NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

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Submitted electronically at: e-ohpsca-mhpaea-disclosure@dol.gov

RE: Solicitation of Comments on Mental Health and Substance Use Disorder Parity Disclosure Request, ACA FAQ #38, Centers for Medicare & Medicaid Form CMS-10307

Dear Ladies and Gentlemen

The National Coordinating Committee for Multiemployer Plans (the "NCCMP") appreciates the opportunity to respond to the Draft Model Mental Health and Substance Use Disorder Parity Disclosure Request (the "Draft Model Form") published by the Departments of Labor, Health and Human Services, and Treasury (the "Departments") in FAQ 38 (June 16, 2017).

The NCCMP is the only national organization devoted exclusively to protecting the interests of the job creating employers of America and the more than 20 million active and retired American workers and their families who rely on multiemployer retirement and welfare plans. The NCCMP's purpose is to assure an environment in which multiemployer plans can continue their vital role for employers in providing benefits to working men and women.

The NCCMP is a non-partisan, nonprofit, tax-exempt social welfare organization established under Internal Revenue Code (the "IRC" or the "Code") Section 501(c)(4), with members, plans and contributing employers in every major segment of the multiemployer universe. Those segments include the airline, agriculture, building and construction, bakery and confectionery, entertainment, health care, hospitality, longshore, manufacturing, mining, office employee, retail food, service, steel, and trucking industries. Multiemployer plans are jointly trusteed by management and employee trustees.

Summary of Comments

The Departments are soliciting comments on a Draft Model Form that participants, dependents, or their authorized representatives could use to request information from their health plan regarding non-quantitative treatment limitations (NQTLs) that may affect their mental health or substance use disorder benefits (MH/SUD), or to obtain documentation after an adverse benefit

determination involving MH/SUD benefits to support an appeal. The Draft Model Form proposed by the Departments is overly complicated for both the participants and the plan administrator, and should be simplified in order to provide clear and accurate information to the participant about their plan benefits.

Background

The Mental Health Parity and Addiction Equity Act (MHPAEA) is an important step toward assuring that individuals receive mental health and substance use disorder benefits that are not more restrictive than those for medical/surgical benefits. The MHPAEA statute and regulations provide that plan administrators must make certain information available to plan participants, beneficiaries, or contracting providers, upon request:[1]

1. The criteria for medical necessity determinations with respect to MH or SUD benefits;

2. The reason for any denial under a group health plan of reimbursement or payment for services with respect to MH or SUD benefits. The regulation provides that plans subject to ERISA, which includes multiemployer plans, must provide the reason for the claim denial in a form and manner consistent with the requirements of the ERISA claims and appeals regulations at 29 CFR 2560.503-1; and

3. Documents with information on medical necessity criteria for both medical/surgical benefits and MH and SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a NQTL with respect to benefits under the plan.

FAQs implementing the MHPAEA issued in 2016 elaborate on the documents that must be provided to authorized representatives of a plan participant.[2] The FAQ provides that the plan must provide the following documents upon request from an authorized representative:

1. Summary Plan Description (SPD);

2. The specific plan language regarding the imposition of the NQTL (such as a preauthorization requirement);

3. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the NQTL will apply to this particular MH/SUD benefit;

4. Information regarding the application of the NQTL to any medical/surgical benefits within the benefit classification at issue;

[1] IRC 9812(a); 26 CFR 54.9812-1(d).
[2] FAQ 31, Q9.

5. The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the NQTL will apply to any medical/surgical benefits within the benefit classification at issue; and

6. Any analyses performed by the plan as to how the NQTL complies with MHPAEA.

The Draft Model Form is designed as a tool to help participants request information relating to MH/SUD benefits, either generally or in connection with a claim or appeal, and includes a request for the following information:

1. The specific plan language regarding the limitation, and identification of all of the medical/surgical and MH/SUD benefits to which it applies in the relevant benefit classification;

2. Identify the factors used in the development of the limitation and the evidentiary standards used to evaluate the factors;

3. Identify the methods and analysis used in the development of the limitation; and

4. Provide any evidence to establish that the limitation is applied no more stringently, as written and in operation, to MH/SUD benefits than to medical and surgical benefits.

Comments

The NCCMP provides the following comments to the Draft Model Form.

1. The Draft Model Form should not address claims and denials of benefits because it could either duplicate or supplant the ERISA claims and appeals process.

The MHPAEA regulations state that the plan should provide information on claims denials through the procedural requirements of the ERISA claims and appeals rules. The Draft Model Form should not be used to request information on a claim or denial because it could create a parallel appeals process that could impair the ERISA process and result in confusion for participants and plan administrators. The process of requesting and responding to information using the Form could either duplicate or supplant the ERISA claims and appeals process.

The MHPAEA statute and regulations clearly require the plan administrator to respond to a denial of benefits with respect to MH or SUD benefits with information relevant to the claim, including information on medical necessity criteria, the specific plan provisions relied upon, and other relevant plan information. The Draft Model Form does not require these documents to be provided to the participant. Consequently, it would not be useful in the appeals process.

The Draft Model Form requires participants to check the reason for their request of information related to claim denials. The reasons the participant would check are confusing, and appear to be more of a complaint than a request for information. The Form indicates it is solely a request for information. However, a participant may consider this a submission of an appeal. If the plan does not treat this as an appeal, the claims and appeals guidelines (including deadlines for filing appeals) may be missed. Alternatively, if the plan treats it as an appeal, the participant may not yet wish to appeal and may only want information. Further, this raises potential legal issues for the plan if the claims and appeals process is not properly followed.

In addition, some of the reasons listed on the Form would not require all of the documents requested to be provided, in order to resolve the "complaint". For example, if a claim is denied as not medically necessary, or experimental/investigational, does the participant need "…the factors used in the development of the limitation and the evidentiary standards used to evaluate the factors", or "…the methods and analysis used in the development of the limitation…?"

2. The Draft Model Form combines a variety of rules concerning requesting information into one form in a manner that will be confusing to plan participants and administrators.

The Draft Model Form combines a variety of requests into one form, making it confusing for both plan participants and plan administrators, resulting in a less useful document. It would be more clear to have one form that requests general information, and a second designed to be used by an authorized representative to request the more specific MHPAEA compliance information. As noted above, a form should not be used for the claims and appeals process.

3. The request to provide evidence supporting the application of NQTL in the Draft Model Form should be separated from the request for general information.

As contemplated by ACA FAQ #31, requests of this type are more likely to come from health care providers acting as authorized representatives, rather than plan participants. The request to provide evidence supporting the application of NQTLs is designed to address MHPAEA compliance, not to provide information about coverage under the plan. Placing these items on a form also designed for a participant to request general information could result in unnecessary confusion. While it makes sense for a participant to have such information if they believe a plan is not in compliance with the MHPAEA, it does not make sense for every denial of MH or SUD benefits.

Determining compliance under MHPAEA is extremely complex, and the typical multiemployer plan relies on service providers, counsel, and consultants with specialized knowledge to ensure that plans are compliant.

4. The Draft Model Form should direct that the authorized representative provide written documentation of his or her status as an authorized representative.

If used by a provider acting as an authorized representative, the Draft Model Form should require documentation from the individual that meets the health plan's requirements for verification, as well as any applicable state or federal laws, such as the HIPAA privacy requirements. Multiemployer health plans are often inundated with requests from non-contracted providers for information on the plan's benefits and coverage terms. The plan should not have to respond to the request without the appropriate verification that the requestor is the participant's authorized representative.

Request for Additional Guidance

We appreciate the efforts the Departments have made to provide guidance with respect to the difficult compliance issued raised under the MHPAEA. In particular, the guidance "Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance" was extremely helpful in identifying NQTLs that should be examined by plan administrators.

However, plan administrators need additional help to comply with the complicated structure of the MHPAEA. For example, guidance should address how to evaluate NQTLs when MH and SUD benefits are administered separately (by specialized behavioral health care service providers) from medical and surgical benefits. In addition, guidance is needed, and in fact required under the 21st Century Cures Act, to help plan administrators comply with the NQTL requirements and information disclosure requirements. Finally, plan administrators would welcome sample analyses demonstrating how to design and implement appropriate NQTLs.

Conclusion

Multiemployer health plans continue to experience significant increases in costs in the area of mental health and substance use disorder treatment for a variety of reasons, including the opioid epidemic, the parity requirements of MHPAEA, and the group health plan mandates in the Affordable Care Act (e.g., covering dependents through age 26). The NCCMP supports the goals of the mental health parity law and would appreciate guidance on how to confront the cost challenges while complying with the MHPAEA.

We look forward to working with the Departments on this important issue.

Respectfully submitted,

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