health law advocates
Lawyers Fighting for Health Care Justice

HLA

One Federal Street, 5th Floor
Boston, MA 02110

T 617-338-5241
888-211-6168 (toll free)
F 617-338-5242
W www.healthlawadvocates.org

January 3, 2017

VIA ELECTRONIC MAIL [e-ohpsca-mhpaea-disclosure@dol.gov]

Phyllis C. Borzi, Assistant Secretary of Labor
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Ave. NW
Washington DC 20210

RE: Comments on Improved Enforcement of the Disclosure Provisions of the Mental Health Parity and Addiction Equity Act

To Whom It May Concern:

Health Law Advocates (HLA) respectfully submits these comments in response to the recent request for comments about the disclosure provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA or the Federal Parity Law), issued on October 27, 2016 in conjunction with the Final Report of the Mental Health and Substance Use Disorder Parity Task Force. *See* FAQs about Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation, Disclosures with Respect to MH/SUD Benefits, Including Request for Comments, available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf.

HLA is a public interest law firm that provides free legal assistance to low-income Massachusetts residents who face barriers to obtaining essential health care. Through our Mental Health Parity and Addiction Equity Initiative, we assist individuals with mental health conditions and substance use disorders to receive the health insurance benefits to which they are entitled. We write on behalf of the Massachusetts Mental Health Parity Coalition, a group of provider and consumer advocacy organizations committed to making mental health and substance use disorder parity a reality.

Thank you for providing the opportunity to offer feedback about this important topic. The disclosure provisions of the MHPAEA are critical to the success of the law, as without consumer access to the necessary information in the possession of health plans and health insurance issuers, parity is an empty promise.

Below we offer our comments on ways in which the disclosure provisions of Federal Parity Law could be strengthened.

Model Forms to Request Comparative Information from Plans/Issuers on NQTLs[1]

In the request for comments, the Departments[2] asked whether issuance of model forms that could be used by participants and their representatives to request information with respect to various NQTLs would be helpful and, if so, what content the model forms should include. For example, is there a specific list of documents, relating to specific NQTLs, that a participant or his or her representative should request?

Issuance of model forms by the Departments could be helpful to participants and their representatives in requesting information with respect to nonquantitative treatment limitations (NQTLs). Such a form would be helpful primarily in assisting the requesting party to identify the type(s) of information s/he needs to conduct the parity analysis in a given situation.

A model form could contain checkboxes for common forms of NQTLs such as the "illustrative" list set forth in the November 13, 2013 Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Final Rules"):

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage

However, the categories should be broken out further and written in simpler terms. So, for example, under medical management standards, there would be separate checkboxes for utilization review, prior authorization, concurrent review, retrospective review, and possibly

[1] Some commenters on the Task Force Report called for model forms that plan members and their representatives could use to request relevant disclosures from plans and issuers.
[2] As used herein, the Departments refers collectively to the Department of Labor, the Department of Health and Human Services and the Internal Revenue Service.

others. The form would also contain a list with checkboxes for the permitted classifications of benefits – inpatient, in-network, inpatient, out-of-network, etc.[3]

Example: A plan member has had coverage for ongoing MH/SUD treatment terminated prior to completion of the recommended program. The member believes that concurrent medical necessity review of inpatient stays may be conducted by his health plan differently for medical/surgical services and MH/SUD services. At a minimum, the member would check the boxes on the model form for concurrent review and for inpatient in-network and inpatient out-of-network classifications.

The Final Parity Rule prohibits a plan or issuer from imposing a NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan or health insurance coverage as written and in operation, *any processes, strategies, evidentiary standards, or other factors used in applying the NQTL* to MH/SUD benefits in the classification *are comparable to, and are applied no more stringently than*, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

Model forms should not be designed or used in such a way as to narrow the information that would otherwise have to be disclosed. The burden should be on the plan/issuer, once a request is made by a participant or his representative, to produce all documents and information that show the *processes, strategies, evidentiary standards, or other factors used in applying the NQTL* both to MH/SUD and to medical/surgical benefits and *how* these factors are applied as written in the plan and in operation.

Nonquantitative treatment limitations limit the *scope or duration* of benefits for treatment under a plan or coverage in ways that are not expressed numerically. There is not uniform agreement as to what constitutes a NQTL, i.e., what it means to limit the scope or duration of treatment. We have encountered plans that refuse to produce information regarding a claimed NQTL on the basis that the practice identified did not limit the scope or duration of benefits and did not appear on the list of examples included in the Final Rule. To counter plan resistance to disclosing appropriate information, any model form should define "scope"

[3] The following classifications of benefits are permitted under the Parity Rule:
(1) Inpatient, in-network. Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage.
(2) Inpatient, out-of-network. Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes inpatient benefits under a plan (or health insurance coverage) that has no network of providers.
(3) Outpatient, in-network. Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage.
(4) Outpatient, out-of-network. Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers.
(5) Emergency care. Benefits for emergency care.
(6) Prescription drugs. Benefits for prescription drugs.
See Final Rules at, e.g., 29 C.F.R. § 54.9812–1 (c)(2)(ii)(A).

broadly, consistent with the remedial purpose of the Parity rule and common-sense interpretation of regulatory language.[4]

In terms of whether there is a specific list of documents that a participant or his representative should request, we believe that the burden should be on the plan/issuer to produce *all* documents that are responsive to the particular request. A form with a specific list of documents requires the requester to know what documents would be responsive in advance, where the plan/issuer is uniquely in a position to identify and produce all responsive documents.

Do different types of NQTLs require different model forms? For example, should there be separate model forms for specific information about medical necessity criteria, fail-first policies, formulary design, or the plan's method for determining usual, customary, or reasonable charges? Should there be a separate model form for plan participants and other individuals to request the plan's analysis of its MHPAEA compliance?

Having multiple forms for different types of NQTLs will add to the burden already imposed on participants and their representatives in obtaining legally required information. It makes more sense to have one overall disclosure request form that contains the NQTLs cited in the Final Rules as well as a category for any other practice that the requester believes fits the definition of a NQTL. The benefit of a model form should be primarily to assist the participant to identify practices or policies a plan may have engaged in. Putting all possible NQTLs, including an open-ended category, on the form will allow participants to more easily identify selections that are responsive to their situation. We would be glad to submit a template for the model form along the lines described, if that would help the Departments.

Each time a plan member asserts possible improper use of an NQTL with respect to MH/SUD benefits and asks for relevant comparative documents, the plan responsible should release responsive documents in a timely fashion. In most cases, this would mean a written response and release of relevant documents within 30 days of the plan's receipt of the request. Ideally, the plan should also provide its analysis of why the practice(s) at issue are in compliance with parity. All plans and issuers are charged with completing the parity analysis with respect to all financial requirements, QTLs and NQTLs. The burden should be on the plans and issuers to promptly produce this prepared analysis in response to a request.

<u>Encouraging Uniformity in State Reviews of Parity Compliance with Use of Model Forms</u>

The Departments also received requests to explore ways to encourage uniformity among State reviews of issuers' compliance with the NQTL standards. Certain commenters stated that model forms for issuers to report NQTL information to state regulators will help facilitate uniform implementation and enforcement of the MHPAEA, and relieve some complexity that compliance poses for health insurance issuers operating in multiple States. Others noted that the use of such model forms may also benefit consumers, as the consumers will be entitled to request the analysis performed to complete the model forms.

[4] Scope (noun): extent, range. *See* https://www.merriam-webster.com/dictionary/scope.

Whether issuance of model forms that could be used by States as part of their review would be helpful and, if so, what content should the model form include? For example, what specific content should the form include to assist the States in determining compliance with the NQTL standards? Should the form focus on specific classifications or categories of services? Should the form request information on particular NQTLs?

Since 2013 the Massachusetts Division if Insurance has had in place a template survey form for health plans to complete to demonstrate compliance with the MHPAEA. *See, e.g.,* 2014 Mental Health Parity and Addiction Equity Supplemental Response Letter, Summary of Responses to Bulletin 2013-6, at http://www.mass.gov/ocabr/docs/doi/mhp-carrier-responses-open-2014.pdf. While we appreciate these efforts, we think they should go further -- asking additional questions and requiring submission of the information and analysis to demonstrate parity compliance. We would support the federal Departments development of a robust and comprehensive model form for plans to complete and submit each year to state insurance regulators.

The current Massachusetts DOI form broadly requests plans to review differences in utilization review between medical/surgical and MH/SUD benefits. The form also asks whether there are differences in practicing physician input into medical necessity review and whether different types of information are requested to support medical/surgical claims versus MH/SUD claims. Since the Final Rules designate certain practices as NQTLs (at a minimum) the model form should ask plans for specifics regarding differences between those practices for medical/surgical and MH/SUD benefits. As with the form for consumers to make information requests, the state compliance form should also include an open-ended question about any plan/issuer policies or practices that limit the scope or duration of benefits but that are not explicitly identified in the Final Rules.

Other Steps the Departments may take to Improve the Scope and Quality of Disclosures or Simplify or otherwise Improve Processes for Requesting Disclosures

What other steps can the Departments take to improve the scope and quality of disclosures or simplify or otherwise improve processes for requesting disclosures under existing law in connection with MH/SUD benefits?[5]

1. Health Plans/Issuers Should Prominently Provide Notice and Explanation of Members' Right to Obtain Information for Parity Analysis

HLA conducts trainings throughout Massachusetts on consumer rights under the Federal Parity Law. Frequently, attendees at the trainings have not heard of the law or, if they have, do not know how it works. Plans and issuers should be required to inform their members and participating providers about the Federal Parity Law, including the right to request and receive information to perform a parity analysis. Plans and issuers should have to make

[5] Commenters on the Task Force Report also requested guidance on ways other than model forms in which disclosures, or the process for requesting disclosures, could be more uniform, streamlined, or otherwise simplified.

transparent the process through which members and providers can obtain the information needed to assess a parity violation. Without more transparency about the rights to this information and how to get it, any model forms will serve little purpose.

2. Health Plans and Issuers Must Consistently and Timely Release to Requesting Members and Providers the Information Necessary to Determine Parity Compliance

Few health plan members know that they have the right to request and receive information from their plan to confirm that mental health and substance use disorder benefits are compliant with the Federal Parity Law. Even if consumers are aware of such rights, they are often faced with major barriers to enforcing them. As attorneys for consumers, we have made explicit and legally supported requests for comparative parity information - medical/ surgical and mental health/substance use disorder. We have come up empty handed each time.

Here is a sample request:

> The XYZ Employee Benefit Plan administered by ABC Insurance Company generally covers medically appropriate treatments for medical/surgical benefits and mental health and substance use disorder benefits. The Plan requires concurrent review to determine whether inpatient mental health/substance use disorder services continue to be medically necessary. Concurrent review of an inpatient stay is a nonquantitative treatment limitation (NQTL) under the MHPAEA, subject to parity requirements.
>
> On information and belief, ABC reviewers routinely deny coverage after approximately 2 weeks of inpatient SUD rehab, regardless of the clinical circumstances. Further, on information and belief, evidentiary standards used in determining whether inpatient substance use disorder rehabilitation is medically appropriate are not applied in a manner that is based on clinically appropriate standards of care. On information and belief, ABC's concurrent review of inpatient medical/ surgical benefits for the XYZ Plan is not based on such arbitrary limits.
>
> John Doe's coverage for inpatient residential SUD treatment was terminated based on concurrent review conducted in a manner and based on standards that, as applied, violate the MHPAEA. Mr. Doe therefore requests, pursuant to 29 CFR § 2590.712(d)(3), disclosure of all information relevant to medical/surgical, mental health, and substance use disorder benefits for purposes of evaluating the Plan's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) in the handling of his claim. This request includes documents with information on medical necessity criteria for *both* medical/surgical benefits and mental health and substance use disorder benefits, and the processes, strategies, evidentiary standards, and other factors used by ABC to apply a nonquantitative

> treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

Despite making clear requests for appropriate parity compliance information, we have yet to receive any comparative information needed to perform a parity analysis. Attorneys handling similar cases around the country have had the same experience. If trained lawyers cannot obtain the information necessary to assess parity compliance, a layperson cannot be expected to do so without additional regulation and oversight by the Departments.

Federal agencies should educate health insurance issuers and health plans about their disclosure obligations under the Federal Parity Law. The Departments should issue regulations that have the force of law, and not mere guidelines, to require plans/issuers to publicize the process for requesting and obtaining parity documents. Enforcement must also be strengthened against issuers and plans that do not meet their disclosure obligations, including imposition of penalties or sanctions to the extent the law permits.

Another tool for enhancing compliance with disclosure provisions is to require issuers and plans to designate a *parity compliance officer* who has access to and is knowledgeable about all plan documents used to design benefits and test for parity compliance. The parity compliance officer should be the point person to respond to requests for documents relevant to parity compliance and alleged parity violations. This role should not be assigned as an afterthought to someone with many other job responsibilities. Rather, it should be a dedicated position with one person in charge and answerable in a timely way to participants, providers and their representatives. Plans and issuers that contract with a separate entity to manage behavioral health benefits are no less responsible for ensuring that the necessary information for parity compliance is shared and analyzed across entities and with requesters.

Another helpful step would be providing health plans and issuers with best practice language and materials to be included in a MH/SUD adverse benefit determination. For example, plans must currently inform members to whom an adverse determination is issued how they can obtain their claim file. Similarly, plans should have to explicitly invite members to request information on parity compliance in connection with a claim or appeal, and should provide all necessary information for completing such a request. Any steps that can be taken to make the process easier for consumers will improve the enforcement of the Parity Law.

<u>Steps to Improve State Market Conduct Exams and Federal Oversight of Parity Compliance</u>

Are there specific steps that could be taken to improve State market conduct examinations and/or Federal oversight of compliance by plans and issuers?

The National Association of Insurance Commissioners (NAIC) issues a Market Conduct Examination Handbook. The Departments should make clear that for purposes of Federal Parity Law compliance, states' market conduct exams should, in addition to Handbook protocol, require that examiners review a statistically significant sample of requests for parity documentation and the associated responses plans/issuers have made to participants and their authorized representatives. If sufficient sample requests are not available – likely

given the barriers that currently exist to making them – state insurance regulators can themselves request parity documentation for selected common NQTLs and follow up to ensure that plans/issuers are responding completely and adequately. A checklist for what examiners should be looking for in each NQTL example can be developed in part from the Self-Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions, Section E, Non-quantitative Treatment Limitations and Section F, Disclosure Requirements at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/cagappa.pdf. For each request for plan documents, for each NQTL, the examiner would review and evaluate the adequacy and completeness of the plan/issuer response. For example, if a request seeks to determine parity compliance in medical necessity review of inpatient residential SUD treatment, the examiner would determine whether the plan/issuer:

1. Provided the medical necessity criteria used to determine eligibility for residential (or equivalent) inpatient treatment for medical/surgical benefits and mental health/substance use disorder benefits;
2. Provided evidence that an analysis was performed and documented that adequately compares the medical necessity criteria employed to both types of benefits to establish comparability;
3. Provided evidence that an analysis was performed and documented that comparable criteria are applied no more stringently to MH/SUD benefits than to medical/surgical benefits;
4. Responded to the request within 30 days.

*****

In conclusion, HLA on behalf of the Massachusetts Mental Health Parity Coalition thanks the Departments for the opportunity to provide feedback on the disclosure provisions of the Federal Parity Law. We are committed to ensuring that the Federal Parity Law achieves its purpose to eradicate discrimination in insurance coverage of mental health and substance use disorders. Please feel free to contact me at (617) 275-2983 or cmcgorrian@hla-inc.org if you have any questions about any of our comments or recommendations.

Sincerely,

Clare D. McGorrian
Director, Mental Health Parity and Addiction Equity Initiative
Health Law Advocates

On behalf of Health Law Advocates and these other members of the Massachusetts Mental Health Parity Coalition: [6]

[6] Please see enclosed list for a brief description of each organizational member of the Massachusetts Mental Health Parity Coalition. Due to the holidays, a number of Coalition members could not review these comments and obtain organizational approval by the January 3 deadline. The absence of those organizations as signers does not indicate disagreement with the content of this letter.

Health Care For All
Association for Behavioral Healthcare
Massachusetts Association of Behavioral Health Systems
Massachusetts Association for Mental Health
Massachusetts College of Emergency Physicians