ 2 addresses autism spectrum disorder (ASD) and the MHPAEA. The fact pattern is relatively limited and focuses on a plan that operates in a manner that violates the MHPAEA. However, multiemployer plan sponsors would appreciate additional guidance regarding how treatment for ASD should be considered under the MHPAEA.

Among the issues plan sponsors struggle with are how to identify and understand ABA therapy, whether such treatment is considered mental health or medical treatment, and whether age limits can be placed on ABA therapy. Given the broad range of State law approaches to ABA therapy coverage, questions also arise as to whether a plan can mimic state coverage rules and still be in compliance with the MHPAEA and the Affordable Care Act (ACA), in part because State laws often contain dollar limits on treatment that could be considered impermissible under the ACA's ban on annual and lifetime dollar limitations on essential health benefits. Further attention to ASD issues would be helpful for plan administrators.

3. Accreditation Standards

The Departments have indicated that they are considering how accreditation programs can be utilized as a best practice to help increase compliance with MHPAEA. While we believe that accreditation programs for plans would be helpful, we also request that the Departments provide a safe harbor for MHPAEA compliance if plans use accredited providers for both behavioral health services and for residential treatment facilities.

Multiemployer plans are generally self-insured, but often rely on service providers to provide claims administration services, utilization review services, behavioral health services, and networks, all of which can implicate MHPAEA compliance. Plan sponsors do not currently have a methodology to measure compliance of these service providers with MHPAEA, and rather must look at each provider on a case by case basis. To the extent that accreditation standards for administrative service providers are developed, plan sponsors should be entitled to rely on that accreditation to assure that the plan is in compliance with the MHPAEA.

A second type of accreditation safe harbor should also be considered by the Departments. One of the most significant and pervasive problems currently faced by multiemployer plans is assuring compliance with the MHPAEA while at the same time dealing with the impact of the nationwide opioid crisis. Many multiemployer plans have both in-network and out-of-network coverage for inpatient and outpatient mental health and substance use disorder benefits. In recent years, plans have seen claims from a new type of substance use disorder residential treatment program – often from destination regions in the south and southwest and usually out-of-network. These facilities advertise heavily to participants on the internet and other media, but it is often difficult for individuals to determine the quality of the facilities. Many of these facilities provide uncertain quality of service at inflated price points. A common denominator of claims from these facilities is frequent, high-cost drug testing. Often patients are tested several times a week at a cost of hundreds or even thousands of dollars for each test. One fund witnessed charges as high as \$12,000 for a single drug test.

Multiemployer plans need permissible tools to be able to prevent payment of unreasonable and inappropriate claims from these residential treatment facilities, including the ability to exclude coverage of certain facilities entirely. Plan sponsors need the ability to allow access to proper care at a reasonable cost and have the necessary tools available to better control questionable facilities and related high costs for what may be less than standard care, while being compliant with MHPAEA requirements.

Under MHPAEA it remains permissible for plans and issuers to look towards current accreditations as a basis for determining whether coverage of certain benefits will be provided under the plan or coverage. For instance, as long as standards are being applied consistently with respect to medical/surgical and mental health and substance use disorder benefits, plans may limit coverage to facilities or providers that have certain accreditations or certifications. Any insights the Departments could provide including possibly through the acknowledgement of effective, existing provider and facility accreditations could help plans and issuers steer participants and beneficiaries away from fraudulent entities while continuing to comply with MHPAEA. Such a list of, for example, Department approved accreditation programs, could also be a useful resource. Additionally, it would be helpful for the Departments to discuss other fraud control strategies that are permissible under the MHPAEA, such as limiting the number of drug tests, limiting payment for drug tests, or other controls to prevent unreasonable billing by out of network facilities.

#### 4. FAQ 8 Network Adequacy

FAQ 8 posits a situation where the plan meets applicable State and Federal standards for network adequacy, but attempts to exceed those standards by ensuring that symptomatic patients can

schedule an appointment with a medical provider within 15 days for non-urgent care. The plan does not utilize a standard to assess waiting times for mental health or substance use disorder (MH/SUD) appointments. The FAQ concludes that this would violate MHPAEA because a plan sponsor using distance standards or waiting times to measure network adequacy for medical care must apply those standards to MH/SUD care in a comparable manner. We suggest that this FAQ raises more questions than it answers and, in its current form, does not provide sufficient guidance to plan sponsors. Furthermore, it may be read to impose a standard that is impossible to meet in the marketplace based upon the availability of networks and providers.

Network adequacy first appeared in the Departments' MHPAEA regulations in the preamble to the final rule published on November 13, 2013. The final rule includes "network adequacy" in a list of non-quantitative treatment limits that are not mentioned in the actual regulatory language, but nonetheless must meet parity standards, without any discussion of what might be required.<sup>1</sup> Prior to the issuance of this set of proposed FAQs, the Departments had not provided any guidance on how to measure network adequacy in the context of the MHPAEA.

It is important to appreciate that there are no State or Federal standards of network adequacy that apply to self-insured group health plans. Moreover, plan sponsors rarely assemble their own network of providers. Instead, they necessarily rely on third-party network providers to assemble a broad and deep network of providers. In many cases, to leverage the special expertise of behavioral health care organizations, plan sponsors use different network providers for medical/surgical care and MH/SUD care. Finally, the Departments need to recognize that networks contain many different types of providers, including health care professionals (itself an extremely broad category), acute care hospitals, outpatient facilities, non-hospital facilities providing inpatient and/or outpatient care, urgent care centers, walk-in clinics, and, increasingly, telemedicine providers. All of these factors need to be taken into consideration in providing useful guidance to plan sponsors. We suggest that if network adequacy is to be considered a non-quantitative treatment limit, plan sponsors need guidance from the Departments on at least the following questions:

- In general, how is it possible to achieve parity when there are fewer MH/SUD providers available and willing to contract with network providers (compared to the number of medical/surgical providers)?<sup>2</sup>
- Can adequacy be assessed by looking at wait times/distance standards for one type of common service (e.g., Primary Care Physician (PCP) office visits compared to office visits with behavioral health providers of any type)? Or, must it be assessed by looking

---

<sup>1</sup> 78 Fed. Reg. 68240, 68246 (Nov. 13, 2013). <https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf>  
"Network adequacy" does not appear in the interim final rule published on February 2, 2010.  
<https://www.gpo.gov/fdsys/pkg/FR-2010-02-02/pdf/2010-2167.pdf>

<sup>2</sup> The Bureau of Labor Statistics (BLS) reports that in May 2017, there were 25,250 psychiatrists in the U.S. (<https://www.bls.gov/oes/current/oes291066.htm>) and 108,060 clinical, counseling and school psychologists (<https://www.bls.gov/oes/current/oes193031.htm>). This compares to 42,280 general internists; 126,440 family and general practitioners; 28,990 general pediatricians; 18,880 obstetricians and gynecologist; 38,600 surgeons; 30,590 anesthesiologists – just a few of the types of medical/surgical providers. Data for various types of health care professionals is available at <https://www.bls.gov/oes/current/oes290000.htm>.

at multiple categories of providers (e.g., professionals, hospitals, outpatient facilities, etc.) or by somehow looking at the network as a whole?

- How is the parity analysis affected if wait times/distance standards for some provider types (e.g., outpatient facilities providing MH/SUD treatment) meet a specific standard but wait times/distance standards for other provider types (e.g., psychiatrists) do not?
- Does a plan network meet parity requirements if the same measure (e.g., a 15-day waiting time) is *applied to* medical/surgical and MH/SUD providers but a smaller number or percentage of MH/SUD providers meet the standard or if, on average, MH/SUD providers do not meet the standard at all? If the same number or percentage of MH/SUD and medical/surgical providers must meet the same standard, then network providers will have no choice but to change the metrics they apply on the medical side in order to increase the likelihood of a positive outcome.
- Finally, if the obligation to measure and assess network adequacy rests with the plan sponsor, what questions must a plan sponsor ask its network provider in order to determine if parity has been achieved?

5. FAQs 11 and 12 Expand Plan Obligations Concerning Provider Directories in an Overly Burdensome Manner and should be revised

FAQs 11 and 12 address ERISA disclosure of mental health and substance use disorder information. These FAQs appear to modify the existing regulations concerning disclosure in a manner that is inconsistent with currently applicable regulatory requirements and current industry practices. We recommend that the FAQs be (1) modified to remove statements suggesting that changes in provider networks require notification to participants in a Summary of Material Modification (SMM) and (2) be revised to reflect consistency with currently applicable requirements related to the electronic disclosure of Summary Plan Descriptions (SPDs) and network provider lists.

As required under Section 102 of ERISA and the Department of Labor's (DOL) implementing SPD content regulations, and under current industry practice, group health plan sponsors include a general description of their health care provider network in the Summary Plan Description (SPD). The list of providers is generally accessed on-line and is often available as part of an application for smart phones or other devices. When plan participants request a paper copy of a provider directory, plan administrators provide a print-out of the directory; often the print-out includes the specific provider specialty requested by the participant (e.g., a list of cardiologists within a certain geographic area). Providing the list online, through a smart phone application, or on request on paper ensures participants have quick and direct access to the most updated provider lists available.

This current industry practice is consistent with the DOL regulations implementing section 102 of ERISA, which are summarized in FAQ 11 and which state:

In the case of plans with provider networks, the listing of providers may be furnished as a separate document that accompanies the plan's SPD, provided that the summary plan description contains a general description of the provider network and provided further that

the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document.

DOL regulations also address how to provide SPDs electronically. A safe harbor permits plans to provide SPDs and other required communications electronically under certain conditions.<sup>3</sup> However, the electronic disclosure safe harbor has not been extended to the provision of the network provider lists. Therefore, the language in FAQ 12 which states, “...such information could be provided electronically, for instance in a hyperlink or URL address , provided the Department of Labor’s electronic disclosure safe harbor requirements at 29 CFR 2520.104b-1(c) are met” creates confusion as to what “such information” might refer and suggests a departure from the current approach to implementation of the SPD content regulations.

Industry practice concerning electronic access to provider network directories has evolved significantly since the publication of regulations governing SPD content and Summaries of Material Modification. Instead of printing paper directories, which are out-of-date before they are shipped, plan sponsors use electronic tools that enable plans to more effectively communicate provider network composition to participants. It is important that FAQ guidance continue to support these practices that provide participants and beneficiaries the access to the most accurate provider information in the most timely manner.

It is also important to recognize that other federal government guidance on communicating provider information encourages electronic communication of provider information. The Centers for Medicare & Medicaid Services (CMS) has extensively reviewed the most efficacious manner in which to provide information about provider networks. In its 2017 and 2018 Annual Letters to Qualified Health Plans, CMS states that QHP issuers must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider’s location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees. CMS considers a provider directory to be up-to-date if the issuer updates it at least monthly. In addition, CMS considers a provider directory to be easily accessible when the general public is able to view all of the current providers for a plan in the provider directory on the issuer’s public website through a clearly identifiable link or tab without having to create or access an account or enter a policy number.

The CMS recommendations concerning maintaining an accurate provider directory also encourage plans to perform self-audits of directory data, work with group practices to ensure that providers are only listed at locations where they accept appointments, and develop better internal processes for participants to report directory errors. We suggest that these techniques are more effective than publishing paper directories.

### **Suggested revision to FAQ 11 concerning Summaries of Material Modification**

FAQ 11 states, in part, “Moreover, an ERISA-covered plan must disclose a summary of material modifications or changes in the information required to be included in the summary plan description not later than 210 calendar days after the close of the plan year in which the

---

<sup>3</sup> 29 CFR 2520.104b-1(c).

modification or change was adopted. See 29 CFR 2520.104b-3(a).” We recommend that this sentence be deleted.

Reiteration of the general rule concerning Summary of Material Modification (SMMs) in FAQ 11 is confusing here and suggests that every change/loss of a provider must be addressed as a material modification. While we do not dispute that a provider directory should be updated regularly and reflect the network providers as accurately as possible, treating a change or loss of provider as a material modification triggering the requirement to issue an SMM has not been understood to be the requirement under Section 102 of ERISA and is not the current industry practice. Further, reading the requirement as such would create additional and unparalleled burden.

Generally, under common industry practice, the SPD provides reference to this separate, stand-alone network provider list/directory. While a change to a provider and the related list/directory may occur, that change would not trigger a need to change the SPD content. In other words, the directory can and often regularly is updated in instances where an SPD is not updated or reissued. This FAQ 11 seems to suggest that even when the network list/directory is separately updated and when there are no other plan changes necessitating reissuance of an SPD, the plan would nonetheless be required to issue SMMs upon every instance a provider leaves the network. With respect to changes that do implicate the SPD, SMMs are not required as long as an updated SPD is provided within 210 days after the close of the plan year of the modification. Therefore, requiring an SMM when the SPD has not been changed and when the network provider list/directory has been updated in a timely manner seems overly burdensome, costly and inconsistent with the approach to date.

### **Suggested revision to FAQ 12 Concerning SPD Requirements**

We suggest that FAQ 12 be revised to make clear that the FAQ does not reflect a change in the SPD content requirements but rather reiterates the existing flexibility under the SPD content rules to provide a directory as a separate document that accompanies the plan’s SPD, provided that the SPD contains a general description of the provider network and that it contains a statement that provider lists are furnished automatically, without charge, as a separate document.<sup>4</sup> As drafted, FAQ 12 suggests additional burdens inconsistent with the currently applicable requirements related to providing access to provider network lists. Under FAQ 12, if SPDs are provided in print, and include url or website links to network directories, the FAQ seems to suggest this would only be permissible if compliant with the electronic disclosure safe harbor. This would be a departure from current guidance, inconsistent with guidance concerning distribution of provider directories in other CMS guidance, and additionally burdensome.

We suggest the following modification to FAQ 12.

Q12: Are ERISA-covered plans and issuers that utilize provider networks permitted to provide a hyperlink or URL address in enrollment and plan summary materials for a provider directory where information related to MH/SUD providers can be found?

---

<sup>4</sup> 29 CFR §2520.102-3(j)(3).

Yes. ERISA-covered plans must provide an SPD that describes provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services under ERISA section 102 and the Department of Labor's implementing regulations. In the case of plans with provider networks, the listing of providers may be furnished as a separate document that accompanies the plan's SPD, provided that the summary plan description contains a general description of the provider network and provided further that the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document. In addition, the complete SPD can be provided electronically, for instance in a hyperlink or URL address, provided the Department of Labor's electronic disclosure safe harbor requirements at 29 CFR 2520.104b-1(c) are met.

### **Conclusion**

We appreciate the opportunity to provide comments on these important issues. The Departments should continue to provide examples to plan sponsors of permissible activities under the MHPAEA that allow multiemployer health plans to continue to provide mental health and substance use disorder benefits in a legally permissible manner. We look forward to working with you on this issue.

Regards,

A handwritten signature in black ink, appearing to read "m. scott", is centered on the page.

Michael Scott  
Executive Director

cc: U.S. Department of Labor-OASAM