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VIA ELECTRONIC SUBMISSION TO [e-ohpsca-MHPAEA-SCT-2020@dol.gov](mailto:e-ohpsca-MHPAEA-SCT-2020@dol.gov)

Department of Labor  
Employee Benefits Security Administration  
200 Constitution Avenue, NW  
Washington, DC 20210

**Re: Updates to Proposed 2020 Mental Health Parity and Addiction Equity Act of 2008 Self-Compliance Tool**

To Whom It May Concern:

Cigna welcomes the opportunity to respond to the updates to the proposed 2020 Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) self-compliance tool issued by the Department of Labor (DOL). Cigna appreciates DOL's efforts to assist stakeholders in determining whether a group health plan or health insurance issuer is in compliance with MHPAEA and its implementing regulations.

Cigna Corporation, together with its subsidiaries (either individually or collectively referred to as "Cigna"), is a global health service organization dedicated to helping people improve their health, well-being, and peace of mind. Our subsidiaries are major providers of medical, pharmacy, dental, disability, life and accident insurance, and related products and services, with over 180 million customer relationships in the more than 30 countries and jurisdictions in which we operate. Worldwide, we offer peace of mind and a sense of security to our customers seeking protection for themselves and their families at critical points in their lives.

Within the U.S., Cigna provides medical coverage to approximately 14 million Americans in the commercial segment. We also provide coverage in the individual insurance segment in several states, both on- and off-Exchange, to about 280,000 people. Additionally, Cigna, together with our Express Scripts business unit, serves more than 4 million people through our Medicare Advantage, Medicare Prescription Drug Program and Medicare Supplemental products.

Cigna supports members' physical, emotional, social, and financial health with an experienced team of behavioral health and service professionals and easy access to life and behavioral health resources. We have over four decades of experience providing innovative, evidence-based behavioral care services. We offer one of the largest national provider networks, made up of a wide range of providers including psychiatrists, advanced practice nurses, master's-level therapists, professional counselors, certified addiction counselors, psychologists, certified autism providers, physician assistants, clinical social workers, and providers offering virtual care services as well as facilities and clinics. From everyday needs to more significant behavioral health conditions, we provide members with the personalized, coordinated support they need.

Cigna has taken great strides to make certain our fully insured products comply with MHPAEA and works closely with our clients offering self-insured products in their own MHPAEA compliance, including:

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- developing tools to test financial requirements and quantitative treatment limitations (QTLs) (*e.g.*, day and visit limits) for each renewing plan design based on recent claim experience;
- ensuring comparable methodologies are in place to determine which medical/surgical services and which mental health/substance use disorder (MH/SUD) services are subject to nonquantitative treatment limitations (NQTLs), including utilization management requirements, drug formulary design, network admission requirements, and methodologies for determining in- and out-of-network health care provider reimbursements; and
- aligning health plan operations to ensure NQTL processes are not applied more stringently to MH/SUD services than to medical/surgical services within the same classification(s) of benefits.

With that context as background, Cigna offers the following comments on the proposed updates.

\* \* \*

### Definitions

Cigna generally agrees with the proposed language on page 6 relating to QTLs and NQTLs asserting that “If a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits.” However, Cigna respectfully requests the guidance allow a limited exception related to an issuer’s or plan’s quantitative testing analysis of financial requirements specific to benefits that may be rendered for the treatment of both medical/surgical conditions and MH/SUD conditions (*e.g.*, speech therapy, physical therapy, occupational therapy, nutritional counseling, etc.) consistent with what the Centers for Medicare & Medicaid Services (CMS) allows for Medicaid and Children’s Health Insurance Program plans. In its FAQ sub-regulatory guidance (Q4), CMS advised:

A variety of...benefits...could be defined as either MH/SUD or medical/surgical (M/S), depending on the condition of the beneficiary being treated. For these benefits, the state may define the benefit as MH/SUD or M/S for the entire beneficiary population using a reasonable method, such as whether the service is most commonly or frequently provided due to a MH/SUD or M/S condition. For example, if more than 50% of spending on personal care is for beneficiaries who are receiving the service due to M/S conditions, the state may reasonably define personal care services as a M/S benefit for the purposes of the parity analysis.

See: <https://www.medicaid.gov/federal-policy-guidance/downloads/faq101117.pdf>

Cigna requests this limited exception specific to the quantitative testing of financial requirements for practical reasons. For example, speech therapy, physical therapy, and occupational therapy are rendered by medical specialists. Generally speaking, more than 50 percent of the claims spend for such services is billed under medical diagnoses. The claims distribution for the combined services (rehabilitative/habilitative benefits) is typically less than three percent of the medical/surgical outpatient spend. Many, if not most, payers are not filtering out the rehabilitative/habilitative claims billed under a mental health diagnosis code when pulling in the rehabilitative/habilitative claims data for the purpose of conducting the quantitative testing analysis of the financial requirements applied to the medical/surgical outpatient classifications of benefits because it is so de minimis. Moreover, because the percentage of rehabilitative/habilitative services billed under mental health diagnosis codes is de minimis, it generally would not change the outcome of the quantitative testing analysis of the financial requirements applied to the medical/surgical outpatient if the mental health rehabilitative/habilitative claims were filtered out.

## **Section B. Coverage in All Classifications**

### **Question 3. Does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in every classification in which medical/surgical benefits are provided?**

#### ***Classifying benefits***

Cigna believes the information within the proposed “Note” on page 11 is not entirely accurate and therefore requests it be amended or removed.

To exemplify our concerns, on the medical/surgical side, a plan may cover acute inpatient care rendered by licensed hospitals or facilities and subacute care rendered by licensed skilled nursing facilities and exclude coverage of intermediate services rendered by assisted living facilities, adult foster care providers, diabetes camps, and weight loss/management camps (all of which include a room and board component). On the MH/SUD side, the plan may cover acute inpatient care rendered by licensed hospitals or facilities and subacute care rendered by licensed psychiatric and substance use residential treatment facilities and exclude coverage of intermediate services rendered by therapeutic group homes, therapeutic boarding schools, and wilderness therapy programs/camps. As long as the plan applies a comparable methodology for excluding certain medical/surgical intermediate services with a room and board component and certain MH/SUD intermediate services with a room and board component, and does not apply the methodology more stringently to MH/SUD intermediate service providers than to medical/surgical intermediate services providers, the plan’s benefit exclusions would generally comply with the MHPAEA regulations governing NQTLs.

## **Section D. Financial Requirements and Quantitative Treatment Limitations**

### **Question 5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding financial requirements or QTLs on MH/SUD benefits?**

#### ***Illustration***

Cigna believes the information within the proposed “Warning Sign” on page 18 is inaccurate and therefore requests it be amended or removed.

For most copay plans, office visits with a primary care physician (PCP) are typically subject to a lower copay level than office visits with a medical specialist. The copay plan must therefore conduct the quantitative testing analysis of the types of financial requirements (*e.g.*, copay, coinsurance, deductible) applied to the medical/surgical benefits within the in-network “Office Visits” sub-classification of benefits to determine:

- The type of cost-share(s) applied to substantially all (at least two-thirds) of the medical/surgical benefits within the in-network “Office visits” sub-classification; and
- If the copay plan applies more than one level of the type of cost-share applied to substantially all medical/surgical benefits within the sub-classification of benefits (*e.g.*, PCP copay level and specialist copay level), the plan must determine which copay level is the predominant level applied to more than 50 percent of the medical/surgical benefits within the sub-classification of benefits as that would dictate the copay level that may be applied to the corresponding MH/SUD in-network “Office Visits” sub-classification of benefits.

For many copay plans, the quantitative testing analysis of the financial requirements applied to the medical/surgical benefits within the in-network “Office Visits” sub-classification of benefits reveals copays are the predominant type of financial requirement applied to at least two-thirds of the medical/surgical benefits, and the specialist copay level is the predominant copay level applied to more than 50 percent of the medical/surgical benefits within the in-network “Office Visits” sub-classification of benefits. As such, it is inaccurate to assert a plan may not be in compliance with MHPAEA if a plan applies a specialist copay to all MH/SUD benefits within

the in-network “Office Visits” sub-classification, but applies specialist copay to only certain medical/surgical benefits within the corresponding in-network “Office Visits” sub-classification.

#### **Section F. Nonquantitative Treatment Limitations**

##### **Question 7. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding NQTLs on MH/SUD benefits?**

With regard to the proposed “Notes” on page 22, the MHPAEA regulation governing NQTLs (*e.g.*, in-network provider reimbursements) requires plans apply a comparable methodology and process for determining medical/surgical in-network provider reimbursement rates and MH/SUD in-network provider reimbursements. If medical/surgical in-network provider reimbursement rates are generally determined based upon a benchmark rate (*e.g.*, Medicare rate) and other factors, then MH/SUD in-network provider reimbursements generally ought to be based upon a comparable methodology, *i.e.*, similar benchmark rate and array of factors. However, because the term “comparable” means similar, not identical, Cigna asserts the benchmark rate for determining MH/SUD in-network reimbursement rates would not necessarily have to be the same benchmark rate. The sub-regulatory guidance ought to show a fidelity to the MHPAEA regulations governing NQTLs, and to the preamble to the final rules, by recognizing that flexibility.

Cigna requests the proposed “Warning Signs” language on page 23 be removed because it raises the same concern noted above.

Cigna requests the proposed language on page 24 be removed. While the MHPAEA regulation governing NQTLs requires plans to disclose narrative descriptions (*e.g.*, summaries) of the “processes, strategies, evidentiary standard or other factors” used in determining which medical/surgical benefits and which MH/SUD benefits within a classification of benefits are subject to an NQTL, there is nothing in the MHPAEA regulations requiring plans produce the underlying data used to develop the plan’s NQTL methodologies. Requiring the disclosure of such data would only add an additional layer of complexity; would not result in any practical benefit or utility; and would be administratively burdensome and/or costly to produce.

Cigna appreciates the addition of the “Note” on page 25.

Related to the proposed bullet point at the top of page 28, Cigna requests the language be revised to make clear not all NQTLs will have “summaries of research.” For example, internally developed Coverage Policies (medical necessity criteria) would generally include a summary of the relevant clinical research; however, a plan’s narrative description of its network admission requirements and processes would not likely be based upon “summaries of research.”

#### **Section G. Disclosure Requirements**

##### **Question 8. Does the group health plan or group or individual health insurance issuer comply with the MHPAEA disclosure requirements?**

Regarding the proposed “Note” on page 33, Cigna asserts all language relating to the Employee Retirement Income Security Act of 1974 Part 4 and the *Wit v. United Behavioral Health* case is irrelevant to MHPAEA compliance/enforcement and therefore ought to be excluded from a MHPAEA Self-Compliance Tool. Moreover, the *Wit v. United Behavioral Health* case is a federal district court decision which is neither precedent, binding, nor settled law.

#### **Appendix I: Additional Illustrations**

Cigna appreciates the addition of Illustration 6.

### **Appendix II: Tool for Comparing Plan Reimbursement Rates to Medicare**

While Cigna appreciates and likes the idea of a proposed parity tool for comparing a plan's in-network provider reimbursement rates, Cigna requests the name of the tool be retitled to "Tool for Comparing Plan MH/SUD Reimbursement Rates to Medical/Surgical Reimbursement Rates." The reference to Medicare Rates should be removed. If medical/surgical in-network provider reimbursement rates are generally determined based upon a benchmark rate (*e.g.*, Medicare rate) and other factors, then MH/SUD in-network provider reimbursements generally ought to be based upon a comparable methodology, *i.e.*, benchmark rate and a similar array of factors. However, because the term "comparable" means similar, not identical, Cigna asserts the benchmark rate for determining MH/SUD in-network reimbursement rates would not necessarily have to be Medicare rates. The sub-regulatory guidance ought to show a fidelity to the MHPAEA regulations governing NQTLs, and the preamble to the final rules, by recognizing flexibility.

Additionally, the Appendix should be re-formatted in a way to better demonstrate the comparison analysis of medical/surgical physician reimbursement rates with MH/SUD physician reimbursement rates; and medical/surgical reimbursement rates for non-physicians (*e.g.*, nurse practitioners, physician's assistants, speech therapists, physical therapists, occupational therapists, etc.) with MH/SUD reimbursement rates for non-physicians (*e.g.*, Master's level therapists, Ph.D, etc.). For example, the Appendix could have separate columns for medical/surgical and MH/SUD services and include rows for additional medical/surgical non-physicians, *e.g.*, nurse practitioners, physician's assistants, etc.

### **Effective Date**

Cigna requests an effective date of January 1, 2022, to give plans a reasonable amount of time to amend existing documentation and internal business operations.

Thank you for your consideration of these comments. Cigna would welcome the opportunity to discuss these issues with you in more detail at your convenience.

Respectfully,



David Schwartz