From:	Adrienne Ellis
To:	E-OHPSCA-FAQ.ebsa
Subject:	MHPAEA Transparency comments
Date:	Wednesday, January 08, 2014 6:15:42 PM
Attachments:	MHAMD MHPAEA Tranparency Comments.pdf

Attached please find requested comments related to the Mental Health Parity and Addiction Equity Act Final Rule and transparency and disclosure requirements.

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January 8, 2014

Ms. Phyllis Borzi
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20001

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
7500 Security Blvd
Baltimore, MD 21244

Dear Secretary Borzi and Administrator Tavenner:

The Maryland Parity Project of the Mental Health Association of Maryland is pleased to provide comments in response to the Departments' request on "what additional steps, consistent with the statute, should be taken to ensure compliance with MHPAEA through health plan transparency, including what other disclosure requirements would provide more transparency to participants, beneficiaries, enrollees, and providers, especially with respect to individual market insurance, non-Federal governmental plans, and church plans."

The Maryland Parity Project was created in 2010 through the use of private foundation funds to educate consumers and providers of their rights under the Mental Health Parity and Addiction Equity Act (MHPAEA), as well as to assist them in filing appeals and complaints of suspected violations. To date, the project has assisted more than 150 individuals with questions or concerns about their health insurance and accessing mental health benefits, including filing many complaints on behalf of consumers and providers.

Current Disclosure Requirements in the Mental Health Parity and Addiction Equity Act (MHPAEA), Employee Retirement Income Security Act (ERISA) and Affordable Care Act (ACA) are Essential to Making Health Coverage Work for Individuals with Mental Health and Addictive Disorders

Transparency regarding insurer policies, procedures, and criteria used to manage care is critical to the ability of MHPAEA to achieve its promise of nondiscriminatory access to care for individuals with mental health and substance use disorders. Given that most patients do not fully understand how their health insurance works until they get sick and try to use it, there is a continuing need for transparency in coverage disclosure to allow individuals to avoid the frustration and complexities in managing their health coverage. For those with mental illness, the need for simple transparent explanations of their rights and benefits is even greater.

MHPAEA and its Interim Final Rule (IFR) included two specific disclosure requirements on health plans and issuers – that medical necessity criteria must be provided to current or potential plan participants, beneficiaries or participating providers upon request and the reason for denials of reimbursement or coverage or payment for services with respect to mental health or substance use disorders (MH/SUD) must be made available upon request or as otherwise required to the participant or beneficiary. Although the intent of the provisions is to allow plan participants, beneficiaries and treating providers to make informed choices about what health plan works best for them and to understand how their plan operates in practice, it remains difficult to understand whether a plan complies with the non-quantitative treatment limits (NQTLs) provisions of MHPAEA without information showing if the "processes, strategies, evidentiary standards and other factors" used in applying an NQTL on MH/SUD benefits and medical/surgical benefits are comparable – without this comparability analysis it is difficult for plan participants to ensure MHPAEA compliance. While we are pleased that the MHPAEA Final Rule and accompanying Frequently Asked Questions (FAQs) reaffirm and clarify that plans and issuers must not only comply with the transparency and disclosure

requirements in MHPAEA but also the relevant transparency and disclosure requirements in ERISA and the ACA, future guidance must also explicitly require issuers and plans to provide this comparability analysis to participants and their authorized representatives upon request. Without this analysis requirement, the onus of MHPAEA compliance is on the consumers and providers to suss out the potential violations in practice, which often does not become apparent until it has become a barrier to accessing care.

In 2011 an insurer in Maryland decided to implement a new prior authorization policy for outpatient mental health visits. The insurer would authorize only the first 9 outpatient mental health visits no matter the illness or severity. After the initial 9 visits, the insurer would review the treatment plans and authorize up to 5 more visits. This process would then repeat after every 5 visits. Nowhere in the evidence of coverage was this process detailed, nor were enrollees alerted to this change. After several written requests for plan documents necessary to test the compliance of this policy, it became apparent that insurer had not done the requisite analysis of this new policy to be sure it met the "comparable and no more stringent" standard of MHPAEA. Insurers often institute similar authorization procedures for inpatient stays for mental illness. It is common for the insurer to approve only the first few days of the stay no matter the initial request of the treating physician, requiring hospital staff, and often the treating provider, to seek authorization for additional days. This often results in the insurer approving on additional day at a time- wasting valuable hospital resources and clinicians time, as they need to repeat the time-consuming authorization process daily. To date, we have been unable to get an insurer to provide appropriate documentation in order to facilitate a parity compliance analysis of this process.

ERISA Disclosure Requirements Provide the Framework for Equitable Application of MHPAEA Disclosure and Transparency Requirements for All Plans but Greater Clarity on Definition of "Plan Instrument" is Needed

Section 104 of ERISA and accompanying implementing regulations require that plans subject to ERISA must provide plan participants instruments under which the plan is established or operated within 30 days of request. Plan instruments include, but are not limited to, medical necessity criteria for both medical/surgical and MH/SUD benefits as well as the processes, strategies, evidentiary standards and other factors used to apply an NQTL with respect to medical/surgical and MH/SUD benefits under the plan. While the Coalition is pleased the Departments referenced these requirements in the MHPAEA Final Rule, additional regulatory guidance and/or FAQs are needed to clarify what documents are included in the definition of "plan instrument" and clarify that these ERISA Section 104 disclosure protections, while not required for non-ERISA beneficiaries, would be helpful for all plan participants and beneficiaries.

RECOMMENDATIONS

1. **Issue additional NQTL guidance**. The Departments should require plans, issuers and claims administrators to provide additional guidance in the following areas:

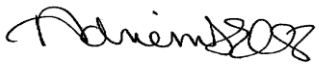
- Clarify that plans must provide the NQTL comparability analysis upon request to plan participants and authorized representatives;
- A description of any NQTLs that the plan has authorized for MH/SUD services within the relevant classification (in- or out-of-network, in- or outpatient) to the claim. This should include the exact written reference to such within the plan documents (as distinguished from an administrator's clinical guidelines) as well as documentary evidence;
- A description of any NQTLs that the plan, insurer or claims administrator believes have been used in any given MH/SUD service adverse benefit determination (ABD) within the relevant classification;

- A description of any NQTL constituent factors (medical management, evidentiary standards, burdens of proof) that the plan has authorized for MH/SUD services within the relevant classification to the claim. This should also include the exact written reference to such within the plan documents (as distinguished from an administrator's clinical guidelines) as well as documentary evidence;
- A description of any NQTL constituent factors that the insurer or claims administrator believes have been used in any given MH/SUD service AND within the relevant classification;
- A description of the NQTLs and NQTL constituent factors that the plan has authorized for use with respect to each medical/surgical service within the same classification as the MH/SUD claim. This should also include the exact written reference to such within the plan documents (as distinguished from an administrator's clinical guidelines) as well as documentary evidence; and
- A description of the NQTLs and NQTL constituent factors that the plan, insurer or claims administrator believes are used with respect to each medical/surgical service within the same classification as the MH/SUD claim. Thus, insurers and claims administrators should be required to post on their websites ALL medical necessity guidelines for medical/surgical procedures broken down by in- and outpatient categories.

2. **Apply ACA, ERISA and MHPAEA transparency and disclosure protections to individual market, non-Federal governmental and church plans**. Because disclosure and transparency protections in the ACA, ERISA and MHPAEA work together to allow participants to understand how health coverage actually works, how and when to access coverage and how to utilize appeals rights, these protections should apply to those who receive their coverage through the individual market, non-Federal governmental plans and church plans. Although statutory constraints currently exist, there is no health policy justification for excluding classes of individuals from these transparency and disclosure protections. The Departments should issue additional guidance that encourages voluntary application of ACA, ERISA and MHPAEA disclosure protections to the individual market, non-Federal governmental and church plans.

Thank you for your time and attention to these comments. If you have any questions or would like more information about our experience assisting consumers in filing complaints, please contact Adrienne Ellis aellis@mhamd.org or 443-901-1150 ext. 206.

Sincerely



Adrienne Ellis
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