ABHW

Advancing Health Care Policy
for Mental Health and Addiction

August 8, 2018

Via Electronic Mail (Petra Wallace - pwallace@naic.org)
Director Bruce R. Ramge
Nebraska Department of Insurance
941 O Street, Suite 400
Lincoln, NE 68508

Re: Mental Health Parity Guidance

Dear Director Ramge,

I am writing to you today in your capacity as Chair of the Market Conduct Exam Standards (D) Working Group of the National Association of Insurance Commissioners (NAIC) to comment on the July 9th, 2018 draft Mental Health Parity Guidance on behalf of the Association for Behavioral Health and Wellness (ABHW).

ABHW is the leading association working to advance federal policy on mental health and addiction services. Founded in 1994, ABHW is dedicated to shifting the paradigm in treatment and policies for mental health and addiction to ensure access to quality care, improve overall health outcomes, and advance solutions for public health challenges. Our members include top national and regional health plans that care for more than 175 million people in both the public and private sectors.

For the last two decades, ABHW has supported mental health and addiction parity. We were an original member of the Coalition for Fairness in Mental Illness Coverage (Fairness Coalition), a coalition developed to win equitable coverage of mental health treatment. ABHW

served as the Chair of the Fairness Coalition in the four years prior to passage of the Mental Health Parity and Addiction Equity Act (MHPAEA). We were closely involved in the writing of the Senate legislation and actively participated in the negotiations of the final bill that became law.

We appreciate the Working Group's efforts to drive consistent interpretation and enforcement of MHPAEA across states. Currently, our members encounter little uniformity in this area and this is extremely problematic for health plans that operate in multiple states.

Before delving into our comments we want to point out an inaccuracy on page one of attachment three of the NAIC draft parity document, it states "An insurer violates MHPAEA if it imposes higher treatment limitations on mental health or substance use disorder benefits, compared to the treatment limitations for medical and surgical benefits." While this may be true in most situations, it is not necessarily true 100 percent of the time and such a statement can mislead a state's interpretation of the law. According to FAQs issued by the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the Departments), "the general rule is that a plan may not impose a financial requirement or quantitative treatment limitation applicable to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative limitation of that type applied to substantially all medical/surgical benefits in the same classification." This is an important point as there could be times where treatment limitations vary between a medical service and a behavioral health service and the plan would not be in violation of parity. We request that you clarify the statement "an insurer violates MHPAEA if it imposes higher treatment limitations on mental health or substance use disorder benefits, compared to the treatment limitations for medical and surgical benefits" to reflect the predominant and substantially all test required by MHPAEA.

Our specific comments are focused on questions nine and ten in your draft guidance and are detailed below. In addition to considering our remarks, we encourage you to wait to finalize your approach in these two

areas until the guidance issued by the Departments on April 23rd, 2018, is finalized in order to help ensure consistency in the interpretation and expectations for compliance.

Question Nine:

The draft NAIC guidance directs reviewers to pages 14-20 of the DOL Self-Compliance Tool for MHPAEA (Compliance Tool). The nonquantitative treatment limit (NQTL) analysis provided in the revised Compliance Tool changes the analysis as described in federal MHPAEA regulation by introducing a new requirement not referenced in the law, regulatory text, or previous parity guidance. We propose NAIC include in their guidance that an NQTL analysis needs to be consistent with the final rule, which does not require that a specific process, strategy, and/or evidentiary standard be used in applying an NQTL.

Background

The Compliance Tool's four-step analysis is to:

1. Identify the NQTL.
2. Identify the factors the plan or issuer considered in the design of the NQTL.
3. Identify the sources (including any processes, strategies, and evidentiary standards) used to define the factors identified in Step 2 to design the NQTL, including any threshold at which each factor will implicate the NQTL.
4. Evaluate whether the processes, strategies, and evidentiary standards used in applying the NQTL are comparable and no more stringently applied to mental health/substance use disorder (MH/SUD) than to medical/surgical benefits.

In Steps 2 and 3, the Departments erroneously separate out "processes, strategies and evidentiary standards" from their equivalent "factors" used in applying the NQTL. In addition, in Step 3, the Departments go on to introduce the term "source" and categorize the processes, strategies and evidentiary standards as sources, rather than factors, as they are

identified in the regulatory text.

Instead of bringing clarity to the NQTL analysis as required by the 21st Century Cures Act, the Departments have added further complexity to the process in their articulation of Step 2 and Step 3 of the analysis defined in the Compliance Tool. Plans and issuers have no context and no resources to reference in clarifying how to interpret the meaning of "source" because it has not previously been used or defined in the parity regulation or associated guidance. It is also not clear how a "source" in Step 3 differs from a "factor" in Step 2 or whether the Departments are making an intentional distinction between these terms by included them in two separate steps.

The tool appears to suggest that there needs to be a process, strategy, and/or evidentiary standard for each factor. In contrast, the final rule requires that compliance be weighed against the processes, strategies, evidentiary standards or other factors actually used in applying an NQTL. It does not necessarily require an evidentiary standard to be used for each factor or that any specific factor be considered when applying an NQTL.

Question Ten:

The draft NAIC guidance expands the disclosure requirements beyond those in MHPAEA; therefore, we recommend that the NAIC language be amended to clearly articulate the disclosure requirements derived from MHPAEA and to the extent that the requirement to disclose additional documents is noted, we suggest that the notation make clear the source for that requirement.

Background

MHPAEA requires disclosure of: 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.". The draft guidance seems to combine what the law requires to

be disclosed under MHPAEA and the relevant documents individuals may request in the context of an appeal.

A 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). The 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.

Thank you for the opportunity to comment on the Workgroup's draft guidance. If you would like to discuss our letter I can be reached at greeenberg@abhw.org or (202) 449-7660.

Sincerely,

Pamela Greenberg, MPP
President and CEO