



June 22, 2018

Office of Information and Regulatory Affairs  
Attn: OMB Desk Officer for DOL-EBSA  
Office of Management and Budget  
725 17th Street NW, Room 10235  
Washington, DC 20503  
[OIRA\\_submission@omb.eop.gov](mailto:OIRA_submission@omb.eop.gov)

U.S. Department of Labor—OASAM  
Office of the Chief Information Officer  
Attn: Departmental Information Compliance Management Program  
200 Constitution Avenue NW, Room N1301  
Washington, DC 20210  
[DOL\\_PRA\\_PUBLIC@dol.gov](mailto:DOL_PRA_PUBLIC@dol.gov)

To Whom It May Concern,

I am writing on behalf of the Association for Behavioral Health and Wellness (ABHW) to provide comments with respect to the revised draft Form to Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations (model form), OMB Control Number 1210-0138. The comments herein were also included within ABHW's comments filed in response to the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (the Departments) request for comment on the "Proposed FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39" and the "Revised Draft Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure Template," due by June 22, 2018.

## **Background**

ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 175 million people in both the public and private sectors to treat mental health, substance use disorders, and other behaviors that impact human health and wellness.

For the last two decades, ABHW has supported mental health and addiction parity. We were an original member of the Coalition for Fairness in Mental Illness Coverage (Fairness Coalition), a coalition developed to win equitable coverage of mental health treatment. ABHW served as the Chair of the Fairness Coalition in the four years prior to passage of MHPAEA. We were closely involved in the writing of the Senate legislation that became MHPAEA, and actively participated in the negotiations of the final bill that became law.

Since the Departments issued the Final Rules under the Mental Health Parity and Addiction Equity Act of 2008 in 2013 (the Final Rule), ABHW member companies have worked vigorously to understand and implement MHPAEA. We have had numerous meetings with the regulators to help us better understand the regulatory guidance and to discuss how plans can operationalize the regulations. Our member companies have teams of dozens of people working diligently to implement and provide MHPAEA compliant mental health and substance use disorder (MH/SUD) benefits to their consumers.

## **Comments on the Form to Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations**

ABHW has a number of significant concerns with the revised draft MHPAEA model form issued on April 23, 2018. The Cures Act directed the Departments

to create a guidance document containing “examples illustrating requirements for information disclosures”<sup>1</sup> pursuant to MHPAEA, but does not impose any new disclosure requirements beyond those in existing law.<sup>2</sup> As currently drafted, however, the disclosure form creates new disclosure obligations to which plans and issuers must adhere.<sup>3</sup> In addition, the form will create an unlawful burden on plans and issuers that has not been adequately assessed under the federal Paperwork Reduction Act process. Finally, the form as currently drafted will create confusion among both enrollees seeking parity related information and plans and issuers trying to compliantly respond to such requests.

The broadly drafted disclosure form subjects plans and issuers to a “general information request” beyond the two disclosures required under MHPAEA which are: 1) “The criteria for medical necessity determinations made under the group health plan with respect to MH/SUD benefits;” and 2) “The reason for any denial under the group health plan (or health insurance coverage offered in connection with such plan) of reimbursement or payment for services with respect to MH/SUD benefits.”<sup>4</sup> The general information request is not only broader than the MHPAEA-required disclosures, it is also more expansive than disclosure rules under ERISA.<sup>5</sup>

---

<sup>1</sup> Sec. 13001(a) of the 21<sup>st</sup> Century Cures Act.

<sup>2</sup> Federal law requires group health plans and health insurance issuers to disclose certain documents to enrollees and beneficiaries, contracting providers, or authorized representatives to ensure compliance with MHPAEA

<sup>3</sup> We further note that, although the Tri-Departments have submitted the draft disclosure form to the Office of Management and Budget under the Paperwork Reduction Act for review of the burden it imposes on affected entities, the burden assessment included in the submission addresses only the burden on the individuals filling out the form and not on the plans and issuers that would actually be producing the documentation requested through the form. Failure to assess how this information collection affects plans and issuers leave regulators with a false sense of the true burden posed by use of the form.

<sup>4</sup> Public Health Service Act Sec. 2726(a)(4) (42 U.S.C. 300gg–26(a)(4)); 45 C.F.R. 146.136(d).

<sup>5</sup> The summary plan description includes information on: cost-sharing provisions; any annual or lifetime limits; coverage of preventive services, existing and new drugs, and medical tests, devices and procedures; rules on use of network providers, the makeup of the provider network and rules on

The form's creation of a new disclosure obligation for release of general information exceeds disclosure requirements in current law, subverting congressional intent as to the scope of mandated disclosure in this area.

In addition, requiring plans and issuers to supply enrollees with general information about the plan will impose an unlawful administrative burden for plans and issuers at a time when the Administration has committed to lowering the level of administrative burden on businesses. In question 12 of the Supporting Statement for this form, submitted for review under the Paperwork Reduction Act of 1995, the Departments' estimated the burden associated with completing the form but did not sufficiently capture the burden on plans and issuers.<sup>6</sup> The Supporting Statement includes only the burden on authorized representatives who would initially complete and submit the form but does not contemplate the burden imposed on third party administrators (TPAs) and issuers who must create such disclosures and then must respond to the information requests. We believe that the vast majority of the burden associated with such disclosures has fallen, or will fall, on issuers and TPAs. Thus, the Departments' calculation is insufficient to contemplate the actual burden resulting from use of the form.

To fulfill the intent of the Cures Act, plans and issuers expected the Departments to provide clarifying guidance on the MHPAEA disclosures that would simplify the process. However, the form does not appear to be aimed at providing clarifying guidance to the plans and issuers as was required under the Cures Act. Rather, the

---

its use; coverage for out-of-network services; conditions or limits on the selection of primary care providers or medical specialists; conditions or limits on emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan. 29 C.F.R. §2520.102-3(j)(3).

<sup>6</sup> "Supporting Statements for Paperwork Reduction Act of 1995 Submissions," OMB Control No. 1210-0138 (April 2018), *available at* <https://www.reginfo.gov/public/do/DownloadDocument?objectID=74490300>.

form seems to be directed at enrollees in elaborating on the range of information they may want to request. This is not useful for the plans and issuers to assess compliance with MHPAEA and also does not fulfill the Cures Act mandate. Plans and issuers do not feel that the form provides sufficient guidance regarding the content that they must disclose with respect to NQTLs upon a request from an enrollee. The Departments claim that the aim of the form is “to simplify the process of requesting relevant disclosures for patients and their authorized representatives.”<sup>7</sup> However, the practical effect of the form will be to introduce ambiguity, confusion, and complexity into the disclosure process.

The form does not identify the requisite disclosure being requested, but rather, enables the enrollee to request the broadest range of information that may be available without necessarily understanding the nature of those materials. Similarly, based on this form, a plan or issuer has no way of assessing the quantity or usefulness of materials being sought, from the perspective of a layman’s review. The form seems to imply that there is no limit to the size and scope of information requests to which plans and issuers must respond because the form allows for enrollees to request information not associated with a particular treatment or condition. As mentioned above, MHPAEA sets forth two required disclosures – the criteria for medical necessity determinations for MH/SUD services and the reasons for denial of a MH/SUD benefit. Applicable guidance from the Departments does not currently require inclusion of the specific information requested under the form as part of MHPAEA disclosures. Should this form be finalized, it would require plans and issuers to create customized disclosures based upon the language describing the general information request and the demands of the requesting enrollee, rather than

---

<sup>7</sup> “Supporting Statements for Paperwork Reduction Act of 1995 Submissions,” OMB Control No. 1210-0138 (April 2018), *available at* <https://www.reginfo.gov/public/do/DownloadDocument?objectID=74490300>.

applicable statutes and regulations. In sum, the burden and costs associated with an undefined disclosure obligation is not evaluated under the Information Collection Request (ICR), is unknown, and may be immense.

With respect to disclosures regarding specific treatments, the form does not identify the specific documents that must be disclosed, such as a summary plan description (SPD), certificate of coverage, plan instrument, relevant documents in the context of full and fair review/ERISA claim appeal and/or relevant documents under MHPAEA and its implementing regulations or under ERISA requirements. If inclusion of specific content is not required within these specified disclosures, may plans create generalized disclosures for purposes of improving transparency with respect to NQTLs? Does MHPAEA require disclosure of data that is not otherwise required to be reported to the DOL under a Form 5500?

In addition, several aspects of the form will likely lead to confusion both for the enrollee as well as the plans and issuers. Use of the checkbox list of potential bases for the claim denial will invite enrollee confusion and may end up creating additional work for plans or issuers in trying to clarify the basis for a denial that had previously been communicated. In fact, the enrollee's understanding of the basis for the denial is extraneous to the disclosure request as the plan or issuer already has this information.

Another aspect that could lead to confusion is the request for plans or issuers to “[i]dentify the factors used in the development of the limitation and the evidentiary standards used to evaluate the factors.” There is no guidance from the Departments on what types of information this sentence would require, or what documents specifically an enrollee should expect in response. Moreover, the list of information requested may lead enrollees to believe they are entitled to categories of information

that may not exist or may force the plan or issuer to develop materials specifically to fulfill disclosure requests. To the extent that enrollees do not receive all of the listed categories of information, they may believe the plan is not in compliance with MHPAEA.

The form further asks plans or issuers to identify all of the medical/surgical and MH/SUD benefits to which the limitation at issue applies in the relevant benefit classification. This could require an extensive list of benefits that we do not believe would be useful to the enrollee in assessing parity compliance. Rather, we recommend limiting the request to identifying categories of services as those are used in the plan or issuer's classification approach, as this is the information an enrollee would need to assess parity. We also note that the form is about medical necessity information, but the form does not ask for this information.

Enrollees may also believe completion of the form constitutes filing an appeal with the plan. Although ERISA requires disclosure of relevant documents subject to an appeal, a pre-appeal disclosure process does not exist under MHPAEA. The form indicates the enrollee has access to the SPD, the denial notice, medical necessity criteria, and documents on the plan establishment or operation, thus effectively creating a pre-appeal grievance process when that is not required under law. ERISA allows the enrollee to request relevant documents in the context of an appeal, but we do not believe that is the legal authority the form relies on with respect to the disclosure requirements.

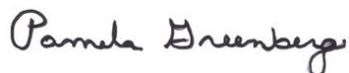
For all of these reasons, we strongly recommend that the Departments redraft the disclosure form. We recommend striking the "check box" format as to the basis for any denial to avoid enrollee confusion. We believe the form should provide two checkbox options for each of the two specific disclosures required under MHPAEA,

and remove all other information, including the general information requests. We believe this would greatly simplify the form, help promote an understanding of MHPAEA's express disclosure requirements, improve the disclosure process, and help improve compliance overall. The Departments can continue to assess the usefulness of the form and whether it should be revised in the future. We do recommend that the Departments add a statement to clarify that the completion and submission of the form does not represent a request to appeal a denial and the disclosure process does not substitute for filing an appeal.

Finally, we want to point out, as a matter of internal consistency that the language regarding the 30-day timeline for plans or issuers to respond differs as stated in the background section and page two of the form. We recommend making the language consistent, preferably using the language in the background section which allows plans to return the form within 30 calendar days of receipt of a request.

Thank you for the opportunity to comment on the model form. ABHW's member companies and I look forward to working with you to address our concerns.

Sincerely,

A handwritten signature in cursive script that reads "Pamela Greenberg".

Pamela Greenberg, MPP  
President and CEO