

COALITION FOR WHOLE HEALTH

July 24, 2020

Amber M. Rivers
Director
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Department of Labor
200 Constitution Ave. NW
Washington, DC. 20201

Re: Proposed Updates to 2020 MHPAEA Self-Compliance Tool

Dear Ms. Rivers:

Thank you for the opportunity to provide comments on the Department of Labor's (DOL) proposed update to the 2020 MHPAEA Self-Compliance Tool. The Coalition for Whole Health is a coalition of national, state, and local organizations advocating for improved coverage for and access to mental health (MH) and substance use disorder (SUD) prevention, treatment, and recovery services. A central goal of the coalition is the strong implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA), and we appreciate your consideration of our comments.

We strongly support the DOL's proposal to incorporate into the Self-Compliance Tool recent guidance and supplement compliance examples. The proposed revisions will ensure a more uniform interpretation of commonly applied non-quantitative treatment limitations (NQTLs) and will help consumers and regulators enforce the Parity Act's protections.

We also believe that each health plan and issuer **must have an internal compliance plan** to meet its legal obligation to "not sell a policy, certificate, or contract of insurance that fails to comply with [parity requirements with respect to aggregate lifetime and annual dollar limits, financial requirements, and treatment limitations].... 29 C.F.R. § 2590.712(h). We respectfully suggest that the proposed MHPAEA Compliance Plan is not sufficient to ensure that issuers and plans meet their legal obligation.

A stronger compliance framework is needed to ensure rigorous internal plan review prior

to the offering of plans and to relieve regulators and consumers of the heavy and unrealistic burden to identify violations when they have limited or no access to essential plan documents.¹

In addition, we do not believe that the NAIC Market Conduct template, which is identified as a possible tool for data gathering and compliance review, is adequate. The NAIC tool omits key NQTLs, does not constitute a tool for comparative analysis of compliance, and is less rigorous than templates being adopted by state insurance regulators.² **We urge the DOL to identify the DOL Self-Compliance Tool itself for purposes of compliance testing and guidance.** Recommending the use of inconsistent guidance and tools to regulators, issuers and plans, and consumers will further inhibit strong enforcement of the Parity Act.

We offer the following comments and recommendations for revisions.

I. Integration of Recent Guidance and Revision of Compliance Examples

We fully support the proposed addition of recent guidance and compliance examples. We are particularly supportive of following additions that clarify standards in the following areas:

- Section B – Coverage in all Classifications:
 - the requirement to cover room and board for MH and SUD residential care on the same basis as coverage of intermediate levels of care for med/surg services; and
 - the impermissibility of a limitation on the coverage of medications for opioid use disorders absent the availability of psychosocial therapies if similar limitations are not imposed on med/surg treatment.
- Section F – Nonquantitative Treatment Limitations:
 - identification of reimbursement rate processes, factors and evidentiary standards that may violate the Parity Act;
 - identification of the need to assess the evidentiary standards used to apply a factor (high cost) in designing NQTLs, such as prior authorization; and

¹ The Maryland Insurance Administration, for example, stated in an order against United HealthCare for Parity Act violations of reimbursement rate setting practices, that it “investigated Respondents for **a year and seven months** before it obtained all information it needed to understand how Respondents were developing reimbursement rates for OON [out-of-network] providers.” *Maryland Insurance Administration v. Optimum Choice, Inc., UnitedHealthcare Ins. Co., and UnitedHealthcare of the Mid-Atlantic*, Case Nos. MIA-2020-04-039, MIA-2020-04-040, and MIA-2020-04-041 (April 21, 2020) at 4 (emphasis added).

² *See, e.g.*, 3 Code Colo. Regs. 702-4:4-2-64 and Appendices (2020).

- identification in the Step 4 compliance tips of the need to check sample claims to evaluate the NQTL in operation.
- Section G – Disclosure Requirements:
- reinforcement of the plan’s obligation to ensure that the provider directory is up-to-date, accurate and complete.

We offer the following suggested revisions.

- Clarification of the NQTL standard: While the Self-Compliance tool makes clear in most sections that the NQTL analysis requires a plan to demonstrate that it applies both comparable processes, strategies, evidentiary standards and other factors **and** no more stringent application of these elements, a reference to the “no more stringent” application standard should be added to several sections, including:
 - Illustration regarding P&T Committee operations (p. 12)
 - Internal Quality Control Reports (p. 27)
- Use of Evidentiary Standards (Step 3, Note at p. 25) The Step 3 note states that “plans and issuers have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ evidentiary standards). . . .” This note suggests that a plan need not employ evidentiary standards when defining the factors used to design an NQTL. **We do not agree with this analysis and recommend that this Note be removed.**

While the evidentiary standards for applying a factor may differ depending on the NQTL, we suggest that a plan **will always employ** some “evidentiary standard” when deciding when a factor applies to covered benefits. In the example provided, the plan would have to identify some basis on which to determine that an “established medical best practices” for determining that ECT is “high cost and has legitimate safety concerns” is, in fact, an established best practice. The failure to do so would provide no standard for differentiating between practices that are purported to be a best practice to support the carrier’s intended result and those that are accepted best practices based on objective and verifiable criteria, such as published literature. The Wit v. United Behavioral Health decision makes clear that a carrier may adopt an NQTL (i.e. medical necessity criteria) that does not conform to generally accepted medical standards, even though the carrier asserts otherwise. For purposes of a parity analysis, United Behavioral Health would have been required to identify the evidentiary standards it used to reach its conclusion that a set of MNC are consistent with accepted medical practices for MH and SUD treatment. The Wit evidence revealed that United applied, as its evidentiary standard, the increased cost associated with the use of the ASAM criteria rather than medical literature and medical evidence.

Indeed, the example offered in the following Note regarding the evidentiary standards supporting the use of “high cost” as a factor (p. 26) **is inconsistent** with the suggestion that carriers would not need to use an evidentiary standard to apply the “high cost” factor. We agree with this guidance that “if high cost is identified as a factor used in designing a prior authorization requirement, *the threshold dollar amount at which prior authorization will be required for any services should also be identified.*” (emphasis added). To ensure consistency and fidelity to the law, we request that the proposed note on p. 25, addressed above, be deleted.

II. Warning Signs

We appreciate the inclusion of the Warning Signs to help plans flag potential violations based on disparate outcome data and the emphasis on specific NQTLs – reimbursement rates, prior authorization requirements for medications for opioid use disorders and authorization for drug screening for SUDs – that are used frequently to deny or limit care. We offer the following observations and comments.

Reimbursement Rate Setting and Appendix II Tool³

We agree that Medicare rates are one of the most common evidentiary standards for setting rates and that a comparison of rates for the most frequently used CPT codes is an important starting point for flagging rate setting violations. We have several concerns related to a plan that relies on Medicare rates and note several limitations in the App. II tool.

- Medicare, which is not subject to the Parity Act, does not cover specific provider types that deliver SUD and MH services – including licensed professional counselors – and other facility-based settings that deliver a substantial portion of SUD services. As a result, evidence of rate comparability for the specific providers and CPT codes identified in App. II should not be construed as an indicator of plan compliance for all MH and SUD services.
- The two codes selected for comparison across medical and MH/SUD providers – 99203 and 99213 – cover new and established patients with mid-level complexity and do not examine reimbursement rates for patients with high complexity conditions (CPT Codes 99205 and 99215). A 2017 analysis of Maryland claims data for private commercial insurers revealed far greater disparities in reimbursement for psychiatrists compared to medical and primary

³ We note that the CPT codes for Occupational Therapy and Physical Therapy have been revised, effective Jan. 1, 2017, and Codes 97001, 97003 and 97004 have been replaced. CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 3654. Available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3654CP.pdf>. We recommend inclusion of the new codes in App. II.

care practitioners for patients with high complexity conditions (both new and established) than for patients with mid-complexity conditions.⁴ **We recommend that these additional E&M CPT codes be added to the tool to achieve better compliance testing.**

To address the limitations inherent in Medicare, we recommend that the DOL include additional guidance that advises plans to evaluate all factors and evidentiary standards and examine outcome data via claims analysis for the full range of covered MH and SUD services, in addition to the codes listed in the App. II tool.

We are also concerned that the framing of the Warning Signs suggests that lower reimbursement rates for MH/SUD physicians compared to med/surgical physicians for the same E&M codes could be compliant with the Parity Act. (Ex. 2) First, it is unclear how **any disparity** between MH/SUD and med/surg practitioners could be shown to be parity compliant, since the RVUs for all practitioner types that bill E&M codes are identical, as is the service being delivered. We recognize that a disparate outcome is not sufficient, alone, to constitute a parity violation and that all factors must be evaluated, including rate differences based on geographical setting. At the same time, the data are far more probative of non-compliance with the Parity Act – both as written and in operation – than the Warning Signs statement conveys. We recommend that the introductory statement be revised as follows:

Warning Signs: The following plan provisions related to provider reimbursement are ~~may be~~ indicative of noncompliance and warrant further review.

The inclusion of the warning signs and additional information about outcome data raises a separate concern about the final NQTL compliance tip (at 29). The statement “Do not focus on results” seems inconsistent with the NQTL “no more stringent” application requirement, as outcome data is the direct result of standards that are not comparable and more restrictive. Given the inclusion of additional examples of outcome data analysis and how disparate outcomes warrant further review of parity compliance, **we suggest that a revision of this phase would be consistent with the Parity Act standard and more effectively guide compliance reviews and enforcement.** We recommend the following minor revision to the Compliance Tip on p. 29 (new language underlined).

Do not focus on results alone.

III. Establishing an Internal MHPAEA Compliance Plan

⁴ Data on file with Ellen Weber, Legal Action Center.

A. Compliance Plan

We appreciate DOL's description of common elements of an internal compliance plan and the identification of plan materials that DOL investigators may request in an audit. We are very concerned, however, by the suggestion that an internal compliance plan is *optional* for plans and issuers. **In our view, the implementation of a rigorous compliance plan is the only way in which an issuer or plan can ensure that it is not offering MH and SUD benefits in violation of the Parity Act. 29 C.F.R. § 2590.712(h).** It is well recognized that an enforcement strategy that relies on consumer complaints is not effective because of the complexity of the Parity Act and the lack of access to plan documents and internal decision-making processes. For this reason, a growing number of states are adopting mandatory parity compliance and data reporting requirements to ensure better enforcement of the Parity Act. Any suggestion that federal regulators construe the law as not requiring an internal compliance program could undermine those and future state efforts and hinder uniform implementation of the law. **We urge, DOL to remove the phrase “[a]lthough not required by MHPAEA” in the introductory statement to Section H. (at 34).**

In addition, we offer the following suggestions to strengthen the components of the proposed internal compliance plan.

- Conducting effective training and education: An issuer or plan's frontline benefits representatives are often the first and only individual that a member will speak with about coverage of and access to their MH/SUD benefits. We are aware of cases in which benefits representatives provide inaccurate coverage and utilization management information, resulting in the delay or denial of life-saving services.⁵ Benefits representatives need thorough and on-going training on the Parity Act, and internal mechanisms should be implemented to monitor and document their performance. Even the most basic organizational changes, such as hiring new personnel in the claims department, could have an “in operation” effect. We urge the DOL to revise the training and education statement as follows (suggested new language underlined):

Successful compliance programs provide on-going training and education to all the individuals responsible for ensuring parity compliance, including those who develop plan design and monitor compliance, communicate with current and prospective plan members and providers about benefit coverage, utilization management, network providers, and

⁵ See, e.g., Maryland Insurance Administration v. UnitedHealthcare Ins. Co., MIA-2020-06-039 (July 7, 2020).

reimbursement, and are responsible for making decisions related to both MH/SUD and medical/surgical benefits on behalf of the plan or issuer (such as claims reviewers at all levels of internal review and grievances, and medical practitioners involved in benefit decisions). Documentation of training and education programs should include information on the frequency of training and familiarity with Parity Act standards.

- Conducting internal monitoring and compliance reviews on a regular basis: As noted above, we do not believe that an internal monitoring program is optional if plans are to comply with the Parity Act's prohibition on offering plans that violate the law. Because plans change benefit coverage and standards on an on-going basis, compliance must be assessed *prior to* the plan adopting any change in financial requirements, quantitative treatment limitations, or NQTLs. Finally, plan audits are essential to ensure compliance on all NQTLs. While an audit of adverse benefit determinations is essential, similar audits must be conducted for all NQTLs, including network adequacy metrics, such as rates of out-of-network utilization and compliance with state quantitative network adequacy metrics, and reimbursement rate setting standards. We urge the DOL to revise the internal monitoring statement as follows (suggested new language underlined):

A plan or issuer must monitor and conduct an internal review for potential non-compliance on an on-going basis and prior to any change in benefit design and identification of problem areas with MHPAEA. Plans that delegate management of mental health and substance use disorder benefits and/or pharmacy benefits to another entity, must have clear protocols regarding the continual and mutual sharing of medical/surgical and mental health and substance use disorder plan information and implement a regular audit mechanism to ensure compliance. A plan or issuer must audit samples of adverse benefit determinations, to assess the application of medical necessity criteria, the level of detail provided to claimants regarding the basis for service denials, and correctness of determinations. A plan or issuer must also audit the application of all NQTLs, including outcome measures that reflect the application of utilization management requirements, provider network admission and adequacy standards, and reimbursement rate setting practices.

We fully support the development of ombudsman programs to assist plan participants and beneficiaries in navigating their benefits and achieving prompt resolution of complaints of non-compliance. While plans should not rely on member complaints as the sole or primary indicator of plan compliance, members, who have MH and SUD benefits questions and concerns, must be able to get prompt and correct guidance from plan representatives with Parity Act expertise. We believe this function should be identified as a separate internal compliance measure and also address the disclosure of plan documents and instruments under which the plan is established or

operated. We urge the DOL to adopt the following new measure:

Establishing an internal consumer ombuds program to assist plan members and beneficiaries. A plan or issuer shall establish an internal consumer ombuds program to assist participants and beneficiaries in navigating their benefits and elevating their complaints of non-compliance to benefits managers with expertise in Parity Act implementation. The ombuds program shall ensure the prompt and complete disclosure of plan documents, upon request from members and beneficiaries, and in connection with internal grievances and external appeals. A plan or issuer shall audit compliance with disclosure standards.

- Responding promptly to detected offenses and developing correction action. We agree with the need for prompt corrective measures to remedy violations for all affected plan participants and beneficiaries. We would also recommend that, upon discovery of a parity violation based on an individual member's complaint, the plan similarly determine whether other plan members have been adversely affected and take remedial measures to promptly address additional adverse impact. Parity violations are system-wide violations, and, to the extent, one member has been adversely affected, it is likely that others have been also. We urge the DOL to adopt the following new measure (recommended new language underlined).

If a plan or issuer discovers a violation of MHPAEA through any means, including an individual complaint or grievance, it should take steps to correct these violations promptly, including providing retroactive relief and notice to all potentially affected participants and beneficiaries....

B. Data Collection Tool

The DOL has identified the NAIC NQTL chart, developed by the Market Conduct Examination Standards (D) Working Group in 2018, as a template that issuers and plans may wish to use for compliance review purposes. **We urge the DOL to delete the suggestion that the NAIC chart is an appropriate tool for self-compliance review and instead require issuers and plans to base compliance review on the DOL Self-Compliance Tool.**

The NAIC chart is incomplete insofar as it omits key NQTLs including:

- the carrier's standards for network admission
- reimbursement rate setting and methods for determining usual and customary rates and reasonable charges
- network adequacy
- scope of services

- other criteria that limit the scope or duration of benefits (catch-all)

In addition, the DOL's endorsement of one tool to the exclusion of others being adopted by state Departments of Insurance in connection with mandatory compliance reporting and those currently under development by the NAIC MHPAEA Working Group B will create confusion and undermine the adoption of more effective tools. **Fundamentally, we believe that the DOL's identification of any particular tool is at odds with the development of the Self-Compliance Tool itself.** The tool constitutes the guidance of the federal regulators that possess authority to enforce the Parity Act.

Thank you for considering our views. Please feel free to contact Gabrielle de la Gueronniere (gdelagueronniere@lac-dc.org) with any questions.

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Co-Chairs, Coalition for Whole Health

