AMERICAN BENEFITS COUNCIL

June 22, 2018

Filed electronically via E-OHPSCA-FAQ39@dol.gov

U.S. Department of Labor
Employee Benefits Security Administration
Office of Health Plan Standards and Compliance Assistance
200 Constitution Avenue, N.W.
Washington, DC 20210
Attn: MHPAEA Proposed FAQs Comments

RE: Comments on Proposed FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act

Dear Sir or Madam,

I write on behalf of the American Benefits Council ("Council") to provide comment in connection with the FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act published on April 23, 2018, by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments). We understand from the request for comments that a response submitted to one Department will be shared with the other Departments.

The "Council" is a national nonprofit organization dedicated to protecting and fostering privately sponsored employee benefit plans. The Council's approximately 425 members are primarily large multistate U.S. employers that provide employee benefits to active and retired workers and their families. The Council's membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council's members either directly sponsor or provide services to retirement and health plans covering virtually all Americans who participate in employer-sponsored benefit programs.

Our members strongly believe in the value of mental health and substance use disorder ("MH/SUD") benefits for employees. As key stakeholders directly impacted by mental health and substance use disorder parity requirements, we are committed to working with the Departments in developing reasonable guidance for the provision of MH/SUD benefits provided by group health plans.

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The Departments are specifically soliciting comments on several proposed FAQs regarding the Mental Health Parity and Addiction Equity Act ("MHPAEA"). The Council appreciates the Departments' emphasis on assisting plans and issuers that are working to comply with the law's requirements and the Departments' understanding that additional compliance information is needed.

The Council takes this opportunity to respond to the following issues addressed by the proposed FAQs provided by the Departments:

- Non-quantitative treatment limitations ("NQTLs") (FAQs # 2-10)
- ERISA disclosure for MH/SUD benefits (FAQs #11-12)

FAQS ON NQTLS (FAQS # 2-10)

First, as a general point, only some of the NQTL FAQs fully outline the NQTL analysis, for example providing that "unless the plan can demonstrate that evidentiary standards or other factors were utilized comparably to develop and apply the differing [NQTL] requirements for these MH/SUD and medical and surgical benefits, this NQTL does not comply with MHPAEA." *See* FAQ #6. We encourage the Departments to include this language in all the NQTL FAQ answers. Otherwise, readers could misinterpret the FAQs as indicating that a particular NQTL is a *per se* violation of MHPAEA, instead of understanding that a particular NQTL only violates MHPAEA if any processes, strategies, evidentiary standards, or other factors considered by the plan in implementing the NQTL are not comparable to and applied more stringently to mental health and substance use disorder ("MH/SUD") benefits as compared to medical and surgical ("M/S") benefits.

FAQs #2 and #3 discuss plan exclusions for treatment that is experimental or investigational. The Departments should clarify that plans continue to have the discretion and flexibility to define the standards for experimental and investigational treatment in their plan and plan documents, as long as any processes, strategies, evidentiary standards, or other factors considered by the plan in implementing the NQTL (in these examples, the exclusion for treatment that is experimental or investigational) are comparable to and applied no more stringently to MH/SUD benefits as compared to M/S benefits, and that the FAQs are only providing examples of non-compliant practices. We encourage the Departments to make clear that the main point of these FAQs is to remind stakeholders that both plan documents and plan practices are reviewed for MHPAEA compliance.

FAQ #5 provides that an exclusion for all benefits for a particular condition or disorder is not a treatment limitation for purposes of the definition of treatment

limitations in the MHPAEA regulations. The Council supports the Departments' affirmation that, under MHPAEA, a group health plan may contain a general exclusion to treat a certain condition.

FAQ #7, describing the NQTL: provider admission to participate in a network, including provider reimbursement, states that plan terms violate MHPAEA if they include reimbursement rates that are "generally the same for physicians and non-physician practitioners" for M/S benefits but provide "reduced reimbursement rates for non-physician practitioners" for MH/SUD disorder benefits. The FAQ explains this answer by stating that the plan is not using a "comparable process with respect to reimbursement of non-physician providers of medical/surgical services." This FAQ oversimplifies the NQTL analysis for provider reimbursement, and we are concerned that stakeholders will interpret this FAQ as concluding that plans may not have reimbursement rates that differ between MH/SUD benefits and M/S services. The Departments should clarify that a plan only violates MHPAEA where it cannot *demonstrate* that the processes, strategies, evidentiary standards, or other factors considered by the plan in implementing the NQTL are comparable to and applied no more stringently to MH/SUD benefits as compared to M/S benefits.

FAQ #8 provides that a plan provision that is not actually a limitation must be analyzed under the NQTL rule. The FAQ includes an example in which a plan meets the applicable network adequacy standards for both M/S and MH/SUD. Additionally, the plan ensures that patients will have access to in-network M/S benefits for non-urgent care within 15 days—but the plan does not use a similar standard relating to the availability of appointments for its MH/SUD provider network. The FAQ states that this plan design violates MHPAEA. We are concerned that this FAQ creates MHPAEA liability, even though there is no limitation on MH/SUD benefits. We therefore encourage the Departments to clarify how additional access time guarantees, beyond those required by the network adequacy standards, function as limitations on benefits. Furthermore, we request the Departments clarify that different outcomes do not necessarily indicate a failure of a comparable process considered by the plan in implementing the NQTL. Our understanding of the example is that the plan in question places no access assurance on MH/SUD services; instead, it simply includes a provision providing for quicker than required access to M/S benefits. Presumably, the plan is capable of providing that quicker access because it has a robust provider network for these services. But it may not be possible for a plan to provide equally quick access to MH/SUD services. A plan's ability to offer a particular access assurance is directly related to the number of providers that are available to provide the necessary treatment. The availability of appropriate providers may be limited for many reasons that are outside of the plan's control. The FAQ appears to premise the example plan's failure to comply with MHPAEA on the plan's failure to analyze the availability of MH/SUD providers in the first instance. The Departments should clarify that *if* a plan actually considers waiting times – and thus uses the same process for MH/SUD benefits as for M/S benefits – then the plan would be permitted to have a benefit provision ensuring access to in-network providers within a certain timeframe for either – but not necessarily

both – types of services, depending on provider availability. As the FAQ currently reads, we are concerned that some readers will interpret it as preventing any discrepancy in access time between MH/SUD and M/S services, and thus preventing plans from offering any uneven access guarantees, even where the process that was used for provider admission to a network was comparable and no more stringent for MH/SUD benefits.

FAQ #10 describes how plans should analyze whether an acute, emergency condition that is physical in nature should be viewed under MHPAEA, if the emergency condition arises as a complication of a MH/SUD condition. While this FAQ is helpful for clarifying that treatment for an individual with a physical condition, with a coexisting MH/SUD condition, is not subject to MHPAEA for the treatment of such physical condition, Departments should clarify that the same analysis would apply in any setting. The FAQ specifically discusses services in an emergency room setting, but arguably this same analysis would apply in any setting for any service that meets the definition of M/S or MH/SUD services.

ERISA DISCLOSURE FOR MH/SUD BENEFITS FAQS (FAQS #11-12)

As a general point, the Department of Labor should clarify that it is not creating new ERISA disclosure requirements with these ERISA disclosure for MH/SUD benefits FAQs (i.e., FAQs #11 and #12), and these FAQs are only intended to reinforce existing law, and do not create new MHPAEA disclosure requirements. Additionally, the Departments should clarify that these FAQs do not create additional MHPAEA liability, and that these requirements are controlled by existing ERISA SPD requirements.

FAQ #11 provides that an out of date provider directory for an ERISA-covered group health plan that utilizes a provider network and provides a provider directory with its summary plan description ("SPD") does not meet the Department of Labor's SPD regulations. This FAQ also provides that in the case of a change to an ERISA-covered plan's provider network, the plan must disclose a summary of material modification consistent with the regulations. The Department of Labor should clarify their expectation regarding summaries of material modifications ("SMMs") and changes to provider networks. A change to a provider in the network is not necessarily a change adopted by the plan and, therefore, it is unclear how the timing requirements of the SMM rules should be applied to such changes. Additionally, depending on the Department of Labor's intent, the requirement to provide a disclosure whenever there is a change to the provider directory could be onerous on plan sponsors.

FAQ #12 provides that ERISA-covered plans may provide a hyperlink or URL address in enrollment and plan summary materials for a provider directory if the disclosure meets the Department of Labor's electronic disclosure safe harbor requirements. The Department of Labor should clarify that it is not creating a new ERISA disclosure requirement with this FAQ, and only intending to reinforce existing law. The

Department of Labor should also clarify the Department's intent relating to satisfying the electronic disclosure rules if a plan includes a link to the provider directory in the SPD. Depending on the Department of Labor's intent, this requirement could be onerous on plan sponsors that provide paper copies of SPDs that include links to the provider directory in the SPD.

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Thank you for the opportunity to share our views and for the continued dialogue. If you have any questions or would like to discuss these comments further, please contact us at (202) 289-6700.

Sincerely,

Kathryn Wilber
Senior Counsel, Health Policy