Electronically submitted via email transmission to laurie.e.brimmer@irs.gov and rjoseph.durbala@irs.gov.

Aug. 31, 2017

Ms. Laurie Brimmer
Internal Revenue Service
Room 6129
1111 Constitution Avenue, N.W.
Washington, D.C. 20224

Re: Proposed Revision of Information Collection Request Submitted for Public Comment; Draft Model Non-Quantitative Treatment Limitations Form

Dear Ms. Brimmer:

Magellan Health, Inc. (Magellan) appreciates the opportunity to respond to the notice and opportunity to comment on a Draft Model Non-Quantitative Treatment Limitations Form that participants and authorized representatives can use to request certain information regarding mental health and substance use disorder (MH/SUD) benefits from their health plans.

As we shared in our August 2016 and January 2017 comments[1], Magellan has long demonstrated its strong commitment to mental health parity in many ways, including testifying in favor of parity before Congress in 2001 and actively supporting passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Headquartered in Scottsdale, Ariz., Magellan is a leader in managing the fastest growing, most complex areas of healthcare, including individuals with special healthcare needs, complete pharmacy benefits, and other specialty areas of healthcare. We connect behavioral, physical, pharmacy, and social needs with high-impact, evidence-based clinical and community support programs to ensure the care and services provided to our members are individualized, coordinated, fully integrated, and cost effective. Magellan develops and supports innovative

1. Magellan Health letter to Ms. Cecilia Muñoz, chair, Mental Health and Substance Use Disorder Parity Task Force (Aug. 31, 2016); and, Magellan Health letter to the Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, U.S. Department of Labor; Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services; and, Internal Revenue Service, U.S. Department of the Treasury (Jan. 3, 2017).

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ways of accessing better health by combining advanced analytics, agile technology, and clinical excellence, while remaining focused on the critical personal relationships necessary to achieve a healthy, vibrant life.

At Magellan, we have spent almost 50 years taking new, innovative ideas to their maximum potential – beginning with behavioral healthcare. Our perspective on parity is informed by this extensive experience providing a tailored spectrum of behavioral health services and employee assistance programs for health plans, employers, and various military and government agencies and public health care programs, including to active-duty service members and their families, the Medicare Advantage and state Medicaid programs, and individuals dually eligible for Medicare and Medicaid. We also contract with more than 77,000 credentialed behavioral health providers nationwide and provide behavioral healthcare services to approximately 1.6 million public-sector members through a range of innovative state programs, including the nation's first Medicaid specialty health plan for adults living with serious mental illness, Magellan Complete Care of Florida.

As an experienced behavioral health specialty organization, Magellan is committed to ensuring access to high quality and fully integrated MH/SUD benefits for the millions of health plan members served by Magellan on behalf of our customers. Our work with Blue Shield of California to proactively identify members, ensure access to services and supports, enhance collaboration among providers, and promote network accessibility is further evidence of our commitment to parity.[2] Our collaborative efforts with Blue Shield of California and issuers, public healthcare programs such as Medicare and Medicaid, behavioral health and primary care providers, and others central to the delivery model of the future is forward-looking and characterized by equitable, quality, and integrated access and coverage of MH/SUD benefits.

This forward-looking and collaboration-oriented perspective informs our feedback, shared below, on the Draft Model Non-Quantitative Treatment Limitations Form that participants and authorized representatives could use to request certain information from their health plans. (We previously provided comments to the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) in response to the Affordable Care Act Implementation FAQs Part 34 on the general concept of a model disclosure request form. Our specific feedback includes:

- Reviewing obligations under current law and regulation requiring group health plans and health insurance issuers under the MHPAEA and the 21st Century Cures Act of 2016 ('Cures') to make particular disclosures of information to current or potential

2. America's Health Insurance Plans, "Ensuring Access to Quality Behavioral Health Care: Health Plan Examples" (May 2016), pages 10-11: https://www.ahip.org/wp-content/uploads/2016/05/ AccesstoBehavioralCare_May-2016.pdf.

participants, beneficiaries, and contracting providers, as they relate to the Departments' promulgation of a draft model disclosure request form, which Magellan believes is neither necessary nor required by law; and,

- Providing input on the Draft Model Non-Quantitative Treatment Limitations Form, should the Departments proceed in their development of such, which the Departments propose participants, enrollees, or their authorized representatives could – but would not be required to – use to request particular information from their health plan or health insurance issuer regarding non-quantitative treatment limitations (NQTLs) that may affect their MH/SUD benefits.

Review of Disclosure Obligations under the MHPAEA and 'Cures'

The MHPAEA obligates group health plans and health insurance issuers to make particular disclosures of information to current or potential participants, beneficiaries, and contracting providers as follows:

> 29 U.S.C. Section 1185A(a)(4):
>
> *The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.*

This disclosure requirement is consistent with what the Employment Retirement Income Security Act of 1974 (ERISA) claims regulation, 29 C.F.R. Section 2560.503-1(g)(v), requires of group health plans:

> *(g)(v) In the case of an adverse benefit determination by a group health plan—*

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

With respect to a group health plans' decision on a participant's or beneficiary's appeal of an adverse benefit determination, the ERISA claims regulation similarly provides:

(5) In the case of a group health plan—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

Id. at (j)(5).

In addition, the ERISA claims regulation requires:

*(j) * * * In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—*

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

Id. at (j).

Finally, paragraph (m)(8) of the ERISA claims regulations defines "relevant" as follows:

(m)(8) A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5)[3] of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's

3. 29 C.F.R. Section 2560.503-1(b)(5) states: "(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants." This section thus ensures consistency of decision-making, and subsection (m)(8)(iii) would make any proof of consistency "relevant."

> *diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.*
> *Id. at (m)(8).*

Fundamentally the MHPAEA obligates disclosure of "medical necessity criteria." THE MHPAEA expands the disclosures required under the ERISA claims regulation in two ways:

- The "medical necessity criteria" are to be available to a "current or potential participant, beneficiary, or contracting provider upon request," rather than only available in the context of an actual ERISA-governed "claim for benefits;" and,

- The "medical necessity criteria" governing "mental health or substance use disorder benefits" are available outside the universe of only ERISA-governed "group health plan" members, both "on request" absent an actual benefits decision and also following an actual benefits decision.

Beyond "medical necessity criteria," neither the MHPAEA nor the ERISA claims regulation requires disclosure of the processes for formulating "medical necessity criteria," or of the efforts of group health plans and health insurance issuers to ensure "plans" or "coverage" are in compliance with the MHPAEA. However, such disclosure requirements are presumed to exist independent of the MHPAEA by reference to, for which we could not find evidence supporting, ERISA regulations in the final regulations adopted under the MHPAEA. The regulations adopting the MHPAEA, 29 C.F.R. Section 2590.712, appropriately implement the statute when it comes to "medical necessity criteria:"

> *(1) Criteria for medical necessity determinations. The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.*
>
> *(2) Reason for any denial. The reason for any denial under a group health plan (or health insurance coverage offered in connection with such plan) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in a form and manner*

consistent with the requirements of § 2560.503-1 of this chapter for group health plans.

Unfortunately, the regulations then go on to invent alleged disclosure requirements under ERISA that do not exist:

> *(3) Provisions of other law. Compliance with the disclosure requirements in paragraphs (d)(1) and (d)(2) of this section is not determinative of compliance with any other provision of applicable Federal or State law. In particular, in addition to those disclosure requirements, provisions of other applicable law require disclosure of information relevant to medical/surgical, mental health, and substance use disorder benefits. For example, ERISA section 104 and § 2520.104b-1 of this chapter provide that, for plans subject to ERISA, instruments under which the plan is established or operated must generally be furnished to plan participants within 30 days of request. Instruments under which the plan is established or operated include documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan. In addition, §§ 2560.503-1 and 2590.715-2719 of this chapter set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.*

It is not true "provisions of other applicable law" compel the disclosure of "processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance abuse disorder benefits." Earlier we quoted the ERISA claims regulation at length to demonstrate the highlighted legal conclusions cannot be drawn from that "other applicable law." Similarly, there is no way to reach the legal conclusion that "instruments under which the plan is established or operated" include more than the plan documents themselves (per 29 U.S.C. Section 1024):

(b) Publication of summary plan description and annual report to participants and beneficiaries of plan. Publication of the summary plan descriptions and annual reports shall be made to participants and beneficiaries of the particular plan as follows:

> *(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of the summary plan description, and all modifications and changes referred to in section 1022(a) of this title—*
>
> > *(A) within 90 days after he becomes a participant, or (in the case of a beneficiary) within 90 days after he first receives benefits, or*
> >
> > *(B) if later, within 120 days after the plan becomes subject to this part.*
>
> *The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, every fifth year after the plan becomes subject to this part an updated summary plan description described in section 1022 of this title which integrates all plan amendments made within such five-year period, except that in a case where no amendments have been made to a plan during such five-year period this sentence shall not apply. Notwithstanding the foregoing, the administrator shall furnish to each participant, and to each beneficiary receiving benefits under the plan, the summary plan description described in section 1022 of this title every tenth year after the plan becomes subject to this part. If there is a modification or change described in section 1022(a) of this title (other than a material reduction in covered services or benefits provided in the case of a group health plan (as defined in section 1191b(a)(1) of this title)), a summary description of such modification or change shall be furnished not later than 210 days after the end of the plan year in which the change is adopted to each participant, and to each beneficiary who is receiving benefits under the plan. If there is a modification or change described in section 1022(a) of this title that is a material reduction in covered services or benefits provided under a group health plan (as defined in section 1191b(a)(1) of this title), a summary description of such modification or change shall be furnished to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such*

description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after August 21, 1996, providing alternative mechanisms to delivery by mail through which group health plans (as so defined) may notify participants and beneficiaries of material reductions in covered services or benefits.

(2) The administrator shall make copies of the latest updated summary plan description and the latest annual report and the bargaining agreement, trust agreement, contract, or other instruments under which the plan was established or is operated available for examination by any plan participant or beneficiary in the principal office of the administrator and in such other places as may be necessary to make available all pertinent information to all participants (including such places as the Secretary may prescribe by regulations).

(3) Within 210 days after the close of the fiscal year of the plan, the administrator (other than an administrator of a defined benefit plan to which the requirements of section 1021(f) of this title applies) [1] shall furnish to each participant, and to each beneficiary receiving benefits under the plan, a copy of the statements and schedules, for such fiscal year, described in subparagraphs (A) and (B) of section 1023(b)(3) of this title and such other material (including the percentage determined under section 1023(d)(11) of this title) as is necessary to fairly summarize the latest annual report.

(4) The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary,[2] plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence.

(5) Identification and basic plan information and actuarial information included in the annual report for any plan year shall be filed with the Secretary in an electronic format which accommodates display on the Internet, in accordance with regulations which shall be prescribed by the Secretary. The Secretary shall provide for display of such information

> *included in the annual report, within 90 days after the date of the filing of the annual report, on an Internet website maintained by the Secretary and other appropriate media. Such information shall also be displayed on any Intranet website maintained by the plan sponsor (or by the plan administrator on behalf of the plan sponsor) for the purpose of communicating with employees and not the public, in accordance with regulations which shall be prescribed by the Secretary.*
>
> *(c) Statement of rights. The Secretary may by regulation require that the administrator of any employee benefit plan furnish to each participant and to each beneficiary receiving benefits under the plan a statement of the rights of participants and beneficiaries under this subchapter.*

There is no way to apply this statutory description of "instruments under which the plan is established" to encompass "processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance abuse disorder benefits." The implementing ERISA regulation likewise cannot be extended (per 29 C.F.R. 2520.104b-1(a)):

> *(a) General disclosure requirements. The administrator of an employee benefit plan covered by Title I of the Act must disclose certain material, including reports, statements, notices, and other documents, to participants, beneficiaries and other specified individuals. Disclosure under Title I of the Act generally takes three forms. First, the plan administrator must, by direct operation of law, furnish certain material to all participants covered under the plan and beneficiaries receiving benefits under the plan (other than beneficiaries under a welfare plan) at stated times or if certain events occur. Second, the plan administrator must furnish certain material to individual participants and beneficiaries upon their request. Third, the plan administrator must make certain material available to participants and beneficiaries for inspection at reasonable times and places.*

The final rule implementing the MHPAEA does not impose any disclosure obligations beyond those contained in the MHPAEA itself with respect to "medical necessity criteria." Rather, the final rule states "provisions of other applicable law" exist independently of the MHPAEA and independently of the final rule compelling the disclosure of the processes for formulating "medical necessity criteria" or of the efforts of group health plans and health insurance issuers to ensure "plans" or "coverage" are in compliance with the MHPAEA. Those statements are not true. So neither the MHPAEA nor ERISA, nor any ERISA regulation, compel the disclosures described, but not compelled, in the final rule implementing MHPAEA.

The 21st Century Cures Act also does not implement any new disclosure requirements beyond what is required under the MHPAEA and ERISA. 'Cures' requires the regulatory agencies to create a "guidance document." With respect to disclosures, the "guidance document"—something less than a regulation—must contain "examples illustrating requirements for information disclosures" (per Section 13001(a) of 'Cures,' amending 42 USC 300gg-26(a)). Under Section 13001(a) of 'Cures,' no new requirements for disclosures are added to existing law. Rather, 'Cures' requires "examples" of current "information disclosures." The current "information disclosures" are those related to "medical necessity criteria."

We reiterate that 'Cures' describes the "disclosures" to be contained in the "guidance document" by reference only to existing law:

> *(B) Disclosure*
>
> > *(i) Guidance for plans and issuers. The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use for disclosing information to ensure compliance with the requirements under this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, (and any regulations promulgated pursuant to such sections, as applicable).*
> >
> > *(ii) Documents for participants, beneficiaries, contracting providers, or authorized representatives. The guidance issued under this paragraph shall include clarifying information and illustrative examples of methods that group health plans and health insurance issuers offering group or individual health insurance coverage may use to provide any participant, beneficiary, contracting provider, or authorized representative, as applicable, with documents containing information that the health plans or issuers are required to disclose to participants, beneficiaries, contracting providers, or authorized representatives to ensure compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, or section 9812 of the Internal Revenue Code of 1986, as applicable, compliance with any regulation issued pursuant to such respective section, or compliance with any other applicable law or regulation. Such guidance shall include information that is comparative in nature with respect to—*

> *(I) nonquantitative treatment limitations for both medical and surgical benefits and mental health and substance use disorder benefits;*
>
> *(II) the processes, strategies, evidentiary standards, and other factors used to apply the limitations described in subclause (I); and,*
>
> *(III) the application of the limitations described in subclause (I) to ensure that such limitations are applied in parity with respect to both medical and surgical benefits and mental health and substance use disorder benefits.*

Section 712 of ERISA is the MHPAEA, as is Section 9812 of the Internal Revenue Code. So nothing in this text of 'Cures' imposes a new disclosure requirement beyond what has already been described herein. The "guidance document" is what Congress in 'Cures' affirmed must contain the "comparative information" described in the three Roman numerals of this section of the Act. The Act does not require the "disclosures" to contain such "comparative information." With regard to the draft model disclosure request form, Magellan contends 'Cures' has been misinterpreted to suggest imposition of "disclosure" obligations on group health plans and health insurance issuers that do not exist under current law or regulation.

Magellan's Recommendation: **Magellan requests the Departments forego the Draft Model Non-Quantitative Treatment Limitations Form. Congress through 'Cures' referenced "Warning Signs – Plan or Policy NQTLs that Require Additional Analysis to Determine Mental Health Parity Compliance," jointly published by the DOL and HHS, as informing the 2016 law.[4] This publication is devoid of any discussion of "disclosures" required under the MHPAEA. Thus, as reflected earlier in our comments, we see no basis in law for the Departments to conclude 'Cures' imposes any new disclosure obligations on group health plans and health insurance issuers. We also believe there is no legal support for the issuance of the draft model disclosure request form the Departments have promulgated.**

4. U.S. Departments of Labor and of Health and Human Services, *Warning Signs – Plan or Policy NQTLs that Require Additional Analysis to Determine Mental Health Parity Compliance* (June 1, 2016), https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf.

Magellan HEALTH

Comments on the Draft Model Non-Quantitative Treatment Limitations Form

We recognize parity continues to pose complexities for stakeholders, including both enrollees and health plans or health insurance issuers. Magellan continues to assist our customers and health plan clients in the understanding and interpretation of MHPAEA requirements and to support compliance with both the financial requirements as well as the NQTLs components. We have created meaningful resources supporting parity's interpretation, which has supported successful compliance efforts. Recognizing the need for tailored information on parity, we have conducted proactive educational webinars for our health plan clients in addition to supporting their implementation of parity. We also participate regularly in meetings with other health plans, state and federal regulators, professional organizations (e.g., American Psychiatric Association), advocacy organizations (e.g., National Alliance on Mental Illness), and our trade association partners to ensure relevant experiences and concerns are shared with decision makers and stakeholders as parity continues to be implemented.

We appreciate the Departments' continuing efforts to provide guidance on implementation of the MHPAEA and to support greater awareness, education, and compliance among health plans and health insurance issuers. Central to success in this regard is the broad accessibility, usefulness, and relevance of additional guidance issued by the Departments and enhancements to existing parity tools. While we reiterate our view that the Draft Model Non-Quantitative Treatment Limitations Form is neither necessary nor required by law, should the Departments proceed with utilizing such a form, Magellan strongly recommends it remain optional and not preclude other ways health plans and health insurance issuers have met MHPAEA disclosure requirements.

If the intent of the Draft Model Non-Quantitative Treatment Limitations Form is to facilitate consumer ease of access to the information of greatest interest and usefulness as they review decisions denying MH/SUD benefits, ensuring the resultant model form is consumer-friendly and aligns with actual consumer interests, needs, and experiences are paramount. In our experience, Magellan has never had a single member request for the information contained, as we list below, in items numbered three and four of the draft model disclosure request form despite our significant number of members receiving MH/SUD services. Further, the information in items numbered two through four of the draft model disclosure request form is information that would be both clinically and legally complex, providing no benefit to the member. Such information is likely to create a significant volume having the potential not only to overwhelm the member but, more importantly, detract from the information noted in item numbered one—information which is what, in our experience, the member is interested in. Should the Departments proceed with a model form, the Departments and the draft form may benefit from direct engagement, inquiry, and use testing by consumers themselves (or another

direct mechanism for incorporating individual and family feedback), particularly on the content of the model form, to ensure the consumer perspective and their needs are reflected in the end result. The consumer perspective and usefulness, given the intent of the model disclosure request form, should be top-of-mind as they are the ones intended to complete the model form and whom presumably it is intended to serve.

Magellan's Recommendation: **Magellan requests the Departments forego the Draft Model Non-Quantitative Treatment Limitations Form. Should the Departments decide to move ahead with the Draft Model Non-Quantitative Treatment Limitations Form, Magellan recommends the following modifications – specifically, the omission of items numbered two through four – in addition to our aforementioned recommendations on consumer-use testing and/or the direct incorporation of the consumer perspective in the model form. Magellan encloses herein a red-lined version of the draft model disclosure request form incorporating the specified modifications recommended, which include:**

- **Improve readability of the form by adjusting its reading level to the average consumer, potentially through application of Medicaid or Medicaid-like reading-level standards. As proposed, the reading level is much too high for the average consumer and, if as the Departments suggest the form could be used with states' Medicaid programs (as the expressed intent of the Medicaid parity regulations is to align with the commercial regulations wherever possible), most states have a required reading level of between the fourth and the sixth grade;**

- **Provide an electronic version to expand accessibility and ease for consumers;**

- **Promulgation of model forms specific to ERISA-governed plans, individual and small group, Medicaid managed care, etc., to appropriately account for and reflect nuances unique to health plan type;**

- **Within the draft model disclosure request form itself, under "Background," the following in-text changes:**
    - **Deleting "regarding" between the words "insurer" and "limitations" in the first sentence of the first paragraph;**
    - **Changing "denial of your" in the second sentence of the first paragraph to "a decision denying mental health or substance use disorder;"**
    - **Deleting "by law" and "and the information will help you determine if the coverage you are receiving complies with the law" in the third sentence of the first paragraph;**

- **Deleting the entire second sentence of the second paragraph; and,**
- **Deleting the entire second sentence of the third paragraph.**

- **Within the draft model disclosure request form, under "Instructions," deleting "your" between the words "why" and "mental" in the first sentence of the first paragraph;**

- **Within the draft model disclosure request form itself, on Pages 3 or 4 (as denoted):**
  - **On Page 3, allowing the form to be completed by an authorized representative does not indicate the health plan or insurance issuer will need additional documentation on this status prior to sharing information with the named individual. We recommend language be added noting plans will require documentation of this authorized-representative relationship;**
  - **On Page 3, under "(Check all that apply)," deleting "that my doctor recommends" of the fourth bullet;**
  - **On Page 4, deleting "prescription drug formulary design" between the words "plan's" and "will" of the second bullet and changing "plan's" to "plan";**
  - **On Page 4, deleting "mental health and/or substance use disorder-related" between the words "my" and "treatment of the third bullet;**
  - **On Page 4, deleting the fourth bullet in full as the calculation of payment for out-of-network services is not a reason a member's claim would be denied, which is what the model disclosure request form's proposed checklist is asking the individual to check off;**
  - **On Page 4, deleting "Because my health coverage is subject to the parity protections, coverage limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. Therefore, for" and replacing with "For;" and,**
  - **On Page 4, deleting items 2, 3, and 4 for the following reasons:**
    - **In Magellan's experience, participants and enrollees seek a copy of the criteria for the specific service they are requesting (i.e., item 1), versus item 2 -- the factors used in the development of the limitation and the evidentiary standards used to evaluate the factors – is likely to result in voluminous and lengthy documents written in terms and language not easily understood and not directly relevant – in the eyes of consumers – to their immediate need;**

- **The meaning of item 3 regarding the methods and analysis used in the development of the limitation is unclear and, to reiterate, in our experience, has not been requested by consumers (i.e., participants, enrollees, or members); and,**
- **Regarding item 4's evidence to establish the limitation is not applied more stringently to MH/SUD than to medical/surgical benefits seem redundant. Providing the specific plan language in item 1 and identifying the medical/surgical and MH/SUD benefits to which it applies should be sufficient and responsive to consumers' needs and interests.**

Magellan appreciates this opportunity to respond to the notice and to comment on a Draft Model Non-Quantitative Treatment Limitations Form, particularly as the Internal Revenue Service assesses the potential impact of this proposed revision of information collection request and the Departments consider further opportunities to ensure comprehensive, high quality, and fully integrated access to MH/SUD benefits in the most equitable, efficient, and effective manner possible. We believe strongly in the potential of an expanded, focused, and stakeholder-inclusive dialogue to increase awareness of the protections parity provides and improve understanding of parity's requirements, and look forward to future opportunities to share further our experiences and insights.

We appreciate your consideration of our comments. Should you have any questions or wish to discuss our comments, please contact Brian Coyne, vice president of federal affairs, at (202) 437-0678 or bcoyne@magellanhealth.com; or, Claire Wulf Winiarek, senior director of public policy, at (860) 507-1918 or cwulfwiniarek@magellanhealth.com.

Sincerely,

Meredith A. Delk, Ph.D., MSW
Senior Vice President, Government Affairs

Enclosure (1)

(OMB Control Number 1210-0138)
Expiration Date XX/XX/20XX

FORM TO REQUEST DOCUMENTATION FROM AN EMPLOYER-SPONSORED HEALTH PLAN OR AN INSURER CONCERNING TREATMENT LIMITATIONS

Background: This is a tool to help you request information from your employer-sponsored health plan or your insurer ~~regarding~~ limitations that may affect your mental health or substance use disorder benefits. You can use this form to request general information about coverage limitations or specific information about limitations that may have resulted in ~~denial of your~~ benefits. Your plan is required ~~by law~~ to provide you this information in certain instances~~, and the information will help you determine if the coverage you are receiving complies with the law~~.

Under a federal law called the Mental Health Parity and Addiction Equity Act, many health plans must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. ~~This generally means that coverage limits applied to mental health and substance use disorder benefits can't be more restrictive than the coverage limits applied to medical and surgical benefits.~~ In other words, coverage limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements – such as deductibles, copayments, coinsurance, or out-of-pocket limits;
- Treatment limits– such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

If you, a family member, or someone you are representing obtains health coverage through a private employer health plan, federal law requires the plan to provide certain plan documents about your benefits, including coverage limitations on your benefits, at your request. ~~For example, you may want to obtain documentation as to why your health plan is requiring pre-authorization for visits to a therapist before it will cover the visits.~~ Generally, the plan must provide the documents you request within thirty (30) calendar days of the plan's receipt of your request.

This form will help you request information from your plan about treatment limits. Many common types of treatment limits are listed on this form. If the type of treatment limit being imposed by your plan is not on the list, you may insert a description of the treatment limit you would like more information about under "Other."

Instructions:

Complete the attached form to request general information from your plan about coverage limitations or specific information about why ~~your~~ mental health or substance use disorder

benefits were denied. This information can help you appeal a claim denial. You do not have to use this form to request information from your plan.

If you have any questions about this form and you are enrolled in a private employer health plan, you may visit the Employee Benefits Security Administration's (EBSA's) Website at www.dol.gov/ebsa for answers to common questions about your private employer health plan. You may also contact EBSA electronically at www.askebsa.dol.gov or call toll free 1-866-444-3272.

You can also use this form if you are enrolled in coverage other than through a private employer health plan, for example if you have individual health coverage or coverage sponsored by a public sector employer, like a city or state government. You may contact the Centers for Medicare & Medicaid Services at phig@cms.hhs.gov or 1-877-267-2323 ext. 6-1565 for questions about your individual health coverage or public sector health plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1210-0138, which expires on XX XX, 20XX. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, gather the necessary data, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0138.

[Insert Date]

Mental Health and Substance Use Disorder Parity Disclosure Request

To: _____ [*Insert name of the health plan or issuer]*

(If you are a provider or another representative who is authorized to request information for the individual enrolled in the plan, complete this section.)

I am an authorized representative requesting information for the following individual enrolled in the plan:

(Check the box to indicate whether your request is for general information or specific information related to your claim or denial for benefits.)

General Information Request

- ☐ I am requesting information on the plan's limitations related to coverage for:
  - ☐ Mental health and substance use disorder benefits, generally.
  - ☐ The following specific condition or disorder: _____.

Claim/Denial Information Request

- ☐ I was notified that a claim for coverage of _____ [*Insert mental health condition or substance use disorder*] was, or may be, denied or restricted for the following reason[s]:

  (Check all that apply)

  - o I was advised that the treatment was not medically necessary.
  - o I was advised that the treatment was experimental or investigational.
  - o The plan requires authorization before it will cover the treatment.
  - o The plan is requiring me to try a treatment that is lower in cost before authorizing the treatment ~~that my doctor recommends~~.

- o The plan will not authorize any more treatments based on the fact that I failed to complete a prior course of treatment.

- o The plan's ~~prescription drug formulary design~~ will not cover the medication my doctor is prescribing.

- o My plan covers my mental health or substance use disorder treatment, but does not have any reasonably accessible in-network providers for my ~~mental health and/or substance use disorder related~~ treatment.

- o ~~I am not sure the methods my plan uses to calculate payment for out-of-network services, such as its methods for determining usual, customary and reasonable charges, complies with parity protections.~~

- o Other: *(Specify basis for denial of, limitation on, or reduction in coverage)*:
  _____
  _____
  _____

~~Because my health coverage is subject to the parity protections, coverage limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. Therefore, for~~ the limitations or terms of the benefit plan specified above, within thirty (30) calendar days of the date of this request, I request that the plan:

1. Provide the specific plan language regarding the limitation and identify all of the medical/surgical and mental health and substance use disorder benefits to which it applies in the relevant benefit classification;

~~2. Identify the factors used in the development of the limitation and the evidentiary standards used to evaluate the factors;~~

~~3. Identify the methods and analysis used in the development of the limitation; and~~

~~4. Provide any evidence to establish that the limitation is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.~~

_____

Printed Name of Individual Enrolled in the Plan or his or her Authorized Representative

_____

Signature of Individual Enrolled in the Plan or his or her Authorized Representative

_____

Member Number (*number assigned to the enrolled individual by the Plan)*

_____

Address

_____

Date