ABHW

Advancing Health Care Policy
for Mental Health and Addiction

May 3, 2019

Laurie Brimmer
Internal Revenue Service
Room 6526
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Draft Model Disclosure Request Form Comments
(OMB Number: 1545–2165)

Dear Ms. Brimmer,

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to comment on the Internal Revenue Service's (IRS's) Notice and Request for Comments on information collection activities related to the draft model disclosure request form that will be issued to meet the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people in both the public and private sectors to treat mental health, substance use disorders (SUDs), and other behaviors that impact health and wellness.

ABHW reviewed the Notice and Request for Comments, the revised draft Model Form to Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations (model form) issued on April 23, 2018, and the accompanying Supporting Statement also issued in April 2018.[1]

[1] Model form available at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template-draft-revised.pdf; "Supporting Statements for Paperwork Reduction Act of 1995 Submissions," OMB Control No. 1210-0138 (April 2018), available at https://www.reginfo.gov/public/do/DownloadDocument?objectID=74490300.

We have the following recommendations:

- Eliminate the "general information request" from the model form because it exceeds disclosure requirements in current law. Also eliminate the checkbox list of potential bases for the claim denial on the model form. The checkbox list could create confusion among enrollees and is extraneous to the disclosure request as the plan or issuer already knows why an individual's claim was denied. Instead provide two checkbox options for each of the two specific disclosures required under MHPAEA.
- The IRS should estimate the burden on plans and issuers. The estimated burden only considers the authorized representatives who would initially complete and submit the form but does not contemplate the burden imposed on plans and issuers.
- Eliminate the request for plans or issuers to "[i]dentify the factors used in the development of the limitation" and "the evidentiary standards used to evaluate the factors" from the model form. These requests could cause confusion among enrollees.
- Instead of requiring plans to identify all medical/surgical and mental health/substance use disorder (MH/SUD) benefits to which the limitation at issue applies, limit the request to identifying categories of services used in the plan's classification approach. This will help prevent confusion and is the information an enrollee would need to assess parity.
- Add a statement to the model form that the completion and submission of the form does not represent a request to appeal a denial and the disclosure process does not substitute for filing an appeal.
- Make the language regarding the 30-day timeline for plans or issuers to respond consistent, preferably using the language in the background section of the model form which allows plans to return the form within 30 calendar days of receipt of a request.

Our detailed comments on the questions set forth in the Notice and Request for Comments are as follows:

(a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information has practical utility.

ABHW member companies are fully committed to complying with all MHPAEA requirements; however, the model form goes beyond what is required under law. As currently drafted, the model form creates new disclosure obligations to which

plans and issuers must adhere. The broadly drafted disclosure form subjects plans and issuers to a "general information request" beyond the two disclosures under MHPAEA which are 1) "The criteria for medical necessity determinations made under the group health plan with respect to MH/SUD benefits;" and 2) "The reason for any denial under the group health plan (or health insurance coverage offered in connection with such plan) of reimbursement or payment for services with respect to MH/SUD benefits."[2] The general information request is not only broader than the MHPAEA-required disclosures, it is also more expansive than disclosure rules under the Employee Retirement Income Security Act (ERISA).[3] The form's creation of a new disclosure obligation for release of general information exceeds disclosure requirements in current law, subverting congressional intent as to the scope of mandated disclosure in this area. Therefore, the general information request should be eliminated.

(b) The accuracy of the agency's estimate of the burden of the collection of information.

Requiring plans and issuers to supply enrollees with general information about the plan will impose an administrative burden for plan and issuers at a time when the Administration has committed to lowering the level of administrative burden on businesses. In the IRS's Notice and Request for Comments, the estimated burden mirrors the estimate of the burden in the Supporting Statement from April 2018. In question 12 of the Supporting Statement for this model form, the Department of Labor, Department of Health and Human Services, and Department of Treasury (the Departments) estimated the burden associated with completing the form but did not sufficiently capture the burden on plans and issuers. The Supporting Statement includes only the burden on authorized representatives who would initially complete and submit the form but does not contemplate the burden imposed on plans and issuers who must create such disclosures and then must respond to the information requests. Both the

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[2] Public Health Service Act Sec. 2726(a)(4) (42 U.S.C. 300gg–26(a)(4)); 45 C.F.R. 146.136(d).

[3] The summary plan description includes information on: cost-sharing provisions; any annual or lifetime limits; coverage of preventive services, existing and new drugs, and medical tests, devices and procedures; rules on use of network providers, the makeup of the provider network and rules on its use; coverage for out-of-network services; conditions or limits on the selection of primary care providers or medical specialists; conditions or limits on emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan. 29 C.F.R. §2520.102-3(j)(3).

Paperwork Reduction Act and Office of Management and Budget rules require agencies to estimate the burdens imposed by information collection requests.[4] We believe that the vast majority of the burden associated with such disclosures has fallen, or will fall, on plans and issuers. Thus, the IRS's and the Supporting Statement's calculation is insufficient to contemplate the actual burden resulting from use of the form.

The model form does not identify the requisite disclosure being requested, but rather, enables the enrollee to request the broadest range of information that may be available without necessarily understanding the nature of those materials. Similarly, based on this form, a plan or issuer has no way of assessing the quantity or usefulness of materials being sought, from the perspective of a layman's review. The form seems to imply that there is no limit to the size and scope of information requests to which plans and issuers must respond because the form allows for enrollees to request information not associated with a particular treatment or condition. As mentioned above, MHPAEA sets forth two required disclosures – the criteria for medical necessity determinations for MH/SUD services and the reasons for denial of a MH/SUD benefit. Applicable guidance from the Departments does not currently require inclusion of the specific information requested under the form as part of MHPAEA disclosures. Should this model form be finalized, it would require plans and issuers to create customized disclosures based upon the language describing the general information request and the demands of the requesting enrollee, rather than applicable statutes and regulations. In sum, the burden and costs associated with an undefined disclosure obligation is not evaluated, is unknown, and may be immense. The IRS should estimate the burden on plans and issuers.

(c) Ways to enhance the quality, utility, and clarity of the information to be collected; and (d) Ways to minimize the burden of the collection of information on or other forms of information technology.

Several aspects of the form will likely lead to confusion both for the enrollee as well as the plans and issuers. Use of the checkbox list of potential bases for the claim denial on pages 1-2 of the model form will invite enrollee confusion and may end up also confusing the plan or issuer as they try to clarify what the enrollee writes on the form versus the actual basis for a denial that had previously been communicated to the enrollee. In fact, the enrollee's checking off the basis for the denial is extraneous to the disclosure request as the plan or issuer already has this information. We recommend striking the "check box" format as to the

[4] 5 CFR §1320.8.

basis for any denial to avoid enrollee confusion. We believe the form should provide two checkbox options for each of the two specific disclosures required under MHPAEA, and remove all other information, including the general information request as stated above. We believe this would greatly simplify the form, help promote an understanding of MHPAEA's express disclosure requirements, improve the disclosure process, help improve compliance overall, and decrease administrative burden and cost.

Another aspect that could lead to confusion is the request for plans or issuers to "[i]dentify the factors used in the development of the limitation" and "the evidentiary standards used to evaluate the factors" on page two of the model form. There is no guidance from the Departments on what types of information this sentence would require, or what documents specifically an enrollee should expect in response. Moreover, this may be too complex for enrollees to understand. The Departments claim that the aim of the form is "to simplify the process of requesting relevant disclosures for patients and their authorized representatives," but using language that enrollees may not understand does not simplify the process.[5] Also, the list of information requested may lead enrollees to believe they are entitled to categories of information that may not exist or may force the plan or issuer to develop materials specifically to fulfill disclosure requests. To the extent that enrollees do not receive all of the listed categories of information, they may incorrectly believe the plan is not in compliance with MHPAEA. This should also be eliminated from the form.

The form further asks plans or issuers to identify all of the medical/surgical and MH/SUD benefits to which the limitation at issue applies in the relevant benefit classification. This could require an extensive list of benefits that we do not believe would be useful to the enrollee in assessing parity compliance. Rather, we recommend limiting the request to identifying categories of services as those are used in the plan or issuer's classification approach, as this is the information an enrollee would need to assess parity. We also note that the form is about medical necessity information, but the form does not ask for this information.

Enrollees may also believe completion of the form constitutes filing an appeal with the plan. Although ERISA requires disclosure of relevant documents subject to an appeal, a pre-appeal disclosure process does not exist under MHPAEA. The model form indicates the enrollee has access to the summary plan description

[5] "Supporting Statements for Paperwork Reduction Act of 1995 Submissions," OMB Control No. 1210-0138 (April 2018), available at https://www.reginfo.gov/public/do/DownloadDocument?objectID=74490300.

(SPD), the denial notice, medical necessity criteria, and documents on the plan establishment or operation, thus effectively creating a pre-appeal grievance process when that is not required under law. ERISA allows the enrollee to request relevant documents in the context of an appeal, but we do not believe that is the legal authority the form relies on with respect to the disclosure requirements. A statement could be added to the model form to clarify that the completion and submission of the form does not represent a request to appeal a denial and the disclosure process does not substitute for filing an appeal.

Finally, as a matter of internal consistency, the language regarding the 30-day timeline for plans or issuers to respond differs as stated in the background section and page two of the form. We recommend making the language consistent, preferably using the language in the background section which allows plans to return the form within 30 calendar days of receipt of a request.

(e) Estimates of start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Plans and issuers will likely experience an increase in the number of information requests when the model form is finalized. This could require costs such as investment in technology, increased employees, and new systems. If the IRS estimated the burden on plans and issuers, it could examine these costs.

Thank you for the opportunity to comment on the Notice and Request for Comments and the model form. Please feel free to contact Kate Romanow, Director of Regulatory Affairs, at romanow@abhw.org or (202) 449-7659 with any questions.

Sincerely,

Pamela Greenberg

Pamela Greenberg, MPP
President and CEO