ABHW
Advancing Health Care Policy
for Mental Health and Addiction

July 24, 2020

Amber Rivers
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20710

Re: Proposed Updates to the 2020 MHPAEA Self-Compliance Tool

Dear Ms. Rivers,

I am writing on behalf of the Association for Behavioral Health and Wellness (ABHW) to provide comments on the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) Mental Health Parity and Addiction Equity Act (MHPAEA) Self-Compliance Tool.

Background

ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to over 200 million people in both the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness.

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 MHPAEA. We were

closely involved in the writing of the Senate legislation that became MHPAEA, and actively participated in the negotiations of the final bill that became law.

Since the final rule for MHPAEA was issued in 2013, ABHW member companies have worked vigorously to understand and implement the law and its accompanying regulations and guidance. We have had numerous meetings with the regulators to help us better understand the regulatory guidance and to discuss how plans can operationalize the regulations. Our member companies have teams of dozens of people working diligently to implement and provide MHPAEA compliant mental health and substance use disorder (MH/SUD) benefits to consumers.

Overarching Comments

We thank the Departments for their efforts in providing additional guidance interpreting mental health parity provisions of the Public Health Service Act and in trying to ensure implementation that serves to protect individual plan members without excessive burden on health plans and insurers.

We also greatly appreciate the opportunity to provide input on the posted materials, and we request that future rounds of guidance continue to be shared in draft form for public comment prior to their formal promulgation.

The profusion of state parity laws and the diversity of enforcement strategies and interpretations of these laws has created significant challenges for health plans and insurers that seek to create standard processes for achieving and documenting parity compliance. In this context, we appreciate EBSA's leadership in attempting to develop guidance that can provide clarity on common points of ambiguity and that can help to achieve a shared vision for compliance across all regulators, regulated entities, advocates, beneficiaries, and other stakeholders.

In particular, ABHW appreciates the inclusion of additional examples of fully-compliant plan processes, strategies, and evidentiary standards. Specifically, ABHW appreciates the following notes and examples: the notes on the use of clinical experts for pharmacy and therapeutics committees (p. 12); the use of clinical experts to inform the design and application of a preauthorization requirement (p. 25); the identification of internal quality control reports and summaries of research as additional examples of ways to demonstrate comparability (p. 27-28); and, the prior authorization analysis set forth in Illustration 6 (p. 37). Continued collaborative work to further elaborate a

shared vision for compliance will help the health plan and insurance industry to understand and implement the actions needed to ensure full compliance.

ABHW recognizes the need for plans and issuers to have internal compliance plans, as described in new Section H. ABHW members already have these in place, which generally include the key components described in Section H in one form or another. ABHW would welcome the opportunity to collaborate with EBSA on discussions of best practices for internal compliance plans.

In this letter, we offer a variety of specific observations about ways in which the proposed updates are likely to create or perpetuate misunderstandings of the federal parity requirements. We offer relatively minor revisions in many instances that we hope will clarify the proper interpretation and enforcement of parity requirements. We also request the opportunity to engage in continued partnership through listening sessions and other processes to develop further guidance on some of the most important and complex issues of compliance, including provider reimbursement.

The revisions and clarifications that we request are particularly important because the federal parity enforcement structure relies, in large part, on state oversight and enforcement. In the absence of more robust public guidance in this area from the Department of Labor, Department of Health and Human Services, and Department of Treasury (the Departments), state regulators often look to the Compliance Tool for insight in interpreting federal intent when enforcing parity requirements and are often interpreting available guidance more stringently than the Departments themselves. This exacerbates the difficulties in maintaining compliance for our members who operate across multiple states and increases confusion for both plans and issuers as regulators do not interpret nonquantitative treatment limit (NQTL) requirements in a uniform manner. In this context, additional attention to framing and commentary on appropriate interpretation is often useful to avoid the improper use or enforcement of the guidance in this Tool.

One specific example of the utility of greater clarity is that we request that Warning Signs consistently be paired with acknowledgement that disparate results are not determinative of non-compliance and with guidance regarding the appropriate next steps for the analysis. In practice, there is widespread disagreement with regard to the proper interpretation of the meaning of the outcomes identified in the Warning Signs, resulting in extreme cases in regulators disregarding the actual NQTL analysis and simply enforcing the outcomes measure as dispositive evidence of non-compliance. Thus we

recommend that the following definition be added to the definitions page for the Tool:

> ***Warning Sign*** means an indicator that further review of the plan or issuer's compliance documentation may be needed with regard to the specific point addressed in the Warning Sign guidance. Warning Signs are not determinative of a MHPAEA violation, and compliance determinations must be made based on the underlying compliance documentation in accordance with the relevant parity test. For example, a reviewer who is analyzing compliance with a given non-quantitative treatment limit (NQTL) and finds evidence that a plan or issuer's benefits align with a fact pattern described in a Warning Sign must then undertake the full analysis of whether the plan or issuer's processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits in the classification.

Finally, ABHW reiterates concerns that some stakeholders have interpreted the EBSA Self-Compliance Tool to require regulated entities to utilize the 4-step framework for analysis and to not permit the use of comparable tools or frameworks. ABHW requests that the instructions for the Self-Compliance Tool be revised to further emphasize that the federal rules for MHPAEA provide flexibility for plans and issuers to select the most appropriate framework for analysis and to adapt that framework to the plan or issuer's own processes, strategies, evidentiary standards, or other factors used in applying the specific NQTL. We request that this clarification acknowledge that various states now require the use of specific tools or templates, and that plans and issuers have an interest in creating a single reporting format that will be acceptable or most easily adaptable to the broadest possible set of markets and jurisdictions, while still retaining the same fundamental information required by all tools and templates and without compromising the level of detail or rigor of the analysis provided therein.

Specific Comments

We provide herein specific concerns with the Self-Compliance Tool, and we propose revised language where relevant. Please note that these comments are ordered by page number except with regard to comments on the analysis

of provider reimbursement methodologies, which have all been grouped together for convenience in a separate section at the end.

Page 6, Definition for "mental health benefits," Note

The proposed note reads:

> ***NOTE***: If a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits. For example, if a plan defines autism spectrum disorder (ASD) as a mental health condition, it must treat benefits for ASD as mental health benefits. Therefore, for example, any exclusion by the plan for experimental treatment that applies to ASD should be evaluated for compliance as a nonquantitative treatment limitation (NQTL) (and the processes, strategies, evidentiary standards, and other factors used by the plan to determine whether a particular treatment for ASD is experimental, as written and in operation, must be comparable to and no more stringently applied than those used for exclusions of medical/surgical treatments in the same classification).

(1) Concerns regarding the proposed note as written

ABHW appreciates the attempt to provide greater clarification regarding the application of the parity test to benefits for treatments and services that are delivered to treat both MH/SUD and medical/surgical (M/S) conditions.

However, we fail to understand what new information is provided by this proposed note or what misunderstanding is intended to be rectified. The note merely states that NQTLs that are applied to MH/SUD benefits must be analyzed for parity under the NQTL test. To our understanding, this point is wholly uncontroversial and rarely misunderstood.

Of greater concern, we observe that the note creates significant potential for confusion or misinterpretation. Plans generally have a single policy and standards to define "experimental and investigational" (E/I) that apply to all benefits for all treatments and services, regardless of the condition that is being treated. Because these policies apply equally to M/S and MH/SUD benefits, they are by definition comparable and no more stringent as written. Because the note emphasizes that a comparability and stringency analysis of E/I policies "as written" is needed, it creates the potential for regulators and stakeholders to misunderstand that such policies are generally compliant with the "as written" aspect of parity by definition, by virtue of the fact that they are written to apply equally to all benefits for all treatments and services.

If the example is intended to highlight the need to examine the stringency with which the plan's E/I policy is applied "in operation," then facts are needed to demonstrate the ways in which the policy may be applied more stringently to MH/SUD benefits than to M/S benefits. One common point of confusion arises for benefits that are delivered to treat both MH/SUD and M/S conditions. It is important to understand that NQTLs that apply to these benefits are permissible as long as (1) the factors used to determine which benefits are subject to the limit are selected and applied comparably and no more stringently in determining which benefits to apply the limit to, (2) they do not result in the limit being applied only to MH/SUD benefits, and (3) they are applied comparably and no more stringently in determining which claims to apply the limit to. One district court recently applied this reasoning to determine that an exclusion for habilitative (non-restorative) speech therapy that applied regardless of the condition being treated did not violate parity.[1] In the proposed note, if the intent is to describe how the E/I policy has been applied to a treatment or service that is delivered to treat autism spectrum disorder (ASD), then the facts of that example should be explained in order for readers to understand how the E/I policy has or has not been applied "in operation" in compliance with parity. However, any new example should be clearly designed to illustrate a specific principle or clarification, and should be included in Section F or Appendix I as an additional illustration of the NQTL analysis rather than as a note in the Definitions section.

For these reasons, we respectfully request that the proposed note, as drafted, be excluded from the finalized publication of the Self-Compliance Tool.

(2) Recommended revision to the proposed note

One point on which further clarity is greatly needed, due to the relatively high degree of inconsistency of interpretation across federal and state officials, and which perhaps was the intended target of the proposed note, is the application of parity to benefits for treatments and services that are delivered to care for both M/S and MH/SUD conditions.

The MHPAEA regulations state that "*Mental health benefits* means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to

[1] *N.R. v. Raytheon Company et al.*, Civil Action No. 20-cv-10153-RGS (D. Mass., June 9, 2020).

be consistent with generally recognized independent standards of current medical practice."[2] Parallel definitions are provided for SUD benefits and for M/S benefits. Neither the MHPAEA regulations nor any FAQ or other federal guidance directly addresses the proper application of parity to benefits for treatments and services that can be delivered to care for both MH/SUD and M/S conditions.

ABHW understands that the general approach that is currently taken by many regulators is that parity applies to claims for benefits with a primary diagnostic code that has been defined by the plan to be a MH or SUD condition (in accordance with federal and state law and consistent with generally recognized independent standards of current medical practice). Under this interpretation, a benefit for treatments or services that are delivered to treat both MH/SUD and M/S conditions, such as emergency room admissions, must in practice be separated into two separate benefits: M/S emergency room admissions and MH/SUD emergency room admissions. For example, if a plan applies a higher copay to non-emergency use of the emergency room, and that higher copay does not meet the predominant test, then some regulators are determining that the higher copay may not be applied when the non-emergency use of the emergency room is delivered to treat a MH/SUD condition. The practical result of this interpretation is therefore to require that benefits for MH/SUD conditions be more generous than benefits for M/S conditions. We do not believe that this was the intent of the statute or the final rules.

ABHW opposes this interpretation or application of the parity analysis based on diagnosis. The current enforcement approach in which regulators require plans and issuers to redefine their benefits (i.e. to create separate MH/SUD and M/S benefits) contravenes the language of the MHPAEA rules, which offer broad flexibility for plans and issuers to define their benefits under the terms of the plan or coverage (constrained only by federal and state law).[3]

Instead, ABHW asserts that the most reasonable and practical interpretation of the final rules is that benefits "for" MH/SUD conditions are benefits for treatments and services that are generally delivered to treat MH/SUD conditions, and to define all other benefits as M/S benefits. This approach

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[2] 29 CFR 2590.712(a)

[3] The clear deference to plans and issuers to create their own definitions for "MH benefits," "SUD benefits," and "M/S benefits" under the terms of the plan or coverage stands in contrast to the narrow instruction for plans and issuers to use "generally recognized independent standards of medical practice" to define "MH conditions," "SUD conditions," and "M/S conditions."

would align with standard plan and coverage terms as currently designed and set forth in the MH/SUD sections of the standard plan description, plan contract or coverage policy, and related plan or coverage materials, and would align with standard claims processing procedures as currently operated.

This approach would also avoid thorny ontological and epistemological questions about whether primary care and other treatments and services for conditions with complex etiologies—such as a patient with co-morbid schizophrenia, tobacco use disorder, obesity, hyperlipidemia, and chronic obstructive pulmonary disorder—are properly considered to derive from (or be "for") the MH/SUD condition or the M/S condition. We recognize that in theory, providers are already forced to grapple with and resolve these questions in determining what primary diagnosis code to enter for a given claim for reimbursement. However, we note that there is little consistency among providers in how to determine which diagnosis is "primary," to the extent that these data fields are generally acknowledged to be unreliable for research and data analytics purposes. It is unwise to base the parity analysis on such unreliable foundations, especially when the language of the MHPAEA regulations suggest a more straightforward and commonsense solution.

From this perspective, ABHW recommends that the following note be provided in the finalized update to the Self-Compliance Tool:

> ***NOTE***: Plans have flexibility to define MH benefits, SUD benefits, and M/S benefits under the terms of the plan or coverage. For the purposes of the parity analysis, the plan or issuer should determine whether a given treatment or service is covered under a MH benefit, a SUD benefit, or a M/S benefit. Plans and issuers should use reasonable methods to do so, including determining:
> - Whether the treatment or service is most commonly delivered to treat MH/SUD or M/S conditions,
> - Whether the treatment or service is most commonly delivered by MH/SUD or M/S providers, and/or
> - In cases where separate payers or coverage are used for MH/SUD and M/S benefits, whether the treatment or service is most commonly covered by MH/SUD payers or coverage or by M/S payers or coverage.

<u>Page 10, Coverage in all classifications, Note</u>

This proposed note stipulates that if a plan or coverage provides benefits for a specific MH or SUD condition in any classification, then it must provide benefits for that condition in every classification. It states:

> ***"NOTE***: If a plan or coverage excludes all other benefits for a particular mental health condition or substance use disorder, but nevertheless covers formulary prescription drugs for that condition or disorder, the plan would be covering mental health or substance use benefits in one classification (prescription drugs). Therefore, the plan would be required to provide mental health or substance use benefits **with respect to that condition or disorder** for each of the other five classifications for which the plan also provides medical/surgical benefits." (Emphasis added.)

This guidance directly contradicts the regulatory text of the MHPAEA rules, which frame the "coverage in every classification" requirement to apply to MH or SUD benefits generally, and not to benefits for specific MH or SUD conditions. The MHPAEA final rules provide:

> "If a plan (or health insurance coverage) provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), **mental health or substance use disorder benefits** must be provided in every classification in which medical/surgical benefits are provided."

Thus the MHPAEA regulations require that some MH or SUD benefits be offered in every classification in which M/S benefits are offered, but do not stipulate that a specific set of conditions must be covered in each classification, or that benefits must be offered for every non-excluded MH or SUD condition in every classification in which M/S benefits are offered.

We recognize that sub-regulatory guidance on this point was set forth Q4 of the Part 39 FAQ that was finalized in 2019. This FAQ stipulates that "The MHPAEA regulations also provide that if a plan or issuer provides benefits for a mental health condition or substance use disorder, benefits for that condition or disorder must be provided in every classification in which medical/surgical benefits are provided." Nonetheless, we observe that this language was not included in the proposed FAQ (which instead focused on the intersection with coverage requirements for essential health benefits) and was introduced in the final FAQ with no opportunity for public comment. We further observe that the MHPAEA regulations do not in fact provide that the "every classification requirement" be applied at the condition level, and that in fact, as quoted above, the regulations merely require that "mental health or substance use benefits must be provided in every classification in which medical/surgical benefits are provided." FAQ 39 and the current proposed

guidance in the Self-Compliance Tool therefore attempt to create a new benefit mandate via sub-regulatory guidance that is not supported by the regulations.

The distinction is important because many drugs are prescribed to treat a wide variety of different M/S and MH/SUD conditions, and current claims processing information systems frequently do not clearly indicate the specific condition for which each individual drug has been prescribed for a given patient. As previously noted, for a patient with complex health conditions it may be difficult to determine with certainty which condition is the true "primary" diagnosis for which a given treatment or service is being prescribed. The proposed approach to enforcement would therefore create the potential for inadvertent coverage for a prescription drug to treat an excluded condition to operate as a "Trojan horse" to then extend coverage to a wide range of treatments and services for that condition that were not priced into the product's premiums. It would be extremely challenging from an operational perspective for plans and issuers to effectively police their coverage to ensure that no benefits are paid for any drug for an excluded condition.

ABHW therefore finds this specific example to present a particularly troubling focus for enforcement and respectfully requests that this note be removed from the final version of the guidance.

Page 11, Classifying benefits, Note

This proposed note reads:

> "***NOTE***: If a plan covers room and board for inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, both of which the plan classifies as inpatient care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction based on facility type - a treatment limitation - only on MH/SUD benefits and therefore violates MHPAEA. The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment."

ABHW objects to (1) the location of this note within the organization of the Self-Compliance Tool, and (2) the misleading framing of the example as written.

(1) This note is located in the section on classifying benefits, but does not clarify or illustrate a point related to appropriate strategies for classifying benefits.

This note creates the potential for misunderstanding because the interpretive point that it appears to attempt to clarify (regarding the application of the NQTL test to restrictions based on facility type) is not related to the section in which it is located (the requirement to apply consistent criteria to the classification of benefits). Should the note be retained, we request that it be moved to Section F or Appendix I and reframed as an illustration of the NQTL analysis.

In the alternative, the note could be reframed to focus on the proper application of a plan's criteria for classifying benefits. For example, it may be useful to add a note to clarify that if a plan defines the inpatient classification to include all treatments and services that involve a stay of at least 24 hours in a covered facility, then benefits for sub-acute residential treatment services should be classified as inpatient benefits. This example would have the additional benefit of clarifying the commonly-misunderstood point that plans and issuers must generally assign benefits for care in skilled nursing facilities and rehabilitation hospitals for M/S benefits to the same classification as benefits for care in residential treatment facilities for MH/SUD benefits not because these benefits are analogous per se, but because reasonable classification factors will generally result in their being assigned to the same benefit classification.

This clarification would be especially valuable because a wide range of regulators and judicial decisions have misinterpreted this language from the preamble of the final rules and the Self-Compliance Tool to erroneously determine that the parity rules require an identification of and comparison between analogous benefits both for classification purposes and for NQTL analyses.[4] These regulators and judges have failed to understand that the final rules instead require that the MHPAEA regulations require the NQTL analysis to be applied across all M/S benefits in the classification, and not merely to benefits that are argued to be "analogous" to the MH/SUD benefit in question. For example, the first step of the NQTL analysis is generally to identify the strategies, processes, evidentiary standards, and other factors have been used to determine which MH/SUD and M/S benefits within a classification are appropriate to subject to a given limit. A wide range of benefits may meet the

[4] *See, e.g. Welp v. Cigna Health & Life Ins. Co.*, CASE NO. 17-80237-CIV-MIDDLEBROOKS, 13 (S.D. Fla. Jul. 20, 2017) ("a plaintiff must identify the treatments in the medical/surgical arena that are analogous to the sought-after mental health/substance abuse benefit and allege that there is a disparity in their limitation criteria.") Numerous courts have now adopted this test as the pleading standard for parity act violations.

plan or carrier's criteria for applying the limit, many of which may not appear to be "analogous."

(2) This note improperly frames the NQTL analysis by failing to properly specify the criteria used to apply the limit and the benefits to which the limit is applied.

Second, this note creates confusion by (a) inappropriately focusing on a comparison between two specific provider types; (b) failing to acknowledge that plans and issuers may provide coverage for some residential treatment provider types but not others; and (c) failing to acknowledge that plans and issuers have flexibility to define covered benefits, and to apply reasonable factors to determine which treatments and services are covered under a given benefit.

(a) The note may perpetuate or promote the common misunderstanding that the parity analysis requires or permits analogies or comparisons between specific MH/SUD and M/S benefits.

It is unambiguous that the NQTL analysis must be done at the classification level, not between specific M/S and MH/SUD benefits that may be perceived to be analogous. This concept is fundamental to the parity analysis, as it acknowledges that analogies between MH/SUD and M/S benefits are inherently imperfect, given fundamental differences between the nature of MH/SUD and M/S treatments and services.

It is therefore unfortunate that the proposed note calls attention to a specific comparison between coverage for skilled nursing facilities and MH/SUD residential care. This framing may have the effect of promoting the common misconception that the first step of the parity analysis is to attempt to identify M/S benefits that are analogous to the MH/SUD benefit that is being subjected to the limit in question.

(b) Plans and issuers may distinguish among a variety of residential facility types and are not required to provide coverage for all residential facility types.

Plans and issuers typically identify and distinguish among a variety of residential treatment facility types, and frequently exclude coverage for certain facility types based on permissible factors that are applied comparably and no more stringently to MH/SUD benefits relative to M/S benefits.

Coverage is frequently offered for skilled nursing facilities, psychiatric nursing facilities, various types of residential substance use disorder treatment facilities (e.g. which may be identified as ASAM Level of Care 3.1, 3.3, or 3.5, among other distinctions), and other facility types which may be defined with varying degrees of granularity.

In contrast, coverage is frequently excluded for residential treatment in assisted living facilities, halfway houses, wilderness therapy programs, and other facility types that do not meet the plan or issuer's coverage policies. This is permissible as long as the processes, strategies, evidentiary standards, and other factors used to apply the exclusion to these facility types meet the comparability and stringency test. For example, plan or issuer may reasonably determine that the medical evidence does not support residential treatment in wilderness therapy facilities or settings, and therefore that coverage for residential MH/SUD treatments and services in wilderness therapy facilities or settings should be excluded as experimental or investigational.

This proposed note, as written, fails to identify the specific facility type or types to which the exclusion is applied. This creates the potential to perpetuate the common misunderstanding that a benefit for residential MH/SUD treatment means that all residential MH/SUD facility types must be covered. The definitions and coverage policies for different residential treatment facility types vary widely, but it is unambiguous that a wide variety of facility types exist and that plans and issuers have flexibility to distinguish among them.

> *(c) Plans and issuers have flexibility to define covered benefits, and to apply reasonable factors to determine which treatments and services are covered under a given benefit.*

As written, the proposed note appears to imply that if room and board is covered in any inpatient M/S facility, then room and board must be covered in all inpatient MH/SUD facilities.[5] However, just as plans and issuers may exclude coverage for certain facility types as long as the factors used to apply that exclusion meet the comparability and stringency test, plans and issuers

[5] Alternatively, and perhaps more problematically, the proposed note may be read to imply that if room and board is covered in skilled nursing facilities, then room and board must also be covered in residential MH/SUD facilities. As discussed above, this direct analogy would constitute an inappropriate application of the NQTL analysis at the benefit level rather than at the classification level. Nonetheless we are concerned that the proposed framing of the note is ambiguous enough to permit some regulators and other stakeholders to adopt this simplistic and flawed conclusion.

may exclude coverage for specific treatments and services within certain facility types as long as the factors used to apply that exclusion meet the comparability and stringency test.

For example, a plan may exclude coverage for treatments and services in facility types that have not met the licensing and certification requirements to provide such treatments and services under the plan's coverage policy. Just as the parity law allows plans the flexibility to define conditions and classifications, plans are permitted to define the benefits that they offer. Crucially, the parity law does not require a plan or issuer that offers benefits for certain treatments and services that are delivered in residential treatment facilities to offer benefits for all treatments and services that are delivered by residential facilities.

(3) Recommended revisions to the proposed note

ABHW respectfully requests that the example be moved to Section F or Appendix I and revised to specify the facility type in which the residential MH/SUD treatments are delivered. For example, we believe that the following revisions would more clearly demonstrate the proper application of the NQTL analysis:

> ***NOTE***: If a plan covers room and board for all inpatient medical/surgical facility types, and the plan imposes an exclusion of coverage for room and board for psychiatric nursing facilities, the plan imposes an impermissible exclusion based on facility type - a treatment limitation - only on MH/SUD benefits and therefore violates MHPAEA. The plan could come into compliance by covering room and board for psychiatric nursing facilities comparably with coverage for inpatient medical/surgical inpatient facilities or by identifying the criteria used to determine that the coverage exclusion is appropriate for psychiatric nursing facilities and then applying these criteria comparably and no less stringently to determine which inpatient medical/surgical facilities are also appropriate to exclude from coverage for room and board.

Page 11, Medication Assisted Treatment (MAT) is subject to MHPAEA

The proposed guidance would illustrate the uncontroversial point that MAT is subject to MHPAEA with the following proposed language:

> For example, a limitation providing that medication for the treatment of opioid use disorder be contingent upon availability of behavioral or

> psychosocial therapies or services or upon the patient's acceptance of such services would generally be not be permissible in the absence of a comparable process to determine limitations for the treatment of medical/surgical conditions.

ABHW respectfully requests that the example be revised to clarify that a comparable process to determine limitations for the treatment of M/S conditions is almost certain to exist—the specific design and implementation of that process varies widely, but this is the core function of the committees that design coverage policies for virtually every plan and issuer. The relevant determination is whether the evidentiary standard is appropriately identified and applied through this process.

ABHW suggests the following revisions:

> For example, if a coverage limit provides that medication for the treatment of opioid use disorder be contingent upon availability of behavioral or psychosocial therapies or services or upon the patient's acceptance of such services, then the plan or issuer must be able to demonstrate that the evidentiary standards that are used to support the requirement of therapy as an adjunctive therapy to MAT are comparable to the evidentiary standards used to support requirements for adjunctive treatments for covered treatments and services for medical/surgical benefits.

Page 18-19, The "predominant" test, Warning Sign

This proposed guidance states:

> "**Warning Sign**: If a plan or issuer applies a specialist copayment requirement for all MH/SUD benefits within a classification, but applies a specialist copayment only for certain medical/surgical benefits within a classification, this may be indicative of noncompliance and warrant further review."

While we appreciate the caveat that further review is needed to determine compliance, we respectfully assert that in practice, this Warning Sign will trigger scrutiny that will generally be unwarranted. For example, the majority of copay plans apply the "office visit" and "all other" subclassifications within the outpatient benefits classification, and include both primary care office visits and specialist office visits within the office visits subclassification. The majority of copay plans conduct actuarial analyses that demonstrate that the

specialist copay level is the predominant level for M/S office visits. These plans will therefore be fully compliant with parity if they apply the specialist copay level to all MH/SUD benefits in the outpatient office visit classifications.

We also note that the same fact pattern is set forth in both the proposed Warning Sign and the existing "Compliance Tip" that directly follows the new Warning Sign, and that it may cause confusion to set forth the same example as both a Warning Sign and a Compliance Tip.

In the interest of minimizing the enforcement burden on both regulators and plans and issuers, ABHW respectfully requests that this Warning Sign be withdrawn, and that Warning Signs be designed to avoid targeting plan designs that are more likely than not, in fact, to comply with parity.

Page 28, NQTL Analysis Step 4, Warning Sign #2

The proposed Warning Sign reads:

> 2. *Denying all drug screening tests for those with SUD*: A plan or issuer denies all claims for drug screening tests for participants and beneficiaries with a sole diagnosis of addiction because they are treated as not medically necessary. However, the plan or issuer covers drug screening tests when the diagnosis is a medical/surgical condition.

ABHW concurs with the conclusion of this example under the facts provided. However, the analysis may be confusing to readers, given that it conflates the concept of medical necessity (which is typically applied in the context of utilization management) with coverage exclusions (which are applied under a variety of separate NQTLs, including experimental and investigational services and provider credentialing requirements). We also note that this is an extreme example that does not seem realistic of any common plan design or coverage limit, and as a black-and-white example does not seem to add any further clarity or new guidance to the proper application of the NQTL analysis. In the interests of clarity and parsimony, ABHW requests that this proposed Warning Sign be withdrawn.

Page 29, NQTL Analysis Step 4, Warning Sign #3

The proposed Warning Sign reads:

> 3. *Different medical necessity review requirements*: A plan or issuer imposes medical necessity review requirements on outpatient MH/SUD

benefits after a certain number of visits, despite permitting a greater number of visits before requiring any such review for outpatient medical/surgical care.

"Soft limits" as described in this example are an appropriate tool for plans and issuers to manage over-utilization of benefits for which plan experience and/or published literature demonstrates that providers commonly prescribe a greater frequency or intensity of treatment than is medically necessary.

ABHW respectfully submits that it is inappropriate to suggest that the number of visits for any set of different treatments for different conditions provides an appropriate point of comparison. Each limit should be designed to apply to that specific service or treatment, and not as a one-size-fits-all approach to utilization management. For example, the denominator for soft limits for acute conditions is often defined per episode of care, whereas the denominator for soft limits for chronic conditions is often defined per unit of time (e.g. per week, per month, or per year). Thus the units of measurement for these different types of soft limits are inherently incomparable.

In addition, the evidentiary standard for the soft limit may indicate a high frequency of visits for some treatments or services within the identified timeframe and a low frequency of visits for others. Intensities of treatment for different conditions are inherently incomparable. The frequency of counseling that is appropriate for the treatment of a substance use disorder has nothing to do with the frequency of nutritional counseling for obesity. But the evidence bases used to determine the appropriate frequency of counseling for these conditions can be compared. The NQTL analysis should focus solely on the processes, factors, evidentiary standards, and other factors used to design and apply soft limits, and should not attempt a quantitative comparison between inherently disparate factors.

The invalidity of the Warning Sign is demonstrated by its converse: regulators should not determine that a lower quantity of visits for a soft limit on MH/SUD benefit than the quantity applied to soft limits on M/S benefits within the same classification provides a "green light."

ABHW therefore respectfully requests that this proposed Warning Sign be withdrawn.

Page 33, Disclosure Requirements, Note

The existing note in this section states:

> ***NOTE***: Compliance with the disclosure requirements of MHPAEA is not determinative of compliance with any other provision or other applicable Federal or State law. Be sure that the plan or issuer, in addition to these disclosure requirements, is disclosing all information relevant to medical/surgical, mental health, and substance use disorder benefits as required pursuant to other applicable provisions of law.

The proposed draft of the Self-Compliance Tool then cites to the *Wit v. United Behavioral Health* decision to illustrate the point that parity compliance is often inter-related with other regulatory compliance issues. The essential point is uncontroversial, and ABHW certainly understands that compliance with MHPAEA does not ensure compliance with the whole of ERISA or other governing laws. However, ABHW objects to the *Wit* case being set forth as an example of noncompliance, given that this district court decision has not been entered as a final judgment, is currently being appealed, sets forth sweeping new requirements that have not been adopted by any other district, and is not binding on any other district nation-wide. Should the *Wit* decision be overturned, and/or should other courts adopt a different analysis of comparable facts, the Self-Compliance Tool would create conflict and confusion for plans and coverage located in those jurisdictions. ABHW respectfully requests that EBSA not address active litigation through the Parity Self-Compliance Tool, especially with regard to points of law that are not specific to parity.

Provider Reimbursement

Page 22, Nonquantitative Treatment Limitations, Note

ABHW objects to the first note on page 22 and requests that it be removed. The note indicates that the use of Medicare as a source for reference pricing for medical/surgical benefits and a different benchmark fee schedule as a source for reference pricing for MH/SUD benefits is a per se violation of MHPAEA. Specifically, it stipulates:

> "NOTE – To comply with MHPAEA, a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network providers for both medical/surgical and MH/SUD benefits. **For example, if reimbursement rates for medical/surgical benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be**

> **determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule**. Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, and market need or availability (demand) must be applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits." (Emphasis added.)

The position articulated in the second sentence—requiring the plan or issuer to use the same benchmark for both medical/surgical and MH/SUD providers, rather than merely to apply a process or strategy that is comparable and no more stringent—is not supported by any previous interpretation of the MHPAEA statute or regulations, will result in significant market disruptions, and may cause adverse outcomes for individuals suffering from MH/SUD conditions.

Reference price methodologies are used to provide a clear and transparent benchmark for negotiations with providers and to reduce the burden on providers associated with the reimbursement rate negotiation and billing processes. It also allows for the alignment of billing and payment policies across markets. It is common for plans and issuers to use the Medicare Physician Fee Schedule (and Part A prospective payment systems) as benchmarks for rate negotiations for this reason. However, plans and issuers also frequently use other sources for reference prices, including FairHealth and state Medicaid fee schedules. Plans and issuers utilize these other reference price benchmarks for a variety of purposes, including the prevailing practice in a local market, provider requests, and to address gaps in the Medicare benefit for behavioral health services. In many instances, benchmark fee schedules other than Medicare cover more MH/SUD services and/or set reimbursement for MH/SUD services at a higher rate than Medicare. For this reason, even if MHPAEA could be interpreted to require the use of the same benchmark source for reference pricing, doing so could inadvertently result in a reduction in coverage for MH/SUD services.

In this context, it is important and appropriate that MHPAEA does not require that plans or issuers use the exact same strategies, processes, evidentiary standards, or factors for the application of an NQTL type to MH/SUD benefits that are used for the application of the NQTL type to medical/surgical benefits. Plans and issuers are therefore permitted to use different benchmark sources as a starting point for their reimbursement rate-setting methodologies, as long as the strategies, processes, evidentiary standards, and other factors used to select the benchmark source for MH/SUD reimbursement rates in a

classification are comparable to and no more stringent than the strategies, processes, evidentiary standards, and other factors used to select the benchmark source for M/S reimbursement rates in that classification.

Page 23, Nonquantitative Treatment Limitations, Warning Signs

The two proposed Warning Signs on Page 23 provide:

1. Inequitable reimbursement rates established via a comparison to Medicare: A plan or issuer generally pays at or around Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for medical/surgical benefits. For assistance comparing a plan or coverage's reimbursement schedule to Medicare, see the TOOL FOR COMPARING PLAN REIMBURSEMENT RATES TO MEDICARE in Appendix II.

2. Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes: A plan or issuer reimburses psychiatrists, on average, less than medical/surgical physicians for the same E&M codes.

ABHW objects to the location and lack of context for these Warning Signs.

The Warning Signs are presented as a component of the introduction to Section F, without any context or instructions as to the use of the warning signs within the four step process outlined in the tool. These Warning Signs address the use of operational data to assess the "in-operation" compliance of the provider reimbursement NQTL type. As such, they should be included as a component of Step 4 and of Section F rather than in the introduction where they are more likely to be misinterpreted.

MHPAEA regulations are clear that operations measure data are not independently dispositive as to MHPAEA compliance and explicitly state that disparate results do not necessarily indicate non-compliance. There are numerous factors that could result, in a MHPAEA-compliant manner, in the disparities in paid rates described in these Warning Signs. These include market dynamics and market need or availability, both MHPAEA-compliant factors that DOL has acknowledged within these proposed updates to the self-compliance tool. The proposed Warning Signs do not acknowledge this possibility. The inclusion of Warning Signs like those proposed here will likely result in stakeholders, including state regulators, interpreting these Warning Signs as per se MHPAEA violations.

Further, the Warning Signs should be accompanied by text explaining that the analysis of data associated with paid reimbursement rates should be

considered in the context of the analyses performed in Steps 1-3. The text should explicitly state that if the analysis of Steps 1-3 indicates that the provider reimbursement rate methodology NQTL type is comparable and no more stringent in-writing, that paid rate data that are roughly comparable should not be considered as a Warning Sign—in other words, parity does not require equal results. It would be helpful to further clarify that plans and issuers should monitor discrepancies in paid rate data on an ongoing basis and continue to reevaluate the compliance of the processes, strategies, evidentiary standards, and other factors used in developing the reimbursement rate methodology for MHPAEA compliance in-writing.

This balanced approach of in-writing vs. in-operation analysis with the latter serving merely as a true warning sign aligns with MHPAEA regulations and the history of agency guidance. These clarifications will hopefully provide useful direction to regulators and other officials who, in some instances, have erroneously applied Warning Signs to constitute de facto indications of non-compliance, and to effectively disregard the substantive NQTL analysis. Further clarity on the proper interpretation and use of the Warning Signs and other operations measures would greatly enhance the predictability and transparency of the enforcement process. Presenting these Warning Signs as currently drafted and in the misleading location currently proposed, carries great risk of confusion and inappropriate enforcement by regulators and courts.

APPENDIX II: TOOL FOR COMPARING PLAN REIMBURSEMENT RATES TO MEDICARE

ABHW objects to the inclusion and design of the tool for comparing plan reimbursement rates to Medicare. Although ABHW agrees that comparisons of paid rates against Medicare allowed amounts at the classification-level is an operations measure that can be useful in performing Step 4 of the self-compliance tool, the Appendix II is not useful for this purpose as designed and will cause confusion in the market if finalized as drafted. Most importantly, no guidance is provided about how to interpret the data that are collected. For example, how should reviewers interpret the fact that a variety of different categories of provider types are surveyed, including both primary and specialty care and physicians and mid-level providers? How should reviewers interpret the fact that the same CPT codes are surveyed across some of the provider types, but other CPT codes are surveyed for other provider types? How should reviewers interpret reimbursement data for services that are delivered to treat both M/S and MH/SUD conditions? Given the need to accompany any analytic tool with adequate instructions and guidance to

resolve these and other challenging questions of use and interpretation, ABHW recommends retracting the Medicare reimbursement rate tool and reconsidering whether such a uniform tool is necessary. If so, ABHW encourages the Department to engage in a stakeholder engagement process to develop a more nuanced and effective tool and accompanying instructions and guidance.

As a technical matter, we note that the tool does not align with MHPAEA guidance about the identification and classification of benefits, which is necessary for the tool to be used to perform the Step 4 "in-operation" assessment. For example, at minimum the Appendix II Tool should be restructured to reflect that the NQTL analysis must be broken out by classification. Similarly, as previously discussed, plans and carriers have flexibility to define "benefits" for parity purposes, and any analytic Tool must indicate the benefits that are being compared. Notably, most plans and carriers do not define benefits or undertake the parity analysis on a code-by-code or provider-by-provider basis. This level of granularity would be incredibly burdensome for plans and carriers to document and for regulators to review. The proposed Appendix II Tool thus introduces confusion by failing to indicate the benefits that are being compared.

Thank you for the opportunity to comment on the Proposed Updates to the 2020 MHPAEA Self-Compliance Tools. Please feel free to contact me at greenberg@abhw.org or (202) 449-7660 with any questions.

Sincerely,

Pamela Greenberg, MPP
President and CEO