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Subject: Parity Implementation Coalition Comments
Date: Wednesday, January 08, 2014 4:51:38 PM
Attachments: [PIC Disclosure Jan 14.pdf](#)

On behalf of the Parity Implementation Coalition, please find attached our comments on the "additional steps, consistent with the statute, should be taken to ensure compliance with MHPAEA through health plan transparency, including what other disclosure requirements would provide more transparency to participants, beneficiaries, enrollees, and providers, especially with respect to individual market insurance, non-Federal governmental plans, and church plans" as requested by the Departments in November.

We appreciate the opportunity to provide these comments and look forward to working with the Departments.

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Parity Implementation Coalition

January 8, 2014

Ms. Phyllis Borzi
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20001

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
7500 Security Blvd
Baltimore, MD 21244

Dear Secretary Borzi and Administrator Tavenner:

The Parity Implementation Coalition (the Coalition) is pleased to provide comments in response to the Departments' request on "what additional steps, consistent with the statute, should be taken to ensure compliance with MHPAEA through health plan transparency, including what other disclosure requirements would provide more transparency to participants, beneficiaries, enrollees, and providers, especially with respect to individual market insurance, non-Federal governmental plans, and church plans."

The Coalition is comprised of addiction and mental health consumer and provider organizations, including the American Psychiatric Association, the American Society of Addiction Medicine, Betty Ford Center, Bradford Health Services, Cumberland Heights, Faces and Voices of Recovery, MedPro Billing, Mental Health America, National Alliance of Mental Illness, National Association of Addiction Treatment Providers, National Association of Psychiatric Health Systems, and The Watershed Addiction Treatment Programs. Coalition members have diligently worked for 15 years to enact a law and implementing regulations that provide access to nondiscriminatory health care for individuals and families with mental health and substance use disorders (MH/SUDs).

The Coalition lauds the provisions set forth in the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act's (MHPAEA's) Final Rules by the Departments, which address the Availability of Plan Information. Specifically, these provisions reaffirm that participants, beneficiaries, and authorized representatives are able to obtain necessary information from health plans pertaining to both medical/surgical and MH/SUD benefits under existing provisions of the Employee Retirement Income Security Act (ERISA) and Affordable Care Act (ACA) that they can use to make decisions about plan participation and challenge adverse benefit determinations. However, it has long been our experience, that despite the protections afforded patients under ERISA and the ACA, it has been difficult for them to obtain necessary information about their benefits in order to determine whether their health plan is in compliance with MHPAEA. Without this information, participants, beneficiaries, and authorized representatives have been hard pressed to challenge plans that are not in compliance with MHPAEA and fight to obtain the benefits they are entitled to.

Given this experience, the Coalition provides the following recommendations for additional guidance that the Departments should publish to provide more clarity in current transparency protections for those covered by MHPAEA, ERISA, and the ACA and for those individuals and plan participants in the individual, non-Federal governmental and church plan markets permitted to opt out of certain federal laws.

Current Disclosure Requirements MHPAEA, ERISA and the ACA are Essential to Helping Individuals with MH/SUDs Understand their Benefits and Ensuring Compliance with MHPAEA's Tests

With the 2008 enactment of MHPAEA and the 2010 enactment of the ACA and the accompanying regulations to implement these laws, significant improvements have been made to make health insurance easier to understand for individuals and families with MH/SUDs. A Kaiser Family Foundation poll conducted in 2012 found that the most popular provision in the ACA is the requirement that health plans must provide a uniform, easy to understand summary of coverage for all enrollees and applicants. Given that most patients do not fully understand how their health insurance works until they get sick and try to use it, there is a continuing need for transparency in coverage disclosure to allow individuals to avoid the frustration and complexities in managing their health coverage. For those with MH/SUDs, the need for simple transparent explanations of their rights and benefits is even greater.

Two years before the ACA passed, and many years after ERISA's disclosure requirements were fully implemented, MHPAEA and its Interim Final Rules (IFR) included two specific disclosure requirements on health plans and issuers – that medical necessity criteria must be provided to current or potential plan participants, beneficiaries or participating providers upon request and the reason for denials of reimbursement or coverage or payment for services with respect to MH/SUDs must be made available upon request or as otherwise required to the participant or beneficiary. The Final Rules and their Preamble confirm this intent by reaffirming that participants, beneficiaries, and participating providers have a number of ways to seek information about their benefits. For example, ERISA Section 104 allows participants of employee health plans to access “plan instruments” (including medical necessity criteria related to medical/surgical and MH/SUD benefits) that would be helpful in allowing plan participants, beneficiaries and treating providers to make informed choices about what health plan works best for them and to understand how their plan operates in practice. It remains difficult, though, to ascertain whether participants, beneficiaries, and participating providers can obtain this same level of disclosure under plans not covered under ERISA. For certain individuals, it may not be possible to obtain the information about plan coverage prior to an adverse benefit determination, and thereby forcing individuals to make uninformed decisions regarding their coverage.

In addition, it also remains difficult to understand whether participants, beneficiaries, and participating providers can obtain the documents or plan instruments related to a plan's medical/surgical and MH/SUD benefits that are necessary to determine a plan's compliance with the tests with respect to financial requirements, quantitative treatment limitations, and non-quantitative treatment limits (NQTLs) set forth in both the IFR and Final Rules. As you know, plans must meet the “predominant” and “substantially all” tests with respect to financial requirements and quantitative treatment limitations and the tests of comparability and stringency with respect to NQTLs. While the Coalition appreciates the clarifications in the Final Rules and accompanying Frequently Asked Questions (FAQs) that plans and issuers must not only comply with the transparency and disclosure requirements in MHPAEA but also the relevant transparency and disclosure requirements in ERISA and the ACA, future guidance must also explicitly require issuers and plans to provide documentation that illustrates how the health plan has determined that the financial requirements, quantitative treatment limitations, and/or NQTLs are in compliance with MHPAEA in the event of a denial. Specifically, this documentation should include any compliance analysis performed by the plan showing that the plan meets the “predominant” and “substantially all” tests or the “comparability” and “stringency tests”, as the case may be.

ERISA Disclosure Requirements Provide the Framework for Equitable Application of MHPAEA Disclosure and Transparency Requirements for All Plans but Greater Clarity on Definition of “Plan Instrument” is Needed

Section 104 of ERISA and accompanying implementing regulations require that plans subject to ERISA must provide plan participants instruments under which the plan is established or operated within 30 days of request. As restated in the Final Rules, plan instruments include, but are not limited to, medical necessity criteria for both medical/surgical and MH/SUD benefits as well as the processes, strategies, evidentiary standards and other factors used to apply an NQTL with respect to medical/surgical and MH/SUD benefits under the plan. While the Coalition is pleased the Departments referenced these requirements in the MHPAEA Final Rules, additional regulatory guidance and/or FAQs are needed to clarify exactly what the term “plan instrument” means. Without more specific guidance, the term is left to the interpretation of the health plan and there is a risk that disclosure of necessary documentation will not occur. It is essential that clarification be made that “plan instruments” includes any compliance analysis performed by the plan showing that the plan meets the “predominant” and “substantially all” tests or the “comparability” and “stringency tests”, as the case may be. This will ensure that participants, beneficiaries, and participating providers obtain enough information to determine whether a plan is in compliance with MHPAEA.

DOL and ACA Claims and Appeals Regulations Offer Significant Claimant Protections

The Department of Labor’s (DOL) claims procedure regulations applicable to ERISA plans and the claims and appeals regulations under the ACA that apply to all non-grandfathered plans and issuers in the group and individual markets set forth important claims and appeal protections.¹ These protections allow claimants, upon request and free of charge, access to and copies of all documents, records and other information relevant to the plan participant’s claim for benefits. The MHPAEA Final Rules clarify that, under the ACA, plans must also provide any new or additional evidence considered, relied upon or generated by the plan in connection with a claim, including any new rationale relied upon during a review of an adverse benefit determination. While state and local employee and church plans currently have the ability to opt out of MHPAEA and certain other federal laws, the Departments should clarify that DOL and ACA claims and appeals regulations should be applied to state and local employee and church plans.

Individuals receiving coverage through the individual market are not afforded disclosure protections under ERISA but are afforded disclosure protections under the ACA and MHPAEA. Individuals receiving health coverage through non-Federal public employee and church plans are *not* subject to ERISA disclosure protections, but are afforded disclosure protections under the ACA. The plans may opt out of MHPAEA and its disclosure protections given the opt out procedures provided under the Health Insurance Portability and Accountability Act (HIPAA) and statutes surrounding HIPAA.

Given the complexities in the underlying disclosure protections in these federal laws, it is critical that the Departments issue additional clarifying guidance about when and how disclosure protections are in place by plan time.

¹ 29 CFR 2560.503-1. See also 26 CFR 54.9815-2719T(b)(2)(i), 29 CFR 2590.715-2719(b)(2)(i), and 45 CFR 147.136(b)(2)(i), requiring non-grandfathered plans and issuers to incorporate the internal claims and appeals processes set forth in 29 CFR 2560.503-1

RECOMMENDATIONS

1. **Issue additional sub-regulatory guidance and examples to entities currently subject to MHPAEA and ERISA on how plans must comply with disclosure and transparency requirements.** The Coalition is supportive of the clarifications provided by the Departments in the MHPAEA Final Rules. However, given the complexities inherent in the application of the law to various plan types, the Departments, at a minimum, should issue explicit clarifying guidance and examples on what specific documents and analyses plans covered under ERISA and MHPAEA must make available to plan participants and their authorized representatives along with timelines. For example:

Question: A health plan is administering a self insured employer benefit plan for more than 50 employees and is therefore regulated by both MHPAEA and ERISA. The plan has instituted a concurrent utilization review (UR) process for outpatient MH/SUD services consisting of a requirement that all office visits for MH/SUD after the 10th visit be reviewed before authorizing future care.

An in-network provider acting on behalf of the patient/beneficiary sends a letter to the insurer stating that this is a likely violation of MHPAEA as the UR process – a type of NQTL- is more stringent and not comparable to similar NQTLs applied to the medical and surgical benefit. The plan answers by sending a link to the plan's medical and behavioral utilization criteria which are publicly available and states that outpatient concurrent reviews are applied to the medical benefit as well as the behavioral benefit. Therefore the plan states that they are in compliance with MHPAEA and no further analysis or information is required.

The provider submits a request for the following additional information: An analysis of how this specific NQTL (outpatient concurrent review after 10 visits) has been applied to outpatient medical and surgical office visits. The provider asks that the plan disclose what types and categories of medical and surgical office visits have any form of UR and also what types have a concurrent review after the 10th visit. The provider also asks what proportion of the medical spending in the outpatient class of benefits have concurrent review as it is likely that MH/SUD office visits constitute 80 to 90% of the spending in the MH/SUD outpatient class and applying a NQTL to the vast majority of the MH/SUD benefits while only applying this a very small amount of the Medical spending is likely to be non compliant but without disclosure of the differences in application it is impossible to tell if a plan is MHPAEA compliant.

The plan writes back and says that the 10 visit concurrent review procedure is applied to physical and occupational therapy visits as well as speech therapy and massage therapy and that these types of medical office visits have similar characteristics to MH/SUD office visits and therefore the plan is compliant. The plan states that no other information will be disclosed.

Is this level and type of disclosure compliant with MHPAEA and the IFR?

Answer: This level of disclosure is not compliant with MHPAEA or the IFR or the Final Rules. The preamble of the FR states that:

“These final regulations make clear that, while an illustrative list is included in these final regulations, all NQTLs imposed on mental health and substance use disorder benefits by plans and issuers subject to MHPAEA are required to be applied in accordance with these requirements. **To the extent that a plan standard operates to limit the scope or duration of treatment with respect to mental health or substance use disorder benefits, the processes, strategies, evidentiary standards, or other factors used to apply the standard must be comparable to, and applied no more stringently than, those imposed with respect to medical/surgical benefits.**”

By being comparable, the processes, strategies, evidentiary standards and other factors cannot be specifically designed to restrict access to mental health or substance use disorder benefits.”

In addition the agencies have provided additional guidance in various FAQs prior to the issuance of the FR and examples in the FR that clarify what information must be considered and disclosed in determining whether or not a NQTL is compliant. See this statement from the Final Rules:

“For example, ERISA section 104 and the Department of Labor’s implementing regulations provide that, for plans subject to ERISA, instruments under which the plan is established or operated must generally be furnished by the plan administrator to plan participants²³ within 30 days of request. Instruments under which the plan is established or operated include **documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.**”

In addition, the agencies have provided in the Final Rules and in FAQs further guidance about how to determine the appropriate application of an NQTL to medical vs behavioral benefits and requires that a number of parameters must be considered as listed below. The preamble to the FR states that:

“However, MHPAEA specifically prohibits separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. Moreover, as reflected in FAQs 18 released in November 2011, it is unlikely that a reasonable application of the NQTL requirement would result in **all** mental health or substance use disorder benefits being subject to an NQTL in the same classification in which less than all medical/surgical benefits are subject to the NQTL.”

Unless a consumer or provider knows how and to what extent a NQTL has been comparably applied to the medical and surgical benefit then it is impossible to know if a violation has occurred.

2. Issue additional NQTL guidance. The Departments should clarify that

- Plans must provide the written compliance analysis for the applicable financial requirement, quantitative treatment limitation, or NQTL in question and how this specific requirement or limitation is applied to the medical/surgical benefit upon request to plan participants and authorized representatives. This would mean that plans would need to provide:
 - A description of the applicable requirement or limitation that the plan has authorized for MH/SUD services within the relevant classification (in- or out-of-network, in- or outpatient) to the claim. This should include the exact written reference to such within the plan documents;
 - A description of the applicable requirement or limitation that the plan, insurer or claims administrator believes have been used in any given MH/SUD service adverse benefit determination (ABD) within the relevant classification;
 - A description of the applicable requirement or limitation's constituent factors (medical management, evidentiary standards, burdens of proof) that the plan has authorized for MH/SUD services within the relevant classification to the claim. This should also include the exact written reference to such within the plan documents (as distinguished from an administrator's clinical guidelines) as well as documentary evidence;
 - A description of any the applicable requirement or limitation's constituent factors that the insurer or claims administrator believes have been used in any given MH/SUD service ABD within the relevant classification;
 - A description of the applicable requirement or limitation and its constituent factors that the plan has authorized for use with respect to each medical/surgical service within the same classification as the MH/SUD claim. This should also include the exact written reference to such within the plan documents (as distinguished from an administrator's clinical guidelines) as well as documentary evidence; and
 - A description of the applicable requirement or limitation and its constituent factors that the plan, insurer or claims administrator believes are used with respect to each medical/surgical service within the same classification as the MH/SUD claim. Thus, insurers and claims administrators should be required to post ALL medical necessity guidelines for medical/surgical procedures broken down by in- and outpatient bases on their websites.
 - A description of the extent and magnitude to which the applicable requirement or limitation applies to both the MH/SUD benefit and the medical/surgical benefit to help establish its compliance with the applicable regulatory tests. For example, does the NQTL for MH/SUD apply to all of the services within a call while only applying to 5% of the medical/surgical services in that class?

- 3. Issue additional guidance on disclosure requirements for independent review organizations to ensure equitable access to MH/SUD benefits and appeals; require IROs to publish decision abstracts and appeals rates.** To ensure compliance with MHPAEA, the Departments must review the requirements that govern when and how independent review organizations (IROs) are required to evaluate external appeals and what documents must be disclosed to appellants. While the application of current state and federal law on IROs varies by state, without further review of if, how and when IROs are required to make clinical guidelines publicly available to claimants, plan participants are severely disadvantaged in external claims appeals if the participant can only receive clinical guidelines after external appeals are submitted. This is necessary because Coalition members have found there are significant disparities between what plan language allows versus what insurers/administrators do in practice. IROs should also be required to publish decision abstracts and statistics on appeals rates.

Given that IROs are a distinct entity with distinct rules governing their activities, Coalition members would be pleased to provide specific cases to discuss with the Departments on how IROs operate in practice.

Conclusion

The Parity Implementation Coalition pledges to continue to work with the Departments to provide detailed and accurate reports and documentation on how MHPAEA is being implemented in states and would be pleased to discuss these recommendations in greater detail.

Sincerely,



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Co-Chair, Parity Implementation Coalition



Carol McDaid

Co-Chair, Parity Implementation Coalition