

June 22, 2018

U.S. Department of Health and Human Services  
200 Independence Ave., NW  
Washington, DC 20201

U.S. Department of Labor  
200 Constitution Ave., NW  
Washington, DC 20210

U.S. Department of Treasury  
1500 Pennsylvania Ave., NW  
Washington, DC 20220

Submitted Electronically to: [E-OHPSCA-FAQ39@dol.gov](mailto:E-OHPSCA-FAQ39@dol.gov)

RE: Proposed FAQs About Mental Health and Substance Use Disorder Parity  
Revised MHPAEA Draft Disclosure Template  
2018 MHPAEA Self Compliance Tool

Dear Sir or Madam:

UnitedHealth Group (UHG) is pleased to respond to three documents addressing issues with respect to implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA):

- Proposed FAQs About Mental Health and Substance Use Disorder (MH/SUD) Parity Implementation and the 21<sup>st</sup> Century Cures Act Part XX published by the Departments of Health and Human Services, Labor, and the Treasury (the “Tri-Agencies”).
- Revised Draft MHPAEA Disclosure Template released by the Tri-Agencies.<sup>1</sup>
- 2018 MHPAEA Self Compliance Tool developed by the Department of Labor (DOL).

UHG is dedicated to helping people live healthier lives and making our nation's health care system work better for everyone through two distinct business platforms – UnitedHealthcare, our health benefits business, and Optum, our health services business. Our workforce of 285,000 people serves the health care needs of nearly 140 million people worldwide, funding and arranging health care on behalf of individuals, employers, and the government. As America’s most diversified health and well-being company, we not only serve many of the country’s most respected employers, we are also the nation’s largest Medicare health plan – serving nearly one in five seniors nationwide – and one of the largest Medicaid health plans, supporting underserved communities in 28 States and the District of Columbia.

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<sup>1</sup> UHG is also filing comment regarding the Disclosure Template with the Office of Management and Budget in a separate submission in response to a Request for Comments from the Department of Labor (85 Fed. Reg. 19299, May 2, 2018).

As a recognized leader in the health and well-being industry, we strive to improve the quality and effectiveness of health care for all Americans, enhance access to health benefits, create products and services that make health care more affordable, and use technology to make the health care system easier to navigate. It is this experience that is the basis upon which we offer the following comments.

## **Question 2: Applied Behavioral Analysis (ABA) Therapy**

UHG supports the analysis in the proposed FAQ. However, while ABA is an appropriate treatment in many cases, the guidance may inadvertently leave the impression that it is always required. As a result, we suggest that the answer be revised to clarify that the plan's approach does not comply with MHPAEA because the plan applies the Non Quantitative Treatment Limit (NQTL) more stringently to mental health benefits than to medical/surgical benefits. We suggest modifying the language as shown in italics below.

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*The plan's administration of mental health benefits in operation is not permissible because the plan applies the NQTL more stringently to mental health benefits than to medical/surgical benefits. A medical management standard limiting . . . .*

*. . . . the requisite number of randomized controlled trials supports the use of ABA therapy to treat children with Autism Spectrum Disorder. Accordingly, because the plan applies the NQTL more stringently to mental health benefits than to medical/surgical benefits, the plan's exclusion of mental health benefits as experimental that meet professionally recognized treatment guidelines and the requisite number of randomized controlled trials for medical surgical benefits does not comply with MHPAEA.*

## **Question 4: Dosage Limits**

The proposed answer to this FAQ addresses two separate issues: (1) how dosage limits should be viewed in the context of parity and (2) the appropriate role for pharmacy and therapeutics (P&T) committees. To ensure clarity, UHG recommends that the guidance be divided into two FAQs addressing each issue separately.

## **Question 6: Step Therapy Requirements**

We believe the guidance question and answer may be misunderstood to state that step therapy and other appropriate medical management approaches are *per se* violations of MHPAEA if they are applied differently between medical/surgical conditions and behavioral health/substance use disorder conditions. The question and answer should be revised to state that if the plan or insurer documents that it has applied the same or less stringent processes, strategies, evidentiary standards or other factors with respect to a behavioral health/substance use disorder NQTL as compared to a NQTL for a medical surgical condition, then the plan or insurer has not violated the MHPAEA.

## **Question 7: Provider Reimbursement Rates**

UHG believes the question and answer could cause additional confusion in the market place. The draft answer states that "While a plan is not required to pay identical provider reimbursement rates for medical/surgical and MH/SUD providers . . . ." We would suggest stating this more clearly and affirmatively as follows:

The MHPAEA does not require reimbursement rates to be the same. A plan is only required to demonstrate that the methodology for developing and applying the

reimbursement rates under the plan is comparable and applied no more stringently for MH/SUD benefits when compared to the methodology for developing and applying reimbursement rates for medical/surgical benefits under the plan.

In addition, it should be noted in the answer that the actual rates may be impacted by external factors outside the terms and limits of the plan, such as the provider's negotiation on the rates.

Finally, the proposed FAQ should be revised because the assumptions in the question are not carried through in the analysis of the answer and explained clearly. The question plainly articulates that the plan documents discuss the use of a provider's required training, licensure, and experience as factors in determining reimbursement rates. However, the FAQ goes on to state that the rates determined using these factors are "generally the same for physicians and non-physicians" which contradicts the earlier statement about how the factors are applied since physicians and non-physicians by definition will have distinct and separate required training, licensure, and experience that would result in differences in the rate of reimbursement paid.

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### **Question 8: Network Adequacy Standards**

As currently written, the proposed FAQ is confusing and should be revised. In the FAQ, network adequacy is not defined. Additionally, network adequacy is not a plan limit on the scope or duration of benefits and thus not an NQTL. The manner in which the scenario is presented is contradictory and it is unclear what the hypothetical plan's network adequacy standards are and how the plan has applied them.

The proposed FAQ references network adequacy without defining the term which could be demonstrated by a number of metrics such as the ratio of providers to members, number of providers within a geographic area, and the time needed to obtain an appointment. These requirements are more properly defined as network access standards which is what the FAQ seems to reference when it states that the plan uses "(s)tate and federal network adequacy standards." These requirements are more properly labeled as network access and composition standards as "adequacy" is a subjective descriptor of an end result of plan terms, conditions, and processes not a plan term, condition, process or limitation itself.

As a result, network adequacy is not an NQTL but a subjective outcome judgement or conclusion that could be shaped by various plan NQTLs such as network admission standards or provider reimbursement methodology. We note that network adequacy is also influenced by external factors that are not defined as limits on the scope or duration of benefits set by a plan such as workforce shortage and treatment supply and demand issues (e.g., the opioid crisis has vastly increased demand for treatment without there being a corresponding expansion of the supply of addiction treatment specialists).

Even if "network adequacy" is defined as an NQTL, the proposed FAQ fails to describe a scenario that is a MHPAEA violation. The FAQ presents a scenario where the plan has defined its methodology for network access as one which "meets applicable State and federal network adequacy standards for MH/SUD services" and "exceeds State and federal network adequacy standards by attempting to ensure that participants . . . can schedule an appointment within 15 days for non-urgent care . . ." This scenario assumes the plan has applied a consistent set of medical and behavioral standards (e.g., both meet "State and federal network adequacy standards") and the medical standard includes an additional provision for ensuring appointment access. However, this service provision – that it attempts to ensure an appointment within a specified timeframe -- does not limit the scope or duration of benefits under the plan. Rather, the provision merely articulates a standard for quality of service by the plan. Since that

provision does not act as a limit on the scope or duration of benefits it cannot be considered a NQTL as that term is defined under the MHPAEA rules.

Accordingly, we would recommend the FAQ should be deleted or revised to more clearly address the network access standards of a plan in a way that: (1) emphasizes actual NQTL network access standards; (2) presents a scenario that demonstrates that the experience of a member with access to services does not constitute a parity issue or MHPAEA violation; and (3) presents the scenario in two forms – one where the variation of certain factual variables in the analysis results in MHPAEA compliance and one where it does not.

#### **Question 10: Emergency Room Care**

The proposed FAQ creates ambiguity and unacceptable variability as to when a given treatment or service is considered a MH/SUD benefit or a medical/surgical benefit. The proposed analysis is impractical as it means that for purposes of plan design a given service could be both a medical/surgical benefit and a MH/SUD benefit which creates an uncertainty that does not allow plans to effectively design and administer benefits in compliance with MHPAEA and may result in violations of other federal law.

We agree with the statement in the FAQ that if, “a plan treats all lacerations as a medical condition, if a participant with a mental health condition or substance use disorder seeks emergency treatment for lacerations, the emergency treatment for the lacerations would be medical/surgical benefits for purposes of MHPAEA.” In most situations it is possible to clearly tie treatments to underlying conditions and determine if they are medical/surgical benefits or benefits for behavioral health. A problem may arise, however, with respect to a limited number of treatments that may be provided in the context of both medical/surgical and behavioral health conditions.

A prime example is a patient going to a physical therapist for treatment and having a copayment that varies based on whether that physical therapy is part of their treatment plan for an autism spectrum disorder or a knee injury. No one understands or expects physical therapy to be considered a mental health service or treats physical therapists as behavioral health providers. However, under the construct suggested in the proposed FAQ, a patient seeing the physical therapist on Monday due to their autism treatment plan might have different copay than on Tuesday when they get the exact same service from the same provider for a dislocated knee. This result is untenable and impractical for all stakeholders and does not advance the cause of parity.

The agencies should consider as a potential approach the guidance recently issued by the Centers for Medicare & Medicaid Services (CMS) in connection with the provision of Long Term Services and Supports (LTSS).<sup>2</sup> Specifically, in FAQ4, CMS recognized the need for plans to be able establish plan designs including plan features that would include quantitative treatment limitations, financial requirements, and non-quantitative treatment limitations without regard to whether in a specific instance the service was a medical/surgical or MH/SUD benefit:

A variety of LTSS benefits, such as personal care and respite care, could be defined as either MH/SUD or medical/surgical (M/S), depending on the condition of the beneficiary being treated. For these benefits, the state may define the benefit as MH/SUD or M/S for the entire beneficiary population using a reasonable method, such as whether the service is most commonly or frequently provided due to a MH/SUD or M/S condition. For example, if more than 50% of spending on personal care is for beneficiaries who are receiving the service due to M/S

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<sup>2</sup> Centers for Medicare & Medicaid Services, *Frequently Asked Questions: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP*, October 11, 2017.

conditions, the state may reasonably define personal care services as a M/S benefit for the purposes of the parity analysis.

UHG recommends that the guidance be clarified to indicate that a plan or insurer may use any reasonable method to determine if a service is most commonly or frequently provided due to a medical/surgical condition or a behavioral health/substance use disorder condition, in situations where the treatments may be provided in connection with both medical/surgical conditions and behavioral health/substance use disorder conditions.

#### **Question 11: Provider Directory Maintenance**

This proposed FAQ is inappropriately drafted, internally contradictory, and misapplies the current law and regulations on this topic. We believe the FAQ requires material revision as noted below.

The proposed answer implies that “(t)he list of providers *in that SPD* must . . . .” (emphasis added). However, in the previous sentence the FAQ correctly notes that the SPD need only contain “a general description of the provider network.” We recommend revising the sentence to read: “The list of providers, whether set forth in the SPD or separately, must be up-to-date, accurate and complete (using reasonable efforts).” This revised language should be moved to follow the next sentence which begins “The list may be provided . . . .”

In addition, the FAQ’s proposed response, including reference to the standard for a summary of material modifications, is misplaced. The updating of directory information for network providers (e.g. change to a telephone number, address change or specialty information), which may include a significant number of changes, does not rise to the level of a material modification of an ERISA plan to which 29 CFR §2520.104(b)-3(a) refers and we believe this reference and language should be omitted from the FAQ entirely.

Finally, the proposed FAQ presents a scenario where “the entire directory is out-of-date and inaccurate.” The use of an impossible (or at the very least extremely unlikely) scenario in an FAQ does not provide clear or suitable guidance to stakeholders. If the goal of the FAQ is to provide guidance with respect to a plan’s obligation to deliver a current and accurate provider directory, we suggest issuing guidance specifically reviewing the statutory and regulatory requirements of group health plans to furnish provider directory information or an FAQ which sets forth an actual example of a provider directory issue a consumer may confront and how the applicable law and regulations address such a scenario. For example, an FAQ might present a scenario where a plan participant finds an entry for their provider is inaccurate and the FAQ might address whether or not the existence of an inaccurate entry in the plan’s provider directory is a violation of ERISA law and regulations and under what circumstances it would or would not be a violation.

#### **Question 12: Provider Directory Links**

The proposed FAQ contains guidance which is consistent with existing ERISA law and regulations, but with one material issue of concern. The proposed FAQ suggests that a plan may use an SPD with a link to an electronic on-line version of a provider directory only if the requirements of the electronic disclosure safe harbor under ERISA regulations are met. This implication causes concern as it is our understanding this would allow such disclosure only in cases of recipients of the SPD (with the embedded link) that have access to the internet as part of their day-to-day job functions or provide specific consent. This would mean that for many plans where plan participants work in roles which do not involve internet access as a job function/capability would have to receive a hard copy provider directory unless they affirmatively agree to receive the electronic disclosure.

This seems inconsistent with current best practice for provider directories which are almost exclusively provided in on-line forms (with print forms being available upon request) given the ubiquity of the internet and the ease of updating and maintain current timely and accurate information in this media (as compared to print directories). Accordingly, we would recommend the guidance permit the use of a link to an on-line directory in the SPD without the need for an affirmatively agreement to receive electronic disclosure by plan participants.

### **Revised Draft Model Parity Disclosure Request Form**

UHG continues to support the comments we submitted in September 2017 on the draft form to request documentation from an Employer-Sponsored Health Plan or an Insurer concerning treatment limitations.<sup>3</sup> In our letter we stated that the use of a model disclosure form may have some utility for individuals in limited circumstances. We noted, however, a few issues with such an approach for the tri-agencies to consider. We believe that a disclosure form should: (1) be optional not mandatory; (2) not duplicate existing disclosure forms and processes; and (3) be streamlined and as consumer-friendly as possible for all stakeholders. With respect to the first item, the Departments have indicated the form is intended as a model and not a mandatory form and we support this approach.

UHG suggests that the recently released draft form should be revised to thoroughly explain or correct the following:

- That, in addition to contacting the Department of Health and Human Services, Department of Labor or state insurance department, individuals should first reach out to their group health plan or insurer for information about what is covered and how treatment or financial limits may be applied.
- Plans and insurers have separate procedures for handling appeals of benefit or claim denials. The individual should follow those procedures when filing an appeal or requesting documentation from the plan or insurer related to the appeal.
- The role of designated representatives and that plans and insurers may ask the individual to specifically designate their representative (in part, to protect the privacy rights of the individual) should be addressed within the instructions.
- Plans and insurers have 30 days from the date they receive the form to respond, not 30 days from the date written on the form as is currently indicated on the draft form.

### **Self-Compliance Tool for the Mental Health Parity and Addition Equity Act (MHPAEA)**

This tool was not included in the formal request for comment however was released contemporaneously with the proposed FAQs and the Revised Draft Model Parity Disclosure Request Form. Accordingly we believe it is appropriate to provide feedback on this document as well.

As a preliminary matter, this self-compliance tool establishes details regarding parity compliance and the process to assess compliance including some specific illustrations and interpretative discussions of the application of MHPAEA that appear to constitute new guidance and material which we believe should be subject to formal public review and comment. Therefore, we would urge the agencies to publish the compliance tool and any subsequent revisions of this tool for formal public review and comment.

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<sup>3</sup> UnitedHealth Group letter in response to the Tri-Agency Request for Comments – FAQs About Mental Health & Substance Use Disorder Parity Implementation & the 21st Century Cures Act Part 38 (September 12, 2017).

Secondly, the overall design of the tool lacks utility for stakeholders to assess compliance with MHPAEA because the construction of the tool is based on questions which simply ask for yes and no conclusions as to compliance rather than asking questions or providing a framework to establish the facts and evidence that would establish compliance. In order to be useful to stakeholders to be able to assess MHPAEA compliance the tool would require questions that establish certain factual information that then would be assessed to reach the conclusions not simply ask questions that call for Yes/No answers.

Finally, the self-compliance tool discussions in Section F regarding NQTLs seems to establish a step by step process for assessment of the treatment limitation that goes to a level of detail beyond the standard contemplated in the regulations. Specifically Step Four on page 16 of the tool discusses the comparability, and no more stringent application, of the various processes, strategies, and evidentiary standards associated with an NQTL rather than the comparability of the NQTL itself. In other words, while the regulations require the comparability and no more stringent application of the NQTL as a whole, the tool seems to require a more exacting and detailed comparison of each of an NQTL's component parts which is a materially different and more stringent requirement than what is set forth in the regulations. This approach implies a standard that is not about "comparability" but more about an exacting comparison requiring that each element of the NQTL, such as each factor, process, strategy or evidentiary standard used must be not just similar or comparable but exactly the same when compared between medical/surgical and mental health/substance use disorders. This is beyond the scope of the regulations and a material deviation from the original intent of MHPAEA. Accordingly we believe the NQTL assessment framework in Section F should be revised to allow for the assessment of the NQTL as a whole and not an exacting comparison of its various parts in order to be consistent with, and maintain the flexibility of, the comparability standard set forth in the regulations.

Thank you for the opportunity to comment. Please feel free to contact us if you have any questions.

Sincerely,

A handwritten signature in blue ink that reads "Martha R. Temple". The signature is written in a cursive, flowing style.

Martha R. Temple  
CEO Optum Behavioral Health