



July 24, 2020

U.S. Department of Labor
Employee Benefits Security Administration
Office of Health Plan Standards and Compliance Assistance
200 Constitution Avenue, N.W.
Washington, D.C. 20210

RE: Request for Comments on Proposed Updates to 2020 MHPAEA Self-Compliance Tool

Submitted electronically via e-ohpsca-MHPAEA-SCT-2020@dol.gov

Dear Sir or Madam:

America's Health Insurance Plans (AHIP¹) is writing on behalf of our members in response to the Department of Labor's (DOL) Request for Comments on Proposed Updates to the 2020 Mental Health Parity and Addiction Equity Act (MHPAEA) Self-Compliance Tool. We appreciate DOL's extensive efforts to engage stakeholders and solicit input in the development of guidance in this complex area. AHIP and our members have been active participants in multiple listening sessions, roundtables, and discussions sponsored by the DOL and we appreciate the opportunity for continued engagement.

Health insurance providers are committed to ensuring access to behavioral health care and have worked diligently to implement the protections afforded by MHPAEA – engaging clinical and administrative personnel across medical, behavioral, and pharmacy departments to promote understanding and implementation of the parity rules.

Beyond parity, our members have long been leaders in pioneering innovative programs focused on promoting patient access to affordable, evidence-based behavioral health care, emphasizing proactive identification and outreach to patients as well as coordination and integration of services. The current public health emergency has highlighted the importance of a robust behavioral health infrastructure -- both to address the immediate needs arising from COVID-19-related social distancing and financial uncertainty and to improve our nation's ability to respond to future behavioral health challenges. Health insurance providers have demonstrated their critical role and responsiveness by taking swift and decisive action to improve access to behavioral health care throughout this crisis, such as by waiving cost sharing for behavioral health tele-visits, providing innovative digital resources for both patients and providers, and/or supporting virtual access to addiction treatment and counseling.

Our comments on the proposed updates to the MHPAEA Self-Compliance Tool are informed by the experiences of health insurance providers in addressing the behavioral health needs of their

members. We understand that the Self-Compliance Tool is intended to support implementation efforts in a manner that is consistent with the underlying MHPAEA statute and regulations, not to establish new requirements. Given that federal guidance materials are looked to as a resource by state regulators, clarity and consistency with MHPAEA's statutory and regulatory intent are critical. Moreover, we recommend that DOL include a notation in the 2020 MHPAEA Self-Compliance Tool for new updates and examples to ensure that any new guidance is applied prospectively. As it is common for DOL and state regulators to rely on federal MHPAEA guidance in the context of enforcement, issuers and group health plans should not be held responsible for requirements and clarifications that did not exist in the regulations or prior guidance.

Our comments on the updates focus on the underlying priorities of:

- (1) emphasizing that parity applies to the comparability of the processes for applying non-quantitative treatment limitations (NQTLs) across behavioral health and medical/surgical benefits, even if disparate outcomes result; and
- (2) including examples showing compliant practices, alongside examples of non-compliance, to provide guidance more effectively to issuers and group health plans.

Our feedback on specific proposed updates to the 2020 MHPAEA Self-Compliance Tool is included below.

Definition of Mental Health Benefits (pp 6-7)

Under MHPAEA, any condition defined by the plan as a mental health condition must be consistent with generally recognized independent standards of current medical practice (e.g. DSM, ICD, etc.). DOL proposes in a new note that if a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits.

Comments: The proposed language is inconsistent with existing guidance issued by CMS in an October 2017 FAQ regarding MHPAEA compliance for Medicaid and CHIP plans and will create operational inconsistencies and confusion. There are services and treatments which may be used only to treat MH/SUD conditions (e.g., psychotherapy) and services which may be used only to treat medical/surgical conditions (e.g. cardiac surgery). For these services, it is a straightforward matter to define the benefit as either medical/surgical or MH/SUD, consistent with the proposed language.

However, there are a number of services and treatments that can be used to treat both medical/surgical and MH/SUD conditions. Physical therapy is one such service which can be used to treat both a mental health condition (for example, when a plan defines Autism

Spectrum Disorder (ASD) as a mental health condition) and a medical condition, such as a dislocated knee. MHPAEA and its implementing regulations provide plans with flexibility to determine whether benefits are considered MH/SUD or medical/surgical under the terms of the plan as written and administered.

Accordingly, for services commonly used to treat MH/SUD and medical/surgical conditions covered by the plan, the plan must use a reasonable method for defining such services as medical/surgical or MH/SUD benefits as long as that methodology is applied consistently across both medical/surgical and MH/SUD benefits. One such method a plan may employ defines the service based on whether the service is predominantly used for a medical/surgical or MH/SUD using the plan's annual claims experience spending on the service in question. Other reasonable methods may include, but are not limited to, making a determination based solely on the underlying diagnosis. Given that guidance already exists with respect to Medicaid and CHIP plans, we recommend DOL adopt CMS' approach to create consistency and avoid confusion.

Coverage of Benefits (p 10)

Under MHPAEA, if a plan provides MH/SUD benefits in any classification, it must provide benefits in every classification in which medical/surgical benefits are provided. DOL proposes a new note stating that if a plan provides coverage for prescription drugs for a MH/SUD condition (even if the plan excludes all other benefits for that particular MH/SUD condition), the plan is required to provide MH/SUD benefits for that condition in each of the other five benefit classifications for which the plan provides medical/surgical benefits.

Comments: The proposed language using prescription drugs as an example is problematic given that health insurance providers do not always know the reasons a clinician prescribed a particular drug. Moreover, a drug may be prescribed for a co-morbidity that does not necessarily relate to an underlying MH/SUD condition. Given that MHPAEA does not mandate a scope of service or that any particular MH/SUD condition must be covered, we recommend a different example be used that more clearly illustrates the rules regarding allowable exclusions and coverage in all classifications.

Medication Assisted Treatment (MAT) (p 11)

DOL proposes additional language stating that a plan cannot require that a medication to treat opioid use disorder (OUD) be contingent upon the availability of behavioral or psychosocial therapies or services unless the same process to determine limits exists on the medical/surgical side.

Comments: Health insurance providers support the provision of MAT to treat OUD and agree that MHPAEA requires that a comparable process be used for determining limitations on the

treatment of MH/SUD conditions as for medical/surgical conditions. The additional language, however, is focused on results rather than processes. We recommend that the example be clarified to note that, as part of the process for determining limitations, plans may take into account clinical considerations and appropriate standards of care and that disparate results are not determinative of a violation.

Use of Clinical Experts to Support NQTL Analysis (p 12)

DOL proposes an additional illustration of how a plan can use clinical experts to support application of NQTLs.

Comments: We support inclusion of this illustration as it provides an additional example of how a health insurance provider may use clinical experts, such as a Pharmacy & Therapeutics committee, to apply NQTLs in a comparable manner across MH/SUD and medical/surgical benefits.

Provider Reimbursement Rates (pp 22-23, 39-40)

Under MHPAEA, standards for provider admission to participate in a network, including reimbursement rates, are considered NQTLs. The updated DOL tool includes new notes, warning signs, and a tool for comparing reimbursement rates to Medicare rates.

Comments: While MHPAEA identifies and allows for a wide range of factors that health insurance providers may take into account in determining reimbursement rates, the proposed updates are heavily focused on using Medicare rates as a benchmark and fail to adequately recognize the existence of other benchmarks and factors that may be considered in combination with Medicare rates. For example, if a plan uses a methodology for setting reimbursement rates that considers Medicare reimbursement rates, along with training, education, licensure, geographic market, and demand for providers, which results in the plan's payment of different reimbursement rates for medical/surgical providers than for MH/SUD providers in the same classification, this would not indicate a lack of compliance with MHPAEA since the same methodology was used and applied for both MH/SUD and medical/surgical providers.

The underlying notion that parity applies to comparable processes being used to determine reimbursement rates, and not equal dollar amounts, gets lost with the multiple new references promoting the comparison to Medicare reimbursement rates as a benchmark. Moreover, while the rate comparison table is meant to be a tool for health plans to use for self-compliance, it could be interpreted by others, including state regulators, as a requirement for assessment of provider reimbursement. We recommend that if the proposed language is retained, additional language be added to clearly state that Medicare reimbursement rates are just one of many

allowable benchmarks and that compliance in determining reimbursement rates can result in different dollar amounts for behavioral health and medical/surgical providers.

Data Used in Weighting Factors (p 24)

Step 2 of DOL's 4-step process to determine NQTL compliance with MHPAEA is to identify the factors considered in the design of each NQTL. Examples of factors include, but are not limited to: excessive utilization; lack of clinical efficiency of the treatment or service; high variability in cost; lack of adherence to quality standards; and claim types with a high percentage of fraud. DOL adds new language to an existing compliance tip regarding determining whether any factors were given more weight than others and the reason(s) for doing so, by adding that plans include the specific data used in the determination (if any).

Comments: The proposed language requires an additional level of information and detail with questionable added value. Given that information on thresholds for factors are already required as part of Step 3, the proposed addition seems to add yet another layer of complexity and burden to an already burdensome process. We recommend the proposed language be stricken.

Flexibility in Determining Sources of Factors/Use of Expert Panels (p 25)

Step 3 of the DOL's 4-step process to determine NQTL compliance with MHPAEA is to identify the sources used to define the factors identified in Step 2 to design the NQTL. Examples of sources of factors include, but are not limited to: internal claims analysis; medical expert review; state and federal requirements; accreditation standards; internal market analysis; Medicare physician fee schedules; and evidentiary standards. DOL adds a new note providing an example of how a panel of medical experts, with equivalent expertise in both medical/surgical and MH/SUD benefits, could be used to assess whether preauthorization (an NQTL) is appropriate to apply to certain services (e.g., electroconvulsive therapy (ECT)), based on the factors of safety and cost.

Comments: While we have raised the issue in the past that Step 3 is a new requirement not specified in the law and adds yet another layer of complexity to an already complex process, we appreciate the example demonstrating how plans have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ evidentiary standards), as long as they are applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits. In this example, as long as the health plan similarly relies on established medical best practices due to legitimate safety concerns and high cost to impose preauthorization requirements on medical/surgical benefits in the same classification, then the NQTL is applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits.

Documentation of Expert Qualifications (p 26)

DOL proposes to add a new compliance tip that recommends that if the plan relies on any experts, the plan should describe the experts' qualifications and whether the experts' evaluations in setting recommendations for both MH/SUD and medical/surgical conditions are comparable.

Comments: Documentation of the qualifications of health insurance providers' clinical leaders and other personnel who serve as experts and whether the experts' evaluations in setting recommendations are comparable for every NQTL decision would be a significant new administrative burden. We recommend that such documentation be referenced as a more general documentation requirement, as opposed to documentation for every NQTL decision, and that DOL clarify that this is one strategy plans could consider without implying that it be a requirement.

Thresholds for Factors (p 26)

As part of Step 3, the DOL proposes additional language regarding thresholds for when a factor will implicate an NQTL. For example, in addition to specifying the threshold dollar amount at which a prior authorization requirement would be applied when based on the factor of high cost, the DOL proposes that plans also consider: (1) what data are used to determine the benefit is "high cost"; and (2) how, if at all, the amount that is to be considered "high cost" is different for MH/SUD benefits as compared to medical/surgical benefits, and what is used to justify this difference.

Comments: The proposed language creates an additional level of information and detail with questionable added value and, as mentioned previously, seems duplicative with the proposed language under Step 2 regarding data used in weighting factors. We recommend that the proposed language be stricken.

Analysis of NQTL In Operation (p 27)

Step 4 of the DOL's 4-step process to determine NQTL compliance with MHPAEA is to assess whether the processes, strategies, and evidentiary standards used in applying the NQTL are comparable and no more stringently applied to MH/SUD and medical/surgical benefits both as written and in operation. Examples of methods and analyses that plans may use to demonstrate comparability include but are not limited to: internal claims database analysis; review of published literature; and a consistent methodology for analyzing factors like high cost variability.

DOL proposes to add two additional examples of methods and analyses plans may use to demonstrate comparability – (1) internal quality control reports showing that the factors, evidentiary standards and processes with respect to MH/SUD and medical surgical benefits are

comparable; and (2) summaries of research (e.g., clinical articles) considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was similarly utilized for both MH/SUD and medical/surgical benefits.

Comments: We support these additional examples of the types of methods and analyses that plans may use to demonstrate NQTL compliance with MHPAEA.

Sample Claims (p 28)

Also as part of Step 4, DOL proposes to add a new compliance tip recommending that plans check sample claims to see how an NQTL operates in practice, indicating that a plan may have written processes that are compliant, yet not follow these processes in practice.

Comments: While there are several mentions in the document that outcomes are not determinative of compliance, this new guidance relies on outcomes rather than process and risks being misinterpreted. If the proposed language is retained, we recommend additional language be included to clearly state that it is the processes for applying NQTLs that must be comparable across behavioral health and medical/surgical benefits, even if disparate outcomes result.

New Warning Signs (p. 28-29)

DOL proposes three additional warning signs related to NQTLs that may be indicative of noncompliance and warrant further review:

- Prior authorization for medication for opioid use disorder but no prior authorization for comparable medications for medical/surgical conditions;
- Denying all claims for drug screening tests for those with SUD on the basis of medical necessity but covering such tests when the diagnosis is a medical/surgical condition; and
- Imposing medical necessity review requirements on outpatient MH/SUD benefits after a certain number of visits, despite permitting a greater number of visits before requiring any such review for outpatient medical/surgical care.

Comments: The proposed additions are problematic as written. For example, prior authorization for MAT medications is sometimes required by Medicaid or used by payers to protect against diversion, promote patient safety, and coordinate recommended behavioral counseling. Also, under MHPAEA, there is no requirement to review an NQTL for one medication as compared to “comparable” medications. The proposed warning sign on drug screening tests is an extreme and unrealistic example and, therefore, of questionable value. Its inclusion and potential misinterpretation could inadvertently thwart efforts to identify improper urine drug screening, which has been singled out by the Healthcare Fraud Prevention Partnership as an area of high concern due to high levels of fraud and abuse. Lastly, medical necessity requirements may differ based on evidence-based guidelines for different types of outpatient care, and this particular

warning sign is highly focused on the outcome and not the process. In practice, there is widespread disagreement with regard to the proper interpretation of warning signs, resulting, in extreme cases, in regulators disregarding the actual NQTL analysis and simply enforcing the outcomes measure as dispositive evidence of non-compliance. Accordingly, we recommend that these warning signs be stricken as they either conflict with widely accepted evidence on appropriate care and/or could be misinterpreted. If they are finalized, we recommend that they be consistently paired with an acknowledgement that disparate results are not determinative of non-compliance.

***Wit v. United Behavioral Health* (p 33)**

DOL proposes additional language that cites the *Wit* case in a note regarding compliance with non-MHPAEA disclosure requirements, namely, requirements under Part 4 of ERISA.

Comments: Inclusion of a citation to a court decision that is not final and under appeal is not only premature but non-germane given that the area under litigation pertains to disclosure requirements under ERISA and not parity requirements under MHPAEA. We recommend the proposed language be stricken.

Internal MHPAEA Compliance Plan (pp 34-35)

Although not required by MHPAEA, the DOL compliance tool adds a new section that lists recommendations, or best practices, for internal MHPAEA compliance plans and includes: conducting effective training and education; ensuring retention of records and information systems; conducting regular internal monitoring and compliance reviews; and responding promptly to detected offenses and developing corrective action.

Comments: Health insurance providers already conduct many of these activities as part of their internal compliance programs, and this new section serves as a useful guide plans can voluntarily consider as they continue to refine and modify their individual programs based on their own assessments. We support the inclusion of this new section and, consistent with our previous comments, recommend that DOL make clear that while these are common attributes of successful programs, plans continue to have the flexibility to conduct their own assessments of what they need to do to ensure compliance with federal and state regulatory requirements and that may differ across plans, products, and markets.

NQTL Disclosures (pp 34-35)

The DOL compliance tool adds a new section specifying the types of information that DOL investigators may request if a plan is audited for MHPAEA compliance. This information includes, but is not limited to, records documenting NQTL processes and how the NQTLs are

being applied to both MH/SUD and medical/surgical benefits to ensure the plan can demonstrate compliance with the law. In addition, plans need to be prepared to provide information on any guidelines, claims processing policies, or other standards the plan relied on to support the rationale that the NQTL is being applied comparably across MH/SUD and medical/surgical benefits. Plans must also be prepared to provide a sample of claims as well as any internal testing conducted to assess parity compliance with respect to financial and quantitative treatment limitations.

Comments: We remain extremely concerned with the voluminous level of information that may be required to support an NQTL analysis, particularly as this information is increasingly being looked to as a required disclosure to consumers as well. Large quantities of technical information, such as comparative effectiveness studies, clinical trials, professional protocols, published research studies, thresholds for evidentiary standards, etc., will not provide consumers with user-friendly information that demonstrates how benefit utilization management practices are comparable across MH/SUD and medical/surgical benefits. If this new section is retained, we recommend DOL include language clearly stating that the type of information to be provided to DOL investigators in the event a plan is audited for MHPAEA compliance is unlikely to be in a format that is useful to consumers.

NAIC Tool (p 35)

The DOL adds reference to the National Association of Insurance Commissioners' (NAIC) Data Collection Tool, which includes a Non-Quantitative Treatment Limitations Chart, to assist issuers in listing and comparing MH/SUD NQTLs to medical/surgical NQTLs. The updated language states that plans and issuers may wish to use this chart to collect information on the NQTLs imposed on medical/surgical and MH/SUD benefits and to identify some basic information on their factors, sources, and comparability.

Comments: We agree that the NAIC's NQTL Data Collection Tool that is part of the Market Regulation Handbook may be a valuable tool for plans to use to assess their compliance with parity. In addition to being a useful tool, DOL's reference to the NAIC work can help promote alignment and consistency between and among federal and state requirements. Consistency in interpretation of parity rules is paramount as we have already seen different interpretations result in different reporting requirements across states. We recommend that DOL continue to work with the NAIC to promote alignment and recognize that federal guidance is often translated into reporting requirements at the state level.

Additional Example of Compliance (pp 37-38)

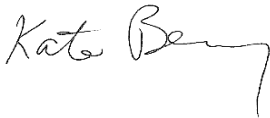
The DOL adds one example to its list of examples of compliance. The example addresses allowable use of prior authorization for psychological testing in the interest of fraud and abuse

detection and describes a fact pattern where the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its preauthorization requirements, particularly the use of prior authorization to detect fraud and abuse, are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

Comments: In previous communications with DOL, we recommended the addition of an example concerning permissible application of NQTLs to address fraudulent practices. We support the inclusion of this additional example of compliance. We recommend that DOL consider inclusion of an additional example of compliance that address residential treatment centers (RTCs). There is significant variation in licensing and certification requirements for RTCs, in addition to concerns of fraud and abuse. An illustration demonstrating allowable use of medical management and/or provider admission standards with respect to RTC would support health insurance provider efforts to promote safe, evidence-based access to residential care services.

Thank you for the opportunity to provide these comments. Health insurance providers will continue to meet the behavioral health needs of their members with proactive and innovative approaches to promoting access to safe, affordable, evidence-based care. We appreciate the work that DOL has done and look forward to continued engagement in our mutual efforts to build a robust and responsive behavioral health care infrastructure.

Sincerely,

A handwritten signature in cursive script that reads "Kate Berry". The signature is written in black ink and is positioned above the typed name and title.

Kate Berry
Senior Vice President