ABHW
Advancing Health Care Policy
for Mental Health and Addiction

August 22, 2022

Andres Garcia
Internal Revenue Service
Room 6526
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Comment Request for Notice of Medical Necessity Criteria Under the Mental Health Parity and Addiction Equity Act of 2008

Dear Mr. Garcia,

On behalf of the Association for Behavioral Health and Wellness (ABHW), we appreciate the opportunity to provide comments concerning the Notice of Medical Necessity Criteria under the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 on the burden associated with the information collection request (ICR) related to the comparative analysis that is required to meet MHPAEA related requirements.

ABHW assumes that the ICRs the Internal Revenue Service (IRS) is referring to are the ICRs released by the Department of Labor (DOL) and the U.S. Department of Health and Human Services (HHS) in the fall of 2021. At the time, we submitted the comments below to DOL and HHS, and as they remain pertinent, we are resubmitting them today for your consideration.

1. ***Protecting confidential information.***

We thanked DOL and HHS for clarifying that the collection will not include Personally Identifiable Information or Proprietary and Confidential Information. We requested that the agencies validate these parts of their ICRs. If correct, we suggested instituting appropriate safeguards to protect against the inadvertent collection of Personally Identifiable Information or Proprietary or Confidential Information.

2. Clarify the discrepancies between DOL and HHS ICRs.

When MHPAEA was first enacted in 2008, only two requirements and related disclosure obligations were identified by Congress: (1) Claims Denial Disclosure and (2) Medical Necessity Disclosure. The initial ICR for 1210-0138 promulgated in 2010 reflects this intent and established those information collections. However, these new ICRs by DOL and HHS created confusion. First and foremost, we request clarification regarding the discrepancy between the information collections. DOL modified one ICR and added one new ICR,[1] while HHS added five new ICRs.[2] The CAA does not appear to support such a wide variance in the total number of information collections between the two agencies. Aligning the information collections between the agencies would help clarify the scope of the anticipated information collections and establish uniformity amongst the agencies.

Second, FAQ 45 published by CMS and attached to each of the five information collections in 0938-1393 includes a disclaimer stating that its contents do not have the force or effect of law.[3] However, DOL's FAQ 45 version does not include this disclaimer.[4] This introduces ambiguity about express or implied requirements derived from the FAQs, the relation to the proposed information collection, and the cost and burden estimates associated with the collection. We request that this ambiguity be clarified and the disclaimers be aligned between the agencies. To the extent other supporting documents do not impose information collection obligations on third parties, such as the Compliance Assistance Guide, we ask that similar disclaimers be attached.

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[1] Office of Information and Regulatory Affairs, Information Collection List, https://www.reginfo.gov/public/do/PRAICList?ref_nbr=202103-1210-004, last visited June 18, 2021.
[2] Office of Information and Regulatory Affairs, Information Collection List, https://www.reginfo.gov/public/do/PRAICList?ref_nbr=202104-0938-001, last visited June 18, 2021.
[3] CCIIO: FAQs About Mental Health and Substance Use Disorder Parity Implications and the Consolidated Appropriations Act, 2021 Part 45, pg. 1. https://www.reginfo.gov/public/do/DownloadDocument?objectID=110493001, last visited June 18, 2021.
[4] DOL: FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf, last visited June 18, 2021.

3. ***Proactively promote uniformity between state and federal requirements.***

Given the significant costs and burdens associated with evaluating MHPAEA compliance, our members support efforts to establish consistency and uniformity regarding MHPAEA compliance examinations. Disparate approaches taken to date by different federal and state regulators confuse the regulatory landscape and impact the ability to effectively scale compliance initiatives. The public would be well served by establishing a uniform information collection program amongst federal regulators that, in turn, is adopted at the state level.

Since the enactment of MHPAEA, DOL, HHS, the National Association of Insurance Commissioners (NAIC), and various states have all codified different requirements, proposed different suggestions, or developed different methodologies for performing analyses imposing significant operational costs on plans and issuers. Our hope is to collaborate with the agencies to develop a uniform MHPAEA examination process to address disparate approaches to collecting information, performing an analysis, and determining compliance. To that end, we strongly urged the agencies to promulgate regulations to codify the Consolidated Appropriations Act's (CAA's) requirements, provide clear rules, and promote uniformity for the examination process.

4. ***Rules for MHPAEA examinations should be established using the normal notice and comment process.***

To the extent that the ICRs attempt to create procedural rules for examinations established pursuant to the CAA, we question the appropriateness of using the ICR process for that purpose. Since the CAA clearly requires a new examination process, agencies should follow the normal notice and comment process for codifying rules of procedure under the code of federal regulations.

Ultimately, issuers and plans are responsible for achieving compliance with mental health parity and proving the same by documenting the analyses that demonstrate compliance. In attempting to meet these requirements, issuers and plans continue to strive to understand expectations with respect to parity compliance, most of which are centered around nonquantitative treatment limitations (NQTLs). Accordingly, we appreciate that the CAA affords parity

stakeholders an opportunity for further clarifications by requiring that the DOL, HHS, and Department of Treasury (collectively "the tri-Departments") promulgate regulations on NQTL analyses and compliance. Under such rulemaking efforts, we urge the tri-Departments to consider the following actions to comply with the CAA mandate and help issuers and plans better understand the regulators' expectations with respect to NQTLs:

- **Define a set of standard or "core" NQTLs that issuers and plans must analyze and document and provide a best-practice example analysis for each**. It is not possible for plans and issuers to develop 5-step analyses for "all" NQTLs proactively (i.e., in advance of a specific request and available on demand) without guidance to establish which NQTLs must be analyzed and documented. The current definition of an NQTL can conceivably involve almost any aspect of plan design and operations. The final rules define "Treatment limitations" to be "limits on the scope or duration of treatment" and define NQTLs somewhat circularly to be treatment limits that "otherwise limit the scope or duration of benefits for treatment under a plan or coverage."[5] However, no guidance has been provided to define or provide any boundaries to what can constitute a "limit on the scope or duration of treatment," and the NQTL types that regulators have focused on for enforcement have varied over time.

ABHW members appreciate the clarity and specificity of FAQ 45, Q8, in which the tri-Departments identify the four specific NQTLs they intend to focus on for the near future. In the long term, ABHW reiterates its request for regulators to define a set of NQTLs on which issuers and plans are expected to have documented analyses prepared for submission within a very short timeframe upon request.[6] Defining such a list will facilitate plans' responsiveness to regulator requests for information relating to the core NQTLs, particularly upon short notice, and would in no way prevent regulators

[5] "Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition." 29 CFR § 2590.712(a), 45 CFR § 146.136(a), and 26 CFR § 54.9812-1(a).

[6] *See* Implications of parity documentation requirements and examination processes and standards under CAA, ABHW, March 3, 2021.

from requesting documentation on other non-core NQTLs should a complaint or specific compliance concern arise.

- **Provide a clear, comprehensive example of an NQTL analysis for each NQTL on the core list.** The CAA requirement to document the plan's compliance analysis is new.[7] Moreover, the 5-step framework mandated by the CAA differs materially from existing guidance in the DOL Self Compliance Guide,[8] and guidance in FAQ 45 on the documentation requirements of the CAA expands substantially on the substantive compliance considerations set forth in previous guidance. No example of a complete NQTL analysis is available that the tri-Departments would consider complying with the CAA requirements. When ABHW met with the tri-Departments, the regulators informed us that, to date, they had not seen what they would consider a model NQTL analysis. Significant ambiguity remains about the breadth and depth of details and supporting documentation required for each component of the CAA's five-step analyses. Model NQTL analyses would help clarify expectations, promote uniformity, and ultimately improve parity compliance. Accordingly, for each NQTL on the core list, we believe the tri-Departments should provide at least one complete example of a compliant analysis. This would help clarify expectations, promote uniformity, and improve parity compliance.

- **Define a standard by which NQTL analyses are evaluated and a process by which examinations are pursued.** In FAQ 45, Q2 and Q4, the tri-Departments address the information plans and issuers must make available to regulators and the types of documents issuers and plans should be prepared to submit in support of a given NQTL analysis. In practice, however, ABHW's members have found that the back and forth with the regulators during examinations can be confusing due to the lack of a defined process for NQTL documentation requests. As such, we hope to work with regulators to outline a process to better MHPAEA compliance.

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[7] *See* attached Appendix A: Timeline of Federal Guidance Regarding a Step-Wise Approach to MHPAEA Compliance.
[8] See Implications of parity documentation requirements and examination processes and standards under CAA, ABHW, March 3, 2021, p. 4-5.

5. The cost burden estimate proposed in the ICRs is not comprehensive.

In terms of cost and burden estimates, the ICRs include many unrealistic assumptions that flow from the conclusion that plans and issuers have operationalized what the agencies call "best practices." "Best practices" appear to correlate with the DOL's suggested approach under its Compliance Assistance Guide, which, for the first time, is now attached as a supporting document to ICR 1210-0138. This document is not attached to ICR 0938-1393. This disconnect introduces yet another ambiguity.

Until the enactment of the CAA, plans and issuers were able to perform an analysis in any reasonable manner so long as it was consistent with MHPAEA's final regulation. HHS, the NAIC, and state regulators, likewise, were free to propose and, in fact, actively used varying means for performing a MHPAEA compliance analysis. As a result, many regulators, plans, and issuers will have to revamp their compliance initiatives to align with the CAA's prescriptive approach.

Both ICR estimates assume two individuals, an operations manager, and a business operations specialist can complete these analyses in less than 80 hours. In the case of HHS, it presumes this timeframe is reasonable to conduct an analysis for all products, keep records, and prepare documentation for HHS or state authorities.[9] While DOL's analysis is more practical in that it attributes its estimate to the plan level ("an average of 20 hours per plan to make any updates, 16 hours of a business operations specialist and four hours of a general or operations manager."), our members do not believe these estimates to be realistic.[10] Furthermore, plans and issuers are already assuming significant costs attempting to implement CAA's requirements without the benefit of proposed or final regulations, given the CAA provided only 45 days to come into compliance.

While we disagree on the accuracy of burden estimates in the ICRs, we support the aim of this request for comment. This information collection exercise helps "assess the impact of its information collection requirements and

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[9] HHS states: "We estimate that in the first year, for each issuer, a business operations specialist will need 72 hours (at an hourly labor cost of $77.14) and a senior manager will need 8 hours (at an hourly labor cost of $118.30) on average to document the analyses for all products, keep records, and prepare the documentation for submission to HHS or state authorities upon request." CMS-10773 NQTL Analysis Review Supporting Statement - Emergency.docx at 7.

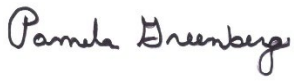
[10] *See* OMB Control Number 1210-0138 MHPAEA Supporting Statement at 13.

minimize the reporting burden on the public and helps the public understand the Department's information collection requirements and provide the requested data in the desired format."[11]

6. Conclusion.

We appreciate the opportunity to comment on this request and look forward to continuing to work with the IRS. Please do not hesitate to contact me at greenberg@abhw.org with any questions or concerns.

Sincerely,



Pamela Greenberg, MPP
President and CEO

[11] See Federal Register / Vol. 86, No. 76 / Thursday, April 22, 2021 / Notices 21349. 11